CPSO

Meeting of Council

March 4 & 5, 2021

NOTICE

OF

MEETING OF COUNCIL

A virtual meeting of the College of Physicians and Surgeons of Ontario (CPSO) will take place on Thursday, March 4 and Friday, March 5, 2021. Due to the current pandemic situation, an in-person meeting at a physical location will not be held.

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

The meeting will convene at 9:00 am on Thursday, March 4, 2021.

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

February 16, 2021

Council Meeting Agenda
March 4-5, 2021

CPSO

THURSDAY, MARCH 4, 2021

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	8:30am	INFORMAL NETWORKING		
1	9:00am	**Call to Order and Welcoming Remarks** (J. Plante)	Discussion	N/A
2	9:20am	**Consent Agenda** (J. Plante) **2.1 Approve Council meeting agenda** **2.2 Approve minutes from Council held December 3-4, 2020** **2.3 Approve minutes of Special Meeting of Council, February 9, 2021** **2.4 Items for information:** • Executive Committee Report • Discipline Committee Cases • Government Relations Report • Finance Report • Policy Report • Medical Learners Report • Revised Operational Policies	Approval (with motion)	 1 2 22 25
3	9:30am	**Status Update on Council Meeting Decisions** • Provide an update on the implementation status of decisions from the last Council meeting	Information	74
4	9:35am	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
5	10:25am	**President's Report** (J. Plante)	Discussion	N/A
*	10:40am	NUTRITION BREAK		
6	11:00am	**Medical Council of Canada Qualifying Examination Part II** (S. Tulipano) • Review and consider the proposed policy regarding the Medical Council of Canada Qualifying Examination Part II for final approval	Decision (with motion)	89

Item	Time	Topic and Objective(s)	Purpose	Page No.
7	11:30am	**COUNCIL AWARD PRESENTATION** (M. Bell) Celebrate the achievements of Dr. Mihaela Nicula, Toronto		
8	11:45am	**Motion to Go in Camera** (J. Plante)	Decision (with motion)	117
*	11:45am	LUNCH		
*	12:45pm	IN CAMERA		
9	1:45pm	**Discipline Committee Enhancements** (D. Wright) • Consider proposed enhancements to the Discipline Committee for approval	Decision (with motion)	118
10	2:15pm	**Member Topics** (J. Plante) • Role of the Executive Committee	Discussion	130
*	2:30pm	NUTRITION BREAK		
11	2:50pm	**Alternative Pathways to Registration** (S. Tulipano) • Consider the revised policy for final approval	Decision (with motion)	134
12	3:20pm	**Delegation of Controlled Acts** (S. Reid) • Consider the revised policy for final approval	Decision (with motion)	148
13	3:50pm	**Adjournment Day 1** (J. Plante)	N/A	N/A

FRIDAY, MARCH 5, 2021

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	8:30am	**INFORMAL NETWORKING**		
14	9:00am	**Call to Order** (J. Plante) • Participate in roll call and declare any conflicts of interest	Discussion	**N/A**
15	9:10am	**Guest Presentation: Anti-Indigenous Racism** (Dr. Lisa Richardson) • Learn some foundational concepts about Anti-Indigenous racism, cultural safety and humility		
*	10:40am	**NUTRITION BREAK**		
16	11:00am	**Council Profile** (B. Copps) • Consider the proposed Council Profile for approval	Decision (with motion)	**174**
17	11:30am	**College Performance Measurement Framework** (B. Copps, L. Cabanas, S. Klejman) • Consider the CPSO's draft College Performance Measurement Framework report for approval	Decision (with motion)	**184**
*	12:30pm	**LUNCH**		
18	1:30pm	**Methadone Maintenance Treatment** (C. Roxborough) • Consider a proposal to rescind the methadone policy and program standards and guidelines for approval	Decision (with motion)	**255**
*	2:00pm	**NUTRITION BREAK**		
19	2:20pm	**Governance Committee Report** (B. Copps)		
		19.1 Governance Committee Vacancy (L. Rinke-Vanderwoude) • Consider a proposed process for appointing members to the Governance Committee for approval	Decision (with motion)	**264**
		19.2 Quality Assurance Committee Renewal/Appointments (D. McLaren) • Consider the recommendations for QAC member appointments	Decision (with motion)	**269**
		19.3 Committee Appointments	Information	**N/A**

Item	Time	Topic and Objective(s)	Purpose	Page No.
20	2:50pm	**Adjournment Day 2** (J. Plante) • Reminder that the next meeting is scheduled for June 17-18, 2021	N/A	N/A
*	2:55pm	**Meeting Reflection Session** (J. Plante) • Share observations about the effectiveness of the meeting and engagement of Council members	Discussion	

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	March 4 & 5, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for March 4 & 5, 2021
- The minutes from Council held December 3-4, 2020
- The minutes of a Special Meeting of Council held February 9, 2021

Items for information:

- Executive Committee Report
- Discipline Committee Report
- Government Relations Report
- Finance Report
- Policy Report
- Medical Learners Report
- Revised Operational Policies

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
December 3 and 4, 2020

December 3, 2020

Attendees:

Dr. Brenda Copps (President)
Dr. Philip Berger
Mr. Shahid Chaudhry
Mr. Jose Cordeiro
Ms. Joan Fisk
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms. Nadia Joseph
Mr. Mehdi Kanji
Ms. Catherine Kerr
Dr. Haidar Mahmoud
Mr. Paul Malette
Dr. Lydia Miljan, Ph.D.
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Peeter Poldre
Dr. Ian Preyra
Dr. John Rapin
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Robert A. Smith
Dr. Andrew Turner
Dr. Janet van Vlymen
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Karen Saperson

1. Call to Order and Welcoming Remarks

Dr. Brenda Copps, Chair, called the meeting to order at 9:00am. and welcomed members of Council and guests to the virtual Council meeting. B. Copps acknowledged the efforts that Ontario's physicians have made in collaboration with system stakeholders to provide patients with care during the COVID-19 Pandemic. B. Copps then gave a traditional land acknowledgement statement as a demonstration of recognition and respect for Indigenous peoples. She reminded attendees of the strategic plan, and the College's mission.

2. Consent Agenda

01-C-12-2020

It is moved by S. Chaudry, and seconded by P. Safieh, that:

The Council approves the items outlined in the consent agenda, which include in their entirety:

- Meeting agenda for Dec 3-4, 2020
- Meeting minutes of Council held on September 10-11, 2020
- For information items:
  - Discipline Committee Report
  - Executive Committee Report
  - Government Relations Report
  - Policy Report
  - Annual Committee Reports

CARRIED

3. CEO/Registrar's Report

Dr. Nancy Whitmore, CEO/Registrar, presented her report on the progress being made on key CPSO initiatives. She shared updates on the CPSO's Quality Improvement program, engagement activities with the public and profession, system collaboration, etc. She also highlighted several improvement updates. A copy of N. Whitmore's presentation is attached as Appendix "A" to these minutes.

4. President's Report

Dr. Copps highlighted the recent launch of the Continuity of Care Guide for Patients and Caregivers (the "Guide"), that was co-designed by CPSO staff and members of the Citizen Advisory Group. CPSO's and the Citizen Advisory Group's goal is to make the Guide accessible and to distribute it as widely as possible.

5. Policy Review Kick-off – Professional Obligations and Human Rights, Medical Assistance in Dying and Planning for and Providing Quality End-of-Life Care

Council was provided with an overview of the current policies, and the key issues that are anticipated to be the focus of each review. At today's meeting, Council members were divided into three breakout rooms, where questions were discussed aimed at engaging Council in a preliminary discussion on these issues. The College plans to undertake significant consultation and engagement activities as part of the early phases of the policy review process.

6. Physician Assistant Regulation

B. Copps introduced Sean Court (Assistant Deputy Minister of the Strategic Policy, Planning and French Language Services Division at the Ontario Ministry of Health) and Allison Henry (Director of the Health Workforce Regulatory Oversight Branch at the Ontario Ministry of Health). S. Court announced that the government will be proceeding with the regulation of Physician Assistants under the CPSO. The regulation of Physician Assistants under the CPSO will provide a mechanism to hold Physician Assistants to consistent education and training requirements and ongoing quality assurance. It will also enable patients who have concerns about the care or conduct of a Physician Assistant to report those concerns to the College.

7. Budget 2021

02-C-12-2020
It is moved by R. Smith and seconded by J. Rosenblum, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 139:

By-law No. 139

(1) Paragraph 20(3) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted, effective January 1, 2021:

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

(a) for attendance at, and preparation for, meetings to transact College business, $522 per half day, and

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

CARRIED

03-C-12-2020

It is moved by P. Giroux, and seconded by J. Fisk, that:

Council approve the "Budget for 2021" (a copy of which forms Appendix "B" to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2021.

CARRIED

8. Member Topics

No member topics were received.

9. eLearning Program Overview

04-C-12-2020

It is moved by P. Hendry, and seconded by P. Malette, that:

The Council approves the Overview of the eLearning Program, a copy of which forms Appendix "C" to the minutes of this meeting, as the basis for the education program to be undertaken by prospective physician Councillors, elected and appointed Councillors and committee members.

CARRIED

10. Declaration of Adherence

05-C-12-2020

It is moved by I. Preyra, and seconded by and seconded by M. Kanji, that:

The Council approves the revised Declaration of Adherence, a copy of which forms Appendix "D" to the minutes of this meeting, and the revised Council and Committee Code of Conduct, a copy of which forms Appendix "E" to the minutes of this meeting.

CARRIED

11. Registration Pathways

06-C-12-2020

It is moved by L. Miljan, and seconded by E. Samson that:

The College engage in the consultation process in respect of the draft Alternative Pathways to Registration policy (a copy of which forms Appendix "F" and "G" to the minutes of this meeting).

12. COUNCIL AWARD PRESENTATION

Dr. Philip Berger, Council Member, presented the Council Award to Dr. Najma Ahmed of

Toronto.

13. Motion to Go In Camera

07-C-12-2020

It is moved by I. Preyra, and seconded by D. Rouselle, that:

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

CARRIED

Adjournment Day 1

B. Copps adjourned the meeting at 4:30 pm.

December 4, 2020

Attendees:

Dr. Brenda Copps (President)
Dr. Philip Berger
Mr. Shahid Chaudhry
Mr. Jose Cordeiro
Ms. Joan Fisk
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms. Nadia Joseph
Mr. Mehdi Kanji
Ms. Catherine Kerr
Dr. Haidar Mahmoud
Mr. Paul Malette
Dr. Lydia Miljan, PhD
Mr. Rob Payne
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Peeter Poldre
Dr. Ian Preyra
Dr. John Rapin
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Robert A. Smith
Dr. Andrew Turner
Dr. Janet van Vlymen
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Karen Saperson

Regrets: Dr. Elizabeth Samson

15. Call to Order

Dr. Brenda Copps called the meeting to order at 9:00am and welcomed members of Council and guests to the second day of the virtual Council meeting.

16. Guest Presentation: Diversity, Equity and Inclusion

Dr. Javeed Sukhera is an Associate Professor in the Division of Child and Adolescent Psychiatry and is cross appointed to the Department of Paediatrics, and a Scientist at the Centre for Education Research and Innovation at Western University. His interdisciplinary research program explores novel approaches to stigma reduction and implicit bias recognition and management in health professionals. At today's meeting, Dr. Sukhera engaged Council members in a stimulating dialogue about Equity, Diversity, Inclusion, and explained how these important concepts could apply to CPSO as the regulator of physicians in the province.

17. Skills and Diversity Matrix

L. Cabanas provided feedback on the skills and diversity matrix that has been developed to enhance diversity on Council and Committees. Council members were generally supportive of the proposed matrix and provided suggestions to further refine it, including consulting with the Citizen Advisory Group to gather feedback on the diversity elements.

18. Key Performance Indicators for 2021

Dr. Whitmore described the proposed performance areas for targeting in 2021, and their relationship to the College's Strategic Plan.

08-C-12-2020

It is moved by P. Hendry and seconded by R. Payne, that:

The Council adopts the following 2021 Key Performance Indicators (KPIs) to

measure and report progress on the Strategic Plan:

1. Target of 735 active physicians assessed who are:
   (a) turning 70; or
   (b) are 71 or older and have not had an assessment in the past five years
2. Target of 325 completed facility assessments
3. Respond to 90% of calls to Public Advisory Services within one business day
4. Target of 3000 Practice Improvement Plans submitted through Quality
5. Improvement Program
6. Target of 20 hospitals collaborating in Quality Improvement Partnership
7. Compliance with Ontario Government's new College Performance Measurement Framework
8. Staff to achieve target of 395 Continuous Improvements
9. Meeting Solis and Vault project timelines
10. Monitor and continue to achieve 2-day benchmark for contacting complainants
11. Target to complete all complaint files within 150 days
12. Target of one year or 365 days to complete a file from referral to discipline to the start of hearing date.

CARRIED

19. Complementary and Alternative Medicine Policy

09-C-12-2020

It is moved by J. Plante, and seconded by P. Safieh, that:

The College engage in the consultation process in respect of the draft policy "Complementary and Alternative Medicine" (a copy of which forms Appendix "H" to the minutes of this meeting).

CARRIED

20. Council Elections

1. District Election Dates for 2021

10-C-12-2020

It is moved by M. Khanji, and seconded by S. Reid, that:

the Council approves the 2021 district election date set out below:

Districts 6, 7, 8 and 9: June 22, 2021

CARRIED

2. Eligibility Criteria

11-C-12-2020

It is moved by P. Poldre, and seconded by J. Rosenblum, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 140:

By-law No. 140

(1) Subsections 13(1)(f), (g), (h) and (i) of the General By-law are revoked and substituted with the following:

Eligibility for Election

13. (1) A member is eligible for election to the council in an electoral district if, on the date of the election, …

(f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario or the Ontario Specialists Association;

(g) the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;

(h) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis);

(i) council has not disqualified the member from council or from one or more committees during the five years before the election date;

(j) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees;

(k) the member has completed and filed with the registrar a Conflict of Interest form by the deadline set by the registrar; and

(l) prior to the member submitting a nomination form and nomination statement for the election, the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

(2) Subsection 22(1)(i) of the General By-law is revoked and substituted with the following:

Disqualification of Elected Members

22. (1) An elected member is disqualified from sitting on the council if the member, …

(i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;

(3) Subsections 24(3)(f), (g) and (h) of the General By-law are revoked and substituted with the following:

Academic Advisory Committee

24. (3) A member is eligible for appointment to the academic advisory committee if, on the date of the appointment, …

(f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;

(g) the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if appointed to the Academic Advisory Committee, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;

(h) the member is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(a);

(i) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time

basis);

(j) council has not disqualified the member from council or from one or more committees during the five years before the election date;

(k) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees; and

(l) the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members.

(4) Subsection 27(1)(i) of the General By-law is revoked and substituted with the following:

Disqualification of Selected Councillors

27. (1) A person selected as a councillor is disqualified from sitting on the council if the member, …

(i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association; or

CARRIED

3. Nominations Review Process

As CPSO continues to review and modernize its governance processes, policies and resources, Council was asked to consider opportunities to move towards a competency-based approach to Council elections. Based on feedback from Council members, staff will further refine the proposed model in consultation with the governance Committee and external advisors.

21. Advertising – Revised Policy for Final Approval

12-C-12-2020

It is moved by L. Miljan, and seconded by A. Turner, that:

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

CARRIED

22. Committee Mentoring Program

13-C-12-2020

It is moved by M. Kanji, and seconded by P. Malette, that:

The Council approves the Committee Mentoring Guide, a copy of which forms Appendix "J" to the minutes of this meeting.

CARRIED

23. Governance Committee Report

1. Governance Committee Election

14-C-12-2020

It is moved by R. Smith, and seconded by Janet van Vlymen, that:

the Council appoints the following people to the 2020-2021 Governance Committee for the term indicated below:

Dr. Brenda Copps, Chair	1 year
Dr. Judith Plante, Vice Chair	1 year
Dr. Janet van Vlymen	1 year
Dr. Ian Preyra	1 year
Mr. Mehdi Kanji - Public Member of Council	1 year
Mr. Pierre Giroux -Public Member of Council	1 year

CARRIED

2. Request for Exceptional Circumstances

15-C-12-2020

It is moved by I. Preyra, and seconded by J. Rosenblum, that:

Council approves the application of the exceptional circumstances clause in Section 37 (8) of the General By-Law in respect to Dr. Patrick Safieh, when his appointment to the Quality Assurance Committee expires at the Annual General Meeting of Council in December 2020.

CARRIED

3. 2021-2022 Chair Appointments

16-C-12-2020

It is moved by R. Smith, and seconded by P. Safieh, that:

The Council appoints the following committee members as Chairs of the following committees for the terms set out below as of the close of the Annual General Meeting of Council in December 2020, which terms supersede the terms previously approved by Council in September 2020 for Dr. Anil Chopra, Dr. Gillian Oliver and Dr. Janet van Vlymen:

Discipline Committee:
Mr. David Wright, Chair, 3 years

Inquiries, Complaints and Reports Committee:
Dr. Anil Chopra, Chair, 1 year

Premises Inspection Committee:
Dr. Gillian Oliver, Chair, 1 year

Quality Assurance Committee:
Dr. Janet van Vlymen, Chair, 1 year

CARRIED

4. Appointment of Vice Chairs/ICRC Specialty Panel Vice Chairs

17-C-12-2020

It is moved by R. Smith and seconded by P. Hendry, that:

The Council appoints the following committee members as Vice Chairs/ICRC Specialty Panel Vice Chairs of the following committees for the following terms, as of the close of the Annual General Meeting of Council in December 2020:

Discipline Committee:
Dr. James Watters, Vice Chair, 2 years

Executive Committee:
Dr. Janet van Vlymen, Vice Chair, 1 year

Finance and Audit Committee:
Dr. Rob Gratton, Vice Chair, 2 years

Fitness to Practise Committee:
Dr. James Watters, Vice Chair, 2 years

Governance Committee:
Dr. Judith Plante, Vice Chair, 1 year

Inquiries, Complaints and Reports Committee:
Dr. Brian Burke, Vice Chair, ICRC, 1 year
Dr. Dori Seccareccia, Specialty Panel Vice Chair, Settlement, 2 years
Dr. Lydia Miljan, PhD, Specialty Panel Vice Chair, General, 2 years
Dr. Elaine Herer, Specialty Panel Vice Chair, Obstetrical, 2 years
Dr. Mary Jean Duncan, Specialty Panel Vice Chair, Surgical, 2 years
Dr. Val Rachlis, Specialty Panel Vice Chair, Family Practise, 2 years
Dr. Mary Bell, Specialty Panel Vice Chair, Internal Medicine, 2 years
Dr. Daniel Greben, Specialty Panel Vice Chair, Mental Health & HIP, 2 years

Premises Inspection Committee:
Dr. James Watson, Vice Chair, 1 year

Quality Assurance Committee:
Dr. Sarah Reid, Vice Chair, 1 year

Registration Committee:
Dr. Bob Byrick, Acting Vice Chair, 1 year

CARRIED

5. 2020-2021 Committee Membership Appointments

18-C-12-2020

It is moved by P. Hendry and seconded by S. Reid, that:

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

PHYSICIAN COUNCIL MEMBERS:	
Dr. Glen Bandiera	3 years
Dr. Michael Franklyn	3 years
Dr. Deborah Hellyer	3 years
Dr. Paul Hendry	3 years
Dr. Roy Kirkpatrick	3 years
Dr. Camille Lemieux	3 years

Dr. Ian Preyra	3 years
Dr. John Rapin	3 years
Dr. Deborah Robertson	3 years
Dr. Andrew Turner	3 years
PUBLIC MEMBERS OF COUNCIL:	
Mr. Jose Cordeiro	1 year
Mr. Pierre Giroux	2 years
Mr. Mehdi Kanji	1 year
Mr. Paul Malette	1 year
Mr. Rob Payne	1 year
Mr. Peter Pielsticker	2 years
Ms. Linda Robbins	1 year
Ms. Shannon Weber	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Ida Ackerman	3 years
Dr. Philip Berger	3 years
Dr. Steven Bodley	1 year
Dr. Joanna Bostwick	3 years
Dr. Pamela Chart	1 year
Dr. Melinda Davie	1 year
Dr. Paul Garfinkel	1 year
Dr. Kristen Hallett	3 years
Dr. Stephen Hucker	3 years
Dr. Veronica Mohr	3 years
Dr. Joanne Nicholson	3 years
Dr. Terri Paul	3 years
Dr. Dennis Pitt	1 year
Dr. Peeter Poldre	2 years
Dr. Robert Sheppard	1 year
Dr. Eric Stanton	1 year
Dr. Yvonne Verbeeten	3 years
Dr. James Watters	3 years
Mr. David Wright	3 years
Dr. Susanna Yanivker	3 years

Executive Committee:

PUBLIC MEMBER OF COUNCIL:	
Ms. Joan Fisk	1 year

Finance and Audit Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Rob Gratton	3 years

Dr. Judith Plante	1 year
Dr. Janet van Vlymen	2 years
PUBLIC MEMBERS OF COUNCIL:	
Mr. Pierre Giroux	1 year
Mr. Rob Payne	1 year
Mr. Peter Pielsticker	2 years
NON-COUNCIL PHYSICIAN MEMBER:	
Dr. Thomas Bertoia	3 years

Fitness to Practise Committee:

PHYSICIAN COUNCIL MEMBER:	
Dr. Glen Bandiera	3 years
Dr. Michael Franklyn	3 years
Dr. Deborah Hellyer	3 years
Dr. Paul Hendry	3 years
Dr. Roy Kirkpatrick	3 years
Dr. Camille Lemieux	3 years
Dr. Ian Preyra	3 years
Dr. John Rapin	3 years
Dr. Deborah Robertson	3 years
Dr. Andrew Turner	3 years
PUBLIC MEMBERS OF COUNCIL:	
Mr. Jose Cordeiro	1 year
Mr. Pierre Giroux	2 years
Mr. Mehdi Kanji	1 year
Mr. Paul Malette	1 year
Mr. Rob Payne	1 year
Mr. Peter Pielsticker	2 years
Ms. Linda Robbins	1 year
Ms. Shannon Weber	1 year
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Ida Ackerman	3 years
Dr. Heather-Ann Badalato	3 years
Dr. Philip Berger	3 years
Dr. Steven Bodley	1 year
Dr. Joanna Bostwick	3 years
Dr. Paul Garfinkel	1 year
Dr. Kristen Hallett	3 years
Dr. Stephen Hucker	3 years
Dr. Allan Kaplan	3 years
Dr. Veronica Mohr	3 years
Dr. Joanne Nicholson	3 years
Dr. Terri Paul	3 years

Dr. Peeter Poldre	2 years
Dr. Yvonne Verbeeten	3 years
Dr. James Watters	3 years
Mr. David Wright	3 years
Dr. Susanna Yanivker	3 years

Inquiries, Complaints and Reports Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Rob Gratton	3 years
Dr. Brenda Copps	3 years
Dr. Kashif Pirzada	3 years
Dr. Jerry Rosenblum	1 year
Dr. Anne Walsh	3 years
PUBLIC MEMBERS OF COUNCIL:	
Mr. Shahid Chaudhry	3 years
Ms. Joan Fisk	3 years
Mr. Murthy Ghandikota	1 year
Ms. Catherine Kerr	1 year
Dr. Lydia Miljan, PhD	2 years
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Haig Basmajian	1 year
Dr. George Beiko	3 years
Dr. Mary Jane Bell	3 years
Dr. Brian Burke	3 years
Dr. Anil Chopra	1 year
Dr. Mary Jean Duncan	3 years
Dr. Gil Faclier	3 years
Dr. Thomas Faulds	3 years
Dr. Kayhan Ghatavi	3 years
Dr. Daniel Greben	3 years
Dr. Andrew Hamilton	3 years
Dr. Elaine Herer	3 years
Dr. Christopher Hillis	3 years
Dr. Robert Hollenberg	1 year
Dr. John Jeffrey	3 years
Dr. Asif Kazmi	3 years
Dr. Edith Linkenheil	1 year
Dr. Jane Lougheed	3 years
Dr. Haidar Mahmoud	3 years
Dr. Robert Myers	3 years
Dr. Wayne Nates	3 years
Dr. Anita Rachlis	3 years
Dr. Val Rachlis	3 years

Dr. Michael Rogelstad	3 years
Dr. Dori Seccareccia	3 years
Dr. David Tam	3 years
Dr. Donald Wasylenki	1 year
Dr. Stephen Whittaker	1 year
Dr. Lesley Wiesenfeld	3 years

Patient Relations Committee:

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Rajiv Bhatla	3 years
Dr. Heather Sylvester	3 years
Dr. Angela Wang	3 years
NON-LGIC PUBLIC MEMBERS:	
Ms. Nadia Bello	3 years

Premises Inspection Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Kashif Pirzada	3 years
Dr. Jerry Rosenblum	3 years
Dr. Andrew Turner	3 years
PUBLIC MEMBERS OF COUNCIL:	
Mr. Peter Pielsticker	2 years
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Andrew Browning	3 years
Dr. Patrick Davison	3 years
Dr. Bill Dixon	3 years
Dr. Marjorie Dixon	3 years
Dr. Mark Mensour	3 years
Dr. Gillian Oliver	1 year
Dr. Holli-Ellen Schlosser	3 years
Dr. James Watson	2 years
Dr. Ted Xenodemetropoulos	3 years
NON-LGIC PUBLIC MEMBERS:	
Dr. El-Tantawy Attia, PhD	3 years
Mr. Ron Pratt	3 years

Quality Assurance Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Michael Franklyn	*Until March 31-2021*
Dr. Deborah Hellyer	*Until March 31-2021*

Dr. Camille Lemieux	*Until March 31-2021*
Dr. Sarah Reid	3 years
Dr. Patrick Safieh	*Until March 31-2021*
Dr. Janet van Vlymen	1 year
PUBLIC MEMBERS OF COUNCIL:	
Mr. Paul Malette	*Until March 31-2021*
Mr. Peter Pielsticker	*Until March 31-2021*
NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Steven Bodley	*Until March 31-2021*
Dr. Lisa Bromley	*Until March 31-2021*
Dr. Jacques Dostaler	*Until March 31-2021*
Dr. Miriam Ghali Eskander	*Until March 31-2021*
Dr. Ken Lee	*Until March 31-2021*
Dr. Meredith MacKenzie	*Until March 31-2021*
Dr. Ashraf Sefin	*Until March 31-2021*
Dr. Robert Smith	*Until March 31-2021*
Dr. Tina Tao	*Until March 31-2021*

Registration Committee:

PHYSICIAN COUNCIL MEMBERS:	
Dr. Glen Bandiera	3 years

PUBLIC MEMBERS OF COUNCIL:	
Mr. Shahid Chaudhry	3 years
Mr. Pierre Giroux	2 years
Mr. Paul Malette	1 year

NON-COUNCIL PHYSICIAN MEMBERS:	
Dr. Bob Byrick	1 year
Dr. Barbara Lent	1 year
Dr. Lynn Mikula	3 years
Dr. Damien Redfearn	3 years
Dr. Kim Turner	3 years

CARRIED

24. President's Items

1. Acknowledge Outgoing Council Members

   B. Copps acknowledged the contributions made by the following outgoing Council members:

- Robert Smith (Academic Representative)
- Dave Rouselle (District 5)
- Elizabeth Samson (District 5)
- Philip Berger (District 10)
- Haidar Mahmoud (District 10)
- Peeter Poldre (District 10)

2. Presidential Address

B. Copps delivered her Presidential Address to Council. She described her year as President, the challenging times, and collective accomplishments, including seamlessly moving the core business of the College offsite, meeting and in some cases exceeding Key Performance Indicators, developing a myriad of policies, and strengthening governance processes etc.

3. Induction of New President

B. Copps welcomed the new president, Dr. Judith Plante and invited her to say a few words. J. Plante received her Council pin.

4. Welcome Incoming Council Members

B. Copps welcomed the following incoming Council members, and invited them to say a few words:

- Roy Kilpatrick (Academic Representative)
- Kashif Pirzada (District 5)
- Anne Walsh (District 5)
- Camille Lemieux (District 10)
- Deborah Robertson (District 10)
- Patrick Safieh (District 10)

Adjournment Day 2

B. Copps adjourned the meeting at 4:45 pm.

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Dr. Brenda Copps, President

_____
Ellen Spiegel, Recording Secretary

Attendees:

Dr. Janet van Vlymen (Vice-President)
Dr. Brenda Copps
Mr. Shahid Chaudhry
Mr. Jose Cordeiro
Ms. Joan Fisk
Dr. Michael Franklyn
Mr. Murthy Ghandikota
Dr. Rob Gratton
Dr. Paul Hendry
Ms. Nadia Joseph
Dr. Roy Kirkpatrick
Dr. Lydia Miljan, Ph.D.
Mr. Rob Payne

Mr. Peter Pielsticker
Dr. Kashif Pirzada
Dr. Ian Preyra
Dr. John Rapin
Dr. Sarah Reid
Dr. Deborah Robertson
Ms. Linda Robbins
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Andrew Turner
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Karen Saperson

Regrets:
Dr. Judith Plante (President), Dr. Glen Bandiera, Mr. Pierre Giroux, Dr. Deborah Hellyer, Ms. Catherine Kerr, Dr. Camille Lemieux, Mr. Paul Malette

Guests:
Dr. Barbara Lent and Dr. Bob Byrick, Co-Chairs, Registration Committee

1. Call to Order and Opening Remarks

Dr. Janet van Vlymen, Vice-Chair, called the meeting to order at 7:00pm. and welcomed members of Council and guests to the virtual Council meeting. She explained that she would be chairing this meeting on behalf of the President, Dr. Judith Plante, who has a conflict with the topic of this meeting.

J. van Vlymen gave a traditional land acknowledgement statement as a demonstration of recognition and respect for Indigenous peoples. She reminded attendees of the strategic plan, and the College's mission.

2. Motion to Go In Camera

01-C-02-2021

It is moved by S. Chaudhry and seconded by I. Preyra that:

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

CARRIED

2. Consent Agenda

02-C-02-2021

It is moved by S. Chaudhry, and seconded by D. Robertson, that:
The Council approves the agenda for the February 9, 2021 Special Meeting of Council.

CARRIED

3. Medical Council of Canada Qualifying Examination Part II

The purpose of this Special meeting was to consider a draft registration policy that would exempt certain applicants from the Medical Council of Canada Qualifying Examination Part II (MCCQE2), given challenges that have resulted from the COVID-19 pandemic.

S. Tulipano, Director, Registration and Membership Services, presented Council with background information on the issue. Following discussion, Council approved the following motion:

03-C-02-2021

It is moved by I. Preyra, and seconded by J. Rosenblum, that:

The College engage in the notice and consultation process in accordance with section 22.21 of the Health Professions Procedural Code, in respect of the draft policy "Requirement For Successful Completion of Part 2 of the MCCQE – Pandemic Exemption" (a copy of which forms Appendix "A" to the minutes of this meeting).

CARRIED

4. Adjournment

J. van Vlymen adjourned the meeting at 8:00 pm.

_____

Dr. Janet van Vlymen, Vice-President

_____

Ellen Spiegel, Recording Secretary

Council Briefing Note

March 2021

TOPIC: Executive Committee Report

FOR INFORMATION

9-EX-November-2020 Upon a motion by J. Plante and seconded by P. Poldre and **CARRIED**, the Executive Committee approves the proposed plan to move the Annual Committee Reports from the December Council Meeting to the March Council Meeting.

11-EX-November-2020 Upon a motion by P. Pielsticker and seconded by J. Fisk and **CARRIED**, the Executive Committee endorses Murthy Ghandikota's request for public member reappointment.

Contact: Judith Plante, President
Lisa Brownstone, Chief Legal Officer

Date: February 13, 2021

Council Briefing Note

March 2021

Topic:	Discipline Committee Report Completed Cases – November 22, 2020 to February 5, 2021
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contacts:	Moira Calderwood, Counsel, Hearings Policy and Publications David Wright, Tribunal Director and Chair of the Discipline Committee
Attachment:	N/A

Issue

- This report covers the nine Discipline Committee decisions released between November 22, 2020 and February 5, 2021, including decisions on discipline hearings and (starting in January 2021) decisions on motions brought before the Discipline Committee.

- This report is for information.

Background

- The report consists of three tables:

  - Table 1, setting out in order of decision release date the findings from each case.
  - Table 2, setting out in order of decision release date the penalty from each case.
  - Table 3, setting out in order of decision release date the Committee's decisions on motions.

  - In the second column of Tables 1 and 2, hyperlinks are provided to the physician's public register profile from the College's website.

- The Committee's decision is available for viewing from the physician's public register profile on the College's website. It contains the full text of the Discipline Committee's decision and reasons document. (If you experience any difficulty opening a hyperlink, please use “Control-click" or right click on the blue text and select “open hyperlink".)

- Physicians' names in the first column of each table are hyperlinked to let you navigate back and forth from the liability findings in Table 1 to the penalty findings in Table 2, for each physician.

Summary

- In the period reported, the Discipline Committee released five decisions and reasons (D&Rs) on hearings. All five set out findings on liability and the Committee's penalty order.

- Each case may have more than one finding, or more than one aspect to penalty.

- Liability findings (see Table 1) included:

  - 2 sexual abuse findings
  - 2 findings of failing to maintain the standard of practice
  - 5 findings of disgraceful, dishonourable or unprofessional conduct

- Penalty orders (see Table 2) included:

  - 2 revocations
  - 5 reprimands
  - 2 suspensions
  - 2 impositions of Terms, Conditions or Limitations on the physician's Certificate of Registration.

- The Committee imposed a costs order on the physician in all five D&Rs.

- From January 1, 2021 to date, the Discipline Committee released 4 decisions and reasons (D&Rs) on motions.

Current Status and Analysis

TABLE 1: DISCIPLINE DECISIONS – FINDINGS (November 22, 2020 to February 5, 2021)

TCL = Term, Condition or Limitation; and DDU = Disgraceful, Dishonorable, or Unprofessional

PHYSICIAN NAME (Click the Hyperlink to see Table 2 for Penalty Details)	**DECISION** Release Date and link to CPSO Public Profile	**FINDINGS**					
		Liability, Penalty or both	**Sexual Abuse**	**Incompetence**	**Found guilty of offence relevant to practice**	**Failing to maintain the standard of practice**	**DDU**
Ismail, Mohamed Abdel Hadi Elmorsi	2020-12-15	Both					✓
Birnbaum, Robert Joel	2020-12-23	Both	✓				✓
Vaidyanathan, Sammy	2021-01-04	Both				✓	✓
Reavely-Diaz, Sheridan	2021-01-05	Both				✓	✓
Herman, Leon	2021-01-19	Both	✓				✓

TABLE 2: DISCIPLINE DECISIONS - PENALTIES (November 22, 2020 to February 5, 2021)

PHYSICIAN NAME (Click the Hyperlink to return to Table 1 For Findings)	REVOCATION	SUSPENSION / LENGHT	REPRIMAND	TERM, CONDITION, LIMITATION			COSTS/ COMMENT
				Requirement to complete education	Prescribing restrictions	Other	
Ismail, Mohamed Abdel Hadi Elmorsi		✓ 6 months	✓	✓			Costs: $10,370
Birnbaum, Robert Joel	✓		✓				Costs: $6,000 + $16,060 (to reimburse CPSO for funding provided to patients under s. 85.7 of the *Code*
Vaidyanathan, Sammy		✓ 12 months	✓	✓	✓	✓	Costs: $10,370
Reavely-Diaz, Sheridan			✓				Costs: $6,000
Herman, Leon	✓		✓				Costs: $6,000 + $16,060 (to reimburse CPSO for funding provided to patients under s. 85.7 of the *Code*

TABLE 3: DISCIPLINE DECISIONS - MOTIONS (November 22, 2020 to February 5, 2021)

PHYSICIAN NAME	DATE OF DECISION	DECISION LINK	NATURE OF MOTION	COMMITTEE DECISION
Pasternak, Harvey Stephen	2021-01-13	2021 ONCPSD 3	Motion to strike, as an abuse of process, certain allegations contained in the Notice of Hearing	Denied
Gill, Harmander	2021-01-14	2021 ONCPSD 4	Motion to adjourn, heard January 8, 2021	Denied
Bélanger, Mathieu	2021-01-18	2021 ONCPSD 5	French language rights motion 1. Request to file documents in French 2. Request for French reasons 3. Request for bilingual panel	1: Granted 2: Granted 3: Denied
Gill, Harmander	2021-02-02	2021 ONCPSD 7	Motion to adjourn penalty hearing, heard October 13, 2020.	Granted

Council Briefing Note

March 2021

Topic:	Government Relations Report
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Government relations supports CPSO to regulate in a more effective, efficient, and coordinated manner
Main Contact(s):	Miriam Barna, Senior Government Relations Advisor Danna Aranda, Government Relations Coordinator
Attachment(s):	N/A

Update on the Ontario Legislature

- The fall legislative session ended on December 8 and a new spring session is scheduled to begin on February 16.

- The fall legislative session saw the passage of 36 bills, among which six were primarily responses to COVID-19. None of the bills passed in this session have a direct impact on CPSO.
    - However, Bill 229, Protect, Support, and Recover from COVID-19 Act (Budget Measures), was of interest to CPSO as it relates to governance modernization. This Bill made significant changes to the governance structure of the Ontario College of Teachers including the elimination of Council elections.

- Criticism of the government's response to and preparedness for the second wave of the pandemic continues to intensify as infection rates soar in the province. The ongoing crisis in long-term care, the government's roll out of vaccinations, and the lack of clarity surrounding public health measures have also been significant areas of criticism by both opposition MPPs and stakeholders.

- The NDP official opposition has been pushing for the legislature to reconvene before February 16 in order to oversee a faster vaccine roll out and pass legislation that would mandate paid sick days for all workers, among other priorities.

- There have been a number of recent changes to Premier Ford's Cabinet and Caucus:

    - At the end of December, news broke that finance minister Rod Phillips travelled to St. Barts for vacation even as officials had urged Ontarians to stay home. Within a number of days of the story breaking, Phillips resigned as minister and Ford announced the appointment of Peter Bethlenfalvy, who had previously served as the president of the Treasury Board, as the new minister of finance.

    - On January 15, PC MPP Roman Baber (York Centre) wrote an open letter to the Premier criticizing the government's COVID-19 response and pleading for an end to lockdown for "the millions of lives and livelihoods ruined by Ontario's public health restrictions". Less than two hours later, Baber was ejected from the PC Caucus and will not be permitted to seek re-election as a PC member.

    - Baber will now be sitting as an Independent MPP, joining four other MPPs who have left or been kicked out of the PC Caucus since the provincial election in 2018 (Amanda Simard has since joined the Liberal Caucus).

- Although the provincial budget was delayed last year due to COVID-19, we are anticipating that the 2021 Budget will be released on schedule, likely sometime in March.

Issues of Interest

Public Member Update

- Over the last number of months, significant activity related to public member reappointments has taken place; five public members were up for reappointment in early 2021.

- To support these reappointments and ensure that Council and committees meet quorum requirements and have stability, staff amplified communications to government stakeholders regarding reappointments, the need for three-year terms, and the vital importance that CPSO have 15 qualified public members.

- These efforts resulted in CPSO receiving early reappointments of three public members for 3-year terms. Catherine Kerr was reappointed for a one-year term and on January 29, Fred Sherman was appointed for a one-year term.

- Despite efforts to seek reappointment, Mehdi Kanji's appointment was not renewed, and his term ended on February 7. Also, in January, Nadia Joseph resigned from Council for health reasons.

- Murthy Ghandikota's term will expire on April 8, and staff will continue to advocate for his reappointment.

- At the time this note was written, there were 13 public members appointed to Council.

- Staff will continue to advocate and work with government stakeholders to appoint 15 public members to Council and maintain the generally positive trends in public appointments.

Governance Modernization and Physician Assistant Regulation

- Staff continue to be in frequent contact with government about our governance modernization priorities and the opportunity to move this agenda forward through the regulation of Physician Assistants.

- We continue to anticipate the introduction of legislation that would regulate Physician Assistants under CPSO in the spring session of the legislature.

- Council will be kept apprised of the introduction and analysis of any legislation.

Interactions with Government

- As noted above, numerous meetings with public appointment government stakeholders have also occurred including with staff in the Minister's Office and in the Ministry of Health.

- Staff remain in contact with both the Ministry of Health and the Minister's Office with regards to ongoing issues related to COVID-19.

- Government relations staff are also working to kick start the MPP contact program for 2021 after a quieter 2020 for MPP meetings due to the pandemic.

Council Briefing Note

March 2021

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

Issue

- The Finance and Audit Committee met on January 16, 2021 and has the following summary for the March 2021 Council meeting.

Background

- The Finance and Audit Committee addressed the following agenda items:
    - Healthcare Insurance Reciprocal of Canada delivered a detailed presentation of the College's insurance to the Committee
    - The Committee was provided with a fulsome education and orientation program
    - The Guide to Financial Statements for Not-for-Profit Organizations was reviewed
    - The Committee discussed the November 2020 Financial Statements and Variance Analysis
    - Nathalie Novak and Deloitte provided the Finance and Audit Committee with a fulsome update on Vault, Solis and the Finance and Operations systems
    - Laurie Cabanas provided the Committee with an update on the Committee's Terms of Reference
    - The Committee was informed that the $50M GIC investment was invested with National Bank, as per the Committee's direction
    - Debbie Baxter from Deloitte presented an update of the workplace strategy for the Committee

Council Briefing Note

March 2021

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

Issue

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

Current Status

1. Critical Care Triage

- A significant surge in demand for critical care resources has the potential to overwhelm the province's health care system, requiring the implementation of a protocol to triage or allocate the available resources in an ethical manner.

- Work has been underway since the beginning of the pandemic to develop such a protocol. This work has been led by the various 'command tables' established by the provincial government.

- While significant system capacity has been built since the outset of the pandemic, challenges remain given evolving nature of the pandemic and the practical reality that a significant proportion of the province's critical care capacity is regularly utilized by non-COVID-19 patients (e.g., accidents, emergencies, post-surgery recovery, etc.) and there are limits to the health human resources available to support this increased system capacity.

- In developing a triage protocol, the central intention of the command tables has been to allocate resources in a manner that maximizes the number of lives saved by allocating resources preferentially rather than through a "first come, first served" approach.

- Triaging of critical care resources can involve both the withholding of potentially life-saving or life-sustaining treatment, as well as the withdrawal of life-sustaining treatment that is being provided to one person to re-allocate the resources to another.

    - The former can be done within the parameters of our current legal frameworks when paired with an understanding that the standard of care evolves with the nature of the pandemic.

    - However, the latter can only be operationalized through an Executive Order issued by Cabinet that creates an exemption to the *Health Care Consent Act, 1996* requirement that consent be obtained prior to withdrawal.

- During the second wave of the pandemic, the system began planning for the implementation of a triage protocol that only contemplated the withholding of potentially life-saving or life-sustaining treatment.

    - Notwithstanding the permissibility of these allocation decisions from a legal perspective, CPSO's *Planning for and Providing Quality End-of-Life Care* policy could reasonably be read as a limiting factor on the implementation of this protocol.

    - As a result, CPSO's COVID-19 FAQs for Physicians have been updated to include a statement intended to remove any real or perceived regulatory barriers regarding the implementation of this protocol. More specifically, by indicating that CPSO is supportive of physicians acting in accordance with the triage protocol, if enacted, even if doing so requires departing from the professional expectations set out in our policies.

- As of the Council submission deadline, the triage protocol had not yet been implemented and surge in demand for critical care resources had begun to flatten or even wane. CPSO will continue to monitor and support developments in this area in a manner that protects the public and supports physicians should the need to implement the protocol arise.

2. Medical Assistance in Dying – Bill C-7 Update

- Bill C-7: *An Act to amend the Criminal Code (medical assistance in dying)* (MAID) was passed by the House of Commons on December 10, 2020 with two amendments that had been made by the House of Commons Standing Committee on Justice and Human Rights.[1]

- The Bill was debated by the Senate at second reading before it rose for the holidays and it is clear that Senators have very polarized views on the new legislative framework for MAID proposed in the Bill: some Senators think the Bill doesn't go far enough to protect the vulnerable, and some think the Bill is too restrictive and will prevent appropriate access to MAID.

- The Bill was studied by the Standing Senate Committee on Legal and Constitutional Affairs and has returned to the Senate for further debate at third reading.

- The court granted the federal government another extension to pass Bill C-7 and the new deadline is February 26, 2021.

- As of the Council Submission deadline, it was not clear whether approval of the bill would be further delayed. CPSO staff will continue to monitor its progress and are drafting revisions to both the MAID policy and *Advice to the Profession* document in order to reflect any changes to the law. These changes will be made as quickly as possible should the bill be approved, with the Executive Committee being asked to approve the updated policy once finalized.

3. Policy Consultation Update

- Following the December 2020 Council meeting four consultations were launched, all of which are still ongoing.

    - Three of these consultations are at the preliminary stage, meaning the intention of the consultation is to seek feedback on the current policies in order to help shape the revisions that are undertaken in the next phases of the policy review cycle.

[1] The first amendment was regarding a procedural safeguard for natural deaths that are not reasonably foreseeable and clarified that if the MAID provider and other clinician who confirmed the patient meets the eligibility criteria do not have expertise in the condition that is causing the patient's suffering, one of them must consult with a clinician who has that expertise and must share the results of the consultation with the other clinician. The second amendment added a requirement for the Minister of Health to consult with the minister responsible for the status of persons with disabilities when exempting a class of persons from the MAID reporting requirements, when appropriate.

- They are: *Medical Assistance in Dying*, *Planning for and Providing Quality End-of-Life Care*, and *Professional Obligations and Human Rights*.

- Given the challenges associated with practising during a pandemic and the importance of each of these policies to the profession and public, the consultation period has been extended from the usual 60-day timeframe, to four months with a commitment to extend further if necessary.

- Given the issues addressed in each of these policies, specific efforts to solicit feedback from and meaningfully engage with stakeholders representing or advocating for the interests of diverse and/or vulnerable groups will be made, to help ensure the policy process unfolds with a diversity, equity, and inclusion lens.

  - The fourth consultation is at the draft policy stage, where an updated draft of the *Complementary and Alternative Medicine* policy is being circulated for feedback to help evaluate the draft policy expectations prior to seeking final approval from Council later this year. The consultation period was similarly extended to three months, with a commitment to extend further if necessary.

- As of the Council submission deadline, the consultations have received 346 responses: 38 through written feedback and 308 via the online surveys. Roughly half of these respondents were physicians.

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

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.

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Professional Obligations and Human Rights	Dec-20	✓						**2022**	
Medical Assistance in Dying	Dec-20	✓						**2022**	
Planning for and Providing Quality End-of-Life Care	Dec-20	✓						**2022**	
Telemedicine	Sep-20	✓						**2022**	
Social Media: Appropriate Use by Physicians (Statement)	Apr-20		✓					**2021**	A review is underway to review and update the statement.
Statements & Positions Redesign	Jan-20		✓					**2021**	All CPSO *Statements & Positions* are being evaluated for relevance and currency.
Professional Responsibilities in Postgraduate Medical Education & ***Undergraduate Medical Education***	Dec-19					✓		**2021**	The two policies have been combined into one draft policy titled *Professional Responsibilities in Medical Education*.
Medical Expert & ***Third Party Reports***	Dec-19					✓		**2021**	The two policies have been combined into one draft policy titled *Third Party Medical Reports*.
Complementary / Alternative Medicine	Mar-19				✓			**2022**	
Delegation of Controlled Acts	Mar-19						✓	**2021**	

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Female Genital Cutting (Mutilation)	2016/17	*Public Health Emergencies*	2023/24
Dispensing Drugs	2016/17	*Closing a Medical Practice*	2024/25
Mandatory and Permissive Reporting	2017/18[1]	*Availability and Coverage*	2024/25
Providing Physician Services During Job Actions	2018/19	*Managing Tests*	2024/25
Physicians' Relationships with Industry: Practice, Education and Research	2019/20	*Transitions in Care*	2024/25
Cannabis for Medical Purposes	2020/21	*Walk-in Clinics*	2024/25
Consent to Treatment	2020/21	*Disclosure of Harm*	2024/25
Blood Borne Viruses	2021/22	*Prescribing Drugs*	2024/25
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	*Boundary Violations*	2024/25
Physician Behaviour in the Professional Environment	2021/22	*Medical Records Documentation*	2025/26
Accepting New Patients	2022/23	*Medical Records Management*	2025/26
Ending the Physician-Patient Relationship	2022/23	*Confidentiality of Personal Health Information*	2025/26
Uninsured Services: Billing and Block Fees	2022/23	*Advertising*	2025/26
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24		

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

Council Briefing Note

March 2021

Topic:	Medical Learners Report
Purpose:	For Information
Relevance to Strategic Plan:	Meaningful Engagement System Collaboration
Main Contact(s):	Judith Plante, President
Attachment(s):	Appendix A: Report from the Professional Association of Residents of Ontario (PARO) Appendix B: Report from the Ontario Medical Students Association (OMSA)

Issue

- Council is pleased to have representatives from the Professional Association of Residents of Ontario and the Ontario Medical Students Association regularly attend Council meetings as invited guests.

- The Professional Association of Residents of Ontario has provided Council with a brief report outlining the key issues impacting their members (Appendix A).

- The Ontario Medical Students Association has provided Council with a brief report outlining the key issues impacting their members (Appendix B).

PARO

Inspired by our love of medicine

CPSO Council February 2021

PARO champions the issues that create the conditions for residents to be their best and ensure optimal patient care.

We have determined that to fulfill this mission we must achieve three key goals.

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

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

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

COVID-19 has unsurprisingly dominated PARO's work this past year, as our members are relied on to care for Ontario's COVID-19 patients on the frontlines in hospitals, Public Health, and long-term care homes.

Our members, doctors who are working and training in CFPC and RCPSC specialty training programs, have been a go-to hospital resource in caring for COVID patients. Many have been redeployed from their scheduled rotations to care for patients in priority services and to alleviate the strain on key areas in the hospital.

We are very grateful for the CPSO's recognition and understanding of the impact of delays in exams have on practice eligible candidates.

Very early on in the pandemic, the CPSO made the commitment that no one would be delayed entering into practice as a result of not being able to challenge the exam. This resulted in the issuing of the COVID provisional license, which has been highly valued and appreciated by PARO and our members.

The most recent decision to waive the requirement of the MCCQE2 exam for these doctors further demonstrates the CPSO's confidence in the training that is provided by our medical schools and residency programs in Ontario. Even more importantly, it is a recognition that all of us are in medicine to serve the population of Ontario. This decision, once fully approved, will provide Ontario's citizens the opportunity to access care from these highly trained and competent doctors.

The impact of the pandemic is region-specific as some areas are experiencing a higher incidence of COVID-19 or more people ill with COVID-19 compared to other areas, but also a regionalized application of public health guidelines. As a result, some of our members are more greatly impacted than others. A concrete example is internal medicine residents in Toronto: when there is a positive COVID result for a team member, the whole team is quarantined,

reducing the workforce and increasing the workload for other teams. This is contrasted with some other jurisdictions, where only the individual who has tested positive is quarantined.

One of the practical implications of this increased workload and reduction in workforce is that some residents who would normally be given a somewhat reduced overnight call frequency in order to prepare for exams are having that taken away or are even providing additional call during the lead up to their exams.

In response to member feedback around high levels of resident burnout due to COVID-19, PARO is undertaking a number of initiatives related to identifying, preventing, and managing burnout. We have completed a resource guide, which helps identify specific signs of burn out and provides specific tips and resources to manage each sign. That guide is currently available on PARO's website.

Our work will continue over the coming weeks, focusing on areas identified by our members, including peer to peer advice for managing stress and fatigue.

One of our priorities in this work is to mitigate the intense stress being experienced by our members who will be transitioning into practice this summer. Like last year's graduating cohort, these members are facing enormous uncertainty and anxiety around what their transition into practice will look like, and we hope to be able to provide resources and strategies to support their wellbeing during this challenging time.

Meanwhile, PARO’s leadership team are steeling ourselves for a potential third wave.

As residents frequently rotate between services and hospitals, and indeed between cities, we have been working to ensure that residents are appropriately prioritized and vaccinated with other prioritized healthcare workers. For residents, particular attention must be paid not just where residents are training but where they are rotating to next, to ensure they don’t fall through the cracks or obtain the first dose at a hospital but then rotate to another hospital or site without a reliable plan to obtain the second dose.

We are exceptionally proud of our members who, in addition to their work caring for patients, have volunteered to administer COVID-19 vaccinations to ensure Ontarians receive them as quickly as supplies are obtained.

Respectfully submitted,

Brendan Lew, MD
PARO Board of Directors

February 11th, 2021

Ontario Medical Students Association
CPSO Update
March 4-5, 2021

Presented by:
Sharon Yeung, President
Ushma Purohit, President-Elect

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

Thank you to the CPSO for inviting a representative from the Ontario Medical Students Association (OMA Section of Medical Students) to observe and participate in your Council meeting.

Since our last update, Ontario medical students have continued to persist through the many challenges that the pandemic has brought to medical education. Our fourth year students recently submitted their CaRMS applications and are anticipating a virtual interview season this month, and our third year students have all begun their clinical rotations despite initial delays. Our first and second year students are continuing with virtual education, coming up with creative virtual means to continue hosting extra-curricular and social activities.

Beyond participating in their academic duties, many Ontario medical students have also volunteered their time and energy at COVID vaccine clinics, assisting in the provincial response to distribute the vaccine as quickly and effectively as possible. However, many of our students, including those who are continuing their clinical clerkships, continue to wait to receive the vaccine themselves.

Members of our team were also pleased to attend the CPSO Special Meeting on February 9th, 2021, regarding the MCCQE Part 2. We are grateful for the invitation and pleased with the accommodations that the CPSO has offered medical graduates whose licensing process has been disrupted by the COVID pandemic. We continue to be hopeful that this examination will continue to be reviewed and assessed in determining meaningful licensure requirements in the future. We additionally thank the CPSO for meeting with medical students specially regarding student concerns with the difficult administration of the virtual MCCQE Part 1 last year and will continue to provide student updates on this front.

Thank you once again for welcoming medical students to the table and we look forward to continuing to work with the CPSO.

Council Briefing Note

March 2021

Topic:	CPSO Revised Operational Policies
Purpose:	For Information
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	**Equity:** Ensuring that all individuals are treated with sensitivity and respect in their dealings with health professionals and CPSO **Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public
Main Contact(s):	Marcia Cooper, Senior Corporate Counsel & Privacy Officer
Attachment(s):	Appendix A: Use of CPSO Technology Policy Appendix B: Email Management Policy Appendix C: Code of Conduct for CPSO Personnel Appendix D: Information Breach Protocol Appendix E: Access Protocol Appendix F: Safe Disclosure Policy

Issue

- Certain technology, privacy and other operational policies have been revised, in particular to clarify that they apply to Council and committee members and to clarify privacy and security expectations.
- In addition, an Access Protocol has been created.
- As these are operational policies, they are being provided to Council for information.

Next Steps

- Committee members and staff will also be made aware of the revisions to these policies and the new protocol, and their application to these members.

Use of CPSO Technology Policy

Application of Policy

This Policy applies to all:

- CPSO employees (whether full-time or part-time, permanent or on contract);
- Council members;
- CPSO committee members;
- CPSO contractors who use or have access to CPSO Technology (as defined below); and
- any other persons or stakeholders working on behalf of the CPSO who use or have access to CPSO Technology (as defined below).

(collectively, **"CPSO Personnel"**).

Failure to follow comply with this Policy may result in discipline, up to and including dismissal.

CPSO Property

"CPSO Technology" means CPSO systems, CPSO-supplied devices and personal devices used by CPSO Personnel for CPSO activities (including, but not limited to, computers, laptops, and phones) and associated computer storage media.

All information and data generated or stored on CPSO Technology (**"CPSO Information"**) are the exclusive and confidential property of the CPSO. All electronic mail, instant messaging chats and associated files are also the intellectual property of the CPSO. Copies of any information or data must NOT be removed from the CPSO's premises without prior management approval or shared or disclosed except as permitted by Section 36 of the *Regulated Health Professions Act, 1991*.[1]

Use of CPSO Technology

CPSO Employees

CPSO employees must conduct CPSO work using CPSO-issued computers or laptops, not personal computers or laptops.

[1] See discussion of Confidentiality in the Information Breach Protocol and the Confidentiality Policy.

CPSO employees must access CPSO Information through the CPSO virtual private network (**"VPN"**) or through the Microsoft Corporate Cloud.

CPSO Information must be saved in CPSO systems. CPSO employees should not download, save or store CPSO Information on CPSO Technology or on personal devices (e.g. on C drive or desktop). If CPSO Information is temporarily or inadvertently downloaded or saved on CPSO Technology or on a personal device, the CPSO Information must be deleted as soon as possible, and such personal device must have password-protected access, and hard drive encryption or Microsoft InTune installed (by CPSO IT department).

Council Members and CPSO Committee Members

Council members and CPSO committee members are highly encouraged to conduct CPSO work using CPSO-issued computers or laptops.

Council members and CPSO committee members may use personal or non-CPSO-issued computers or laptops once the CPSO IT department has assessed the personal device (such as for security and other features) and approved its use for conducting CPSO work.

Council members and CPSO committee members must access CPSO Information through the CPSO VPN or through the Microsoft Corporate Cloud. For CPSO committees that have a SharePoint On-line site, those CPSO committee members must conduct their committee work through SharePoint On-line.

Council members and CPSO committee members should not download, save or store CPSO Information on CPSO Technology or on personal devices (e.g. on C drive or desktop). If CPSO Information is temporarily or inadvertently downloaded or saved on CPSO Technology or on a personal device, the CPSO Information must be deleted as soon as possible and such personal device must have password-protected access, and hard drive encryption or Microsoft InTune installed (by CPSO IT department), and TeamViewer installed (by CPSO IT department).

Other CPSO Personnel

For CPSO Personnel other than CPSO employees, Council members and CPSO committee members, such CPSO Personnel must comply with directions given by CPSO (such as CPSO IT department or applicable CPSO program area) from time to time regarding the handling of CPSO Information.

No Expectation of Privacy

CPSO Personnel should have no expectation of privacy in their use of CPSO Technology or in CPSO Information. Please note that this includes, but is not limited

to, files, pictures, e-mail, instant messaging etc. of a personal nature that CPSO Personnel generate or store on CPSO Technology.

The College may monitor and review the use of CPSO Technology, and may open and review e-mail messages, instant messaging, internet activity and other CPSO Information (including those of a personal nature), at any time without notice to CPSO Personnel for the purposes of verifying compliance with CPSO policies, to protect CPSO Information and other CPSO property, and for other lawful purposes. The College will conduct such monitoring and review in accordance with a protocol established for this purpose.

Acceptable Use Guidelines

In accessing and using CPSO Technology, CPSO Personnel must not engage in any illegal, harmful, unauthorized or unlawful activity, including, without limitation:

- violation of any applicable law or regulation;
- infringement of intellectual property rights;
- spamming and invasion of privacy of others;
- accessing pornography or gaming sites;
- uploading or transmitting any material or information that is libelous, defamatory, obscene, pornographic or abusive (except as necessary for performing work for CPSO);
- hacking or distribution of internet viruses, worms, Trojan horses or other destructive activities;
- accessing illegally or without authorization, computers, accounts, equipment or networks belonging to another party or attempting to penetrate security measures of another system; and
- forwarding of graphics, jokes, games, chain letters or other similar or "inappropriate"[2] material.

[2] One example of the forwarding of "inappropriate" material would occur if one employee sent another employee an offensive joke by email. If the recipient or anyone else in the workplace who sees the email finds the joke offensive and makes a complaint that the joke is discriminatory, harassing or creates a poisoned work environment, the College would be required to investigate and take appropriate action. In some cases, the College would also be required to investigate the forwarding of an offensive joke even if there was no complaint; for example, where a Manager becomes aware of the circulation of material that is objectively offensive.

Internet

CPSO Personnel are expected to be professional in their conduct in any communication or other activities conducted on the Internet.

1) Internet access is intended for CPSO business purposes. Personal use during the workday should be kept as brief as possible and occur during breaks and lunch periods.
2) CPSO Personnel must be aware that they leave a CPSO "***footprint***" at every web site they visit. CPSO Personnel are representing the CPSO during all Internet travels using CPSO Technology.
3) The Internet is a public network, in other words — *nothing is private.* No information of a confidential or sensitive nature should be sent over the Internet.
4) The Information Technology department must approve the downloading of any software into CPSO Technology.
5) CPSO Personnel must not allow others to use their CPSO Technology ID and password.
6) CPSO Personnel should be aware that the use of large images, animation or complex graphics can take up large amounts of server and network capacity and can adversely affect performance of our computing equipment. For this reason, CPSO Personnel should limit their use of large images, animation and complex graphics except as necessary to perform their work for CPSO.
7) Mobile Phones:
    a) As with other CPSO Technology, CPSO Personnel should be responsible and reasonable in their use of data on CPSO-owned mobile phones. CPSO Personnel should not use excessive amounts of data on CPSO-owned mobile phones, respecting the fact that mobile phone data is a shared, limited and costly resource. This applies to use of data on the CPSO WiFi (see below) when on premises as well as use of data externally when not using WiFi.
    b) When travelling, CPSO Personnel should be careful not to access CPSO systems via VPN or direct network access (not including cloud services i.e. Office.com) using unsecured connections through mobile phones. CPSO Personnel are advised to inform IT Helpdesk before travelling to make sure that they have an RSA Key or that the method of connection they will be using is secure. Also, note that it is good to advise the IT department of travel activities as Microsoft security may lock users out of their account since logging in at different locations may be perceived as a threat.

Electronic Mail

CPSO has an e-mail system which communicates both internally and on the Internet to outside addresses. Since e-mail is sent over the Internet, it is inherently insecure. As a result, CPSO Personnel should consider the nature of the information being included in all e-mails addressed to persons outside of the CPSO, and CPSO Personnel should use secure or encrypted means of sending information of a confidential or sensitive information, and not regular e-mail. (Note that e-mails sent from a *cpso.on.ca* e-mail address to another *cpso.on.ca* e-mail addresses are secure.)

All e-mail communications containing CPSO Information to or from CPSO Personnel who have a CPSO email address[3] (i.e. *cpso.on.ca*) must be sent from or to their CPSO email address. CPSO Personnel must not forward emails relating to CPSO business or send CPSO documents, files or other CPSO Information to their personal email accounts (and in the case of CPSO personnel who work at hospitals or other institutions, to their email accounts at such other institutions). Not only is the transmission of the CPSO Information in this way not secure, but the CPSO Information, due to its confidential nature, should not be stored on non-CPSO servers and systems.

The CPSO e-mail system is intended for the exchange of business information with other CPSO Personnel, members of the public and profession and other stakeholders. The use of the CPSO e-mail system by CPSO Personnel for personal matters should be incidental and kept to a minimum.

CPSO e-mails, including attachments, are CPSO records that must be managed according to CPSO record management policies. Please see the E-mail Management Policy in this regard.

Please see the CPSO Visual Identity Guide for the required standardization of CPSO e-mails.

If CPSO Personnel receive an email from other CPSO Personnel in error or that they do not believe should have been sent to them, the recipient should so advise the sender as soon as possible.

[3] This would include CPSO employees, Council members and CPSO committee members.

CPSO Wireless Network (WiFi) — Terms of Use

CPSO provides CPSO Personnel on CPSO premises with access to a wireless (WiFi) network, "CWA-04" as a courtesy for personal use with their personal devices, such as personal mobile phones.

A separate WiFi network, "CWA-05", is provided for CPSO Personnel who have CPSO-owned mobile phones or personal phones that are connected to CPSO Technology systems primarily to facilitate conducting CPSO business. These CPSO Personnel should connect their phones to the CWA-05 Network (as advised by IT when they received or connected their phone) when working in the CPSO building to save on data usage (Refer to the Accessing CPSO Information Through a Mobile Phone policy). These Terms of Use apply to both the CWA-04 network and the CWA-05 network (collectively, the **"CPSO Personnel Networks"**).

The CPSO Personnel Networks are separate from the WiFi network made available for guests of the CPSO. CPSO Personnel should not provide guests with access to the CPSO Personnel Networks.

CPSO Personnel may use the CPSO Personnel Networks to which they have access for personal use provided that such use:

- does not interfere in the performance of their CPSO duties;
- is not for business activities not related to CPSO business;
- is not excessive, and respects the fact that the CPSO Personnel Network is a shared and limited resource (See also note under Internet above about limiting use of large images, animation or complex graphics.);
- meets the Acceptable Use guidelines set out above; and
- is consistent with CPSO's professional standards and complies with CPSO policies, including this Policy.

CPSO Personnel access to the CPSO Personnel Networks is completely at the discretion of the CPSO and may be blocked, suspended or terminated at any time for any reason, including, but not limited to, violation of this policy, actions that may lead to liability for CPSO, or disruption of access to other users or networks.

CPSO Personnel should have no expectation of privacy when using the CPSO Personnel Networks, whether for personal or business use.

NOTE: Internet communication is not private or confidential. There may be potentially serious security issues encountered by any device connected to the Internet or any unknown network, ranging from viruses, worms and other programs that can damage

the user's computer, to attacks on the computer by unauthorized or unwanted third parties.

If you are connecting your own personal phone, computer or other device to the CPSO Personnel Networks, it is recommended that you take steps to protect your device by installing and maintaining current anti-virus software and appropriate firewall protection.

E-mail Management

Purpose

As a primary method for communicating and recording actions, decisions and information, e-mail messages are crucial records for the College of Physicians and Surgeons of Ontario ("CPSO" and "the College"). The efficient management of e-mail is required for the College to continue to fulfill its duties to legislators, members, and the public and to ensure that key information remains accessible for action, reference, and official documentation. The purpose of this policy is to outline the rules, procedures, and roles and responsibilities for the management of e-mail at the CPSO.

Scope

This policy applies to all e-mail records created, received and maintained by all staff and organizational units at the College of Physicians and Surgeons of Ontario, including, but not limited to, full time, contract, and temporary employees; assessors; and Council and committee members (collectively, "CPSO Personnel"). E-mail usage, etiquette, and security are out of the scope of this policy. Please refer to the *Use of CPSO Technology Policy* for policy statements on these topics.

Policy

E-mail messages and attachments are College records that must be managed according to records management best practices. All e-mail records created, received and maintained on CPSO systems are the property of the CPSO.

Key Terms

E-mail record(s): written communications sent to or received from internal or external addresses on an electronic mail system, including any file attachments transmitted with the message and associated transmission and receipt data.
Recordkeeping system: College tracking and activity workflow systems, shared drive folders, and paper filing systems that ensure that all records are identifiable, available, retrievable, and usable until their disposition in accordance with approved records retention schedules. A recordkeeping system is not an individual's personal desktop environment, the H: drive, a backup system, or Microsoft Outlook.
Records retention schedule: A document that describes a group of records, specifies how long those records need to be kept by the creating body, where those records

should be kept (in office or offsite), and specifies the final disposition of those records: either destruction or transfer to the CPSO Archives.

Procedures

1. Categorization and Retention of E-mail Records

The CPSO *Corporate Records Management Policy* defines three types of records produced at the College: official records, transitory records, and personal records. The following definitions expand on the *Corporate Records Management Policy* by categorizing College emails and defining their retention:

A. Official Records

- Official e-mail records are messages or conversations that are the unique authoritative source for recording information relevant to a process, task or activity of the College. They authorize a decision or action, document key information, and/or provide evidence of interactions between employees and the College and its stakeholders.
- Examples include approval e-mails recording that a file has closed; final decisions and deliberations on a College business-related issue or matter of concern; legal opinions; and important information to or from individuals, organizations and government bodies outside of the College.
- Official e-mail records and attachments must be filed in a recognized CPSO recordkeeping system and maintained and disposed of according to the appropriate records retention schedule.

B. Transitory Records

- Transitory e-mail records document temporary information as part of an event, task or process relating to CPSO business and operations. Though they may be necessary to keep for action or reference for anywhere from a few hours to several years, they are no longer useful when a task is completed or when an activity or process has ended. In many cases, they will duplicate official information in official records that are kept in one of the College's recordkeeping systems. Similarly, if an individual is CC'd or BCC'd on an internal College e-mail message, it is likely that this message is a transitory record and can be deleted.
- Examples include routine e-mails informing individuals of meeting times or sending copies of meeting minutes; conversations discussing routine operational and administrative issues or questions; messages attaching drafts of documents for review; or requests for information from other CPSO Personnel.
- Transitory e-mail records and attachments must be deleted once they are no longer needed for action or reference.

C. Personal Records

- Personal e-mail records are messages sent or received using CPSO e-mail systems that do not record information relevant to the business and operations of the College.
- Examples include invitations to events or meetings occurring outside of work, and communications with friends and family.
- College e-mail systems are intended primarily for business purposes. The use of e-mail for personal matters should be kept to a minimum.
- Personal e-mail records and attachments must be maintained separately from College-related records and deleted as soon as they are no longer needed.
- CPSO Personnel does not have a reasonable expectation of privacy in their use of CPSO e-mail systems or in any data, messages or electronic files stored on, or accessed or sent using CPSO e-mail systems. The College may inspect and monitor CPSO e-mail systems, including the content of any messages sent by CPSO Personnel or files created or stored by CPSO Personnel at any time, with or without notice to CPSO Personnel. CPSO Personnel should use their own personal devices not connected to CPSO e-mail systems if they wish to access or use data and files or communicate privately (vis-à-vis the College).

2. Filing Official E-mail Records

Filing an official e-mail record means placing it into a recognized recordkeeping system for documentation, retention and disposition. Saving important e-mail records and attachments outside of individual and group e-mail accounts enables others to access the information. The following procedures apply when filing official e-mail records:

- All official e-mail records and attachments must be filed in the appropriate CPSO recordkeeping system. CPSO recordkeeping systems are College tracking and activity workflow systems, shared drive folders, and paper filing systems.
- Microsoft Outlook is not a recordkeeping system. Official e-mail records must be filed outside of Outlook inboxes, H: drive folders, and Outlook Archive/Data files.

3. Printing E-mails

E-mail records and attachments should be printed only when the relevant records retention schedule designates paper as the single authoritative records format.

Roles and Responsibilities

All CPSO Personnel provided with an e-mail account are responsible for:

- Identifying official, transitory and personal e-mail records both as senders and receivers.

- Filing official e-mail records and attachments in the appropriate locations; and
- Printing official e-mail records only when required by the relevant records retention schedule.
- Using the “Everyone” e-mail list responsibly. The “Everyone” list is intended for messages relating to College business.

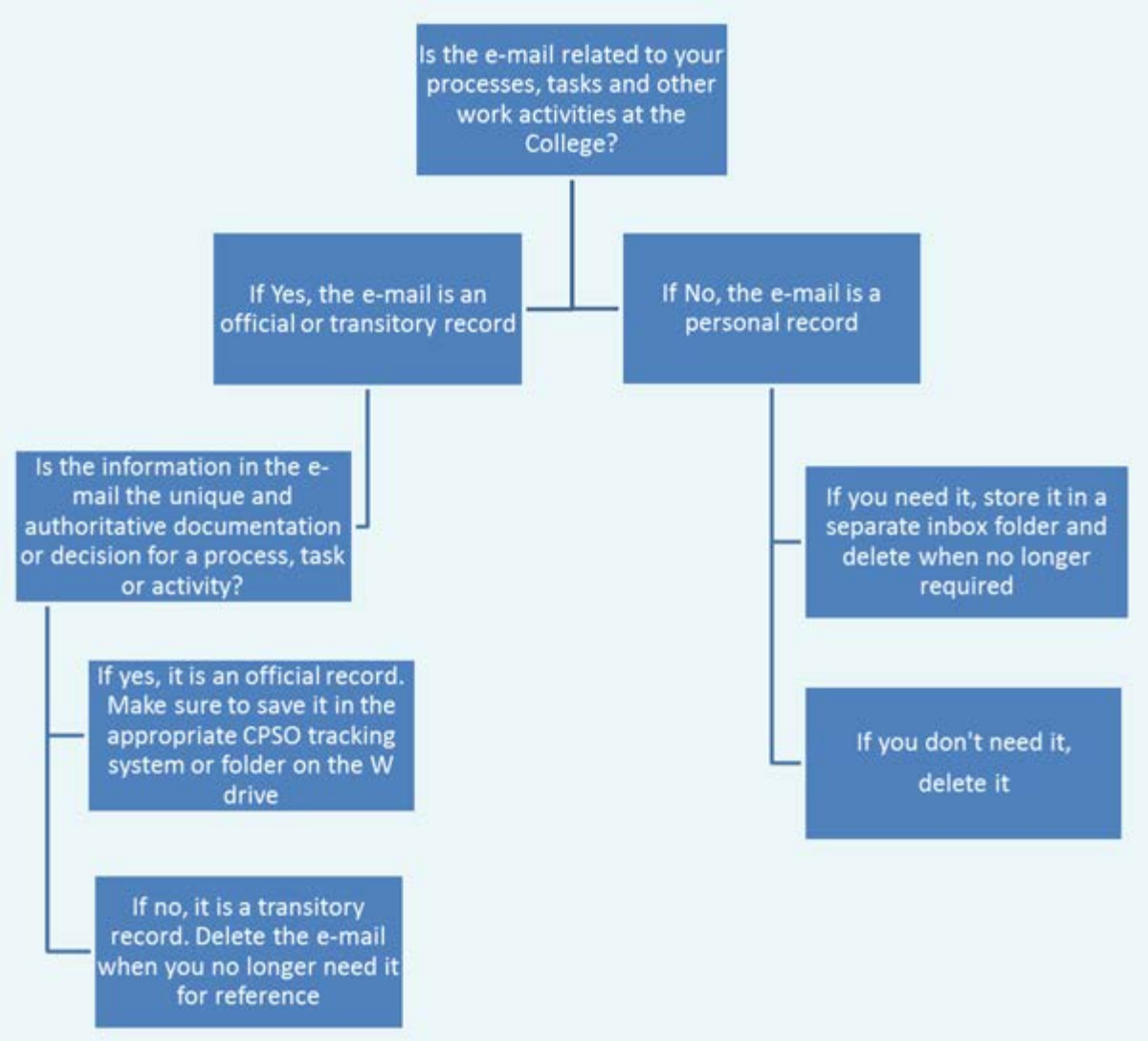
Department managers are responsible for:

- Ensuring that CPSO Personnel is aware of and able to implement their responsibilities for e- mail management.
- Ensuring that e-mail procedures are available for CPSO Personnel to consult.
- Designating an individual department member to manage the sent and received messages for group or department e-mail accounts according to the same terms as above.

Records Management and Archives Department is responsible for:

- Assisting departments with managing e-mail records according to the *Corporate Records Management Policy* and procedures for electronic records through classification, scheduling and disposition; and
- Providing assistance and training to all Departments in the efficient management of their e-mail records.

Appendix A: Email Decision Flowchart



Appendix B: Policy Summary Chart

Record Types	What they are	Examples	What to do
Official E-mail Records	Messages or conversations that are the unique authoritative source for documenting information Authorize a decision or action, document key	Approval e-mails recording that a file has closed Final decisions and deliberations on an issue or matter of concern	File in the appropriate CPSO recordkeeping system, such as AMS, CATS or shared drive

Record Types	What they are	Examples	What to do
	information, and/or provide evidence of interactions between CPSO Personnel and the College and its stakeholders	Legal opinions Important information to or from individuals, organizations and government bodies outside of the College	
Transitory E-mail Records	Document routine and temporary information as part of a task, activity or process Are no longer useful for action or reference when the task is complete Often include information that is also recorded in a recordkeeping system like AMS or the W drive Are often CC or BCC'd copies of internal e-mails	Announcements and invitations Messages attaching drafts of documents for review Conversations discussing routine operational or administrative matters Quick questions and requests for information from other CPSO Personnel	Delete when task, activity or project is complete, or the information is no longer needed for reference
Personal E-mail Records	Information that is not relevant to the business and operations of the College	Invitations to events or meetings outside of work Notes to and from friends and family	Organize in separate folder Delete when no longer needed

Updated: Jan 2021

Code of Conduct for CPSO Personnel

Scope

This document outlines the general expectations for professional standards and conduct of CPSO employees[1], assessors and other persons who work directly for or on behalf of the College or whose adherence to this Code of Conduct would be beneficial to CPSO (collectively, "CPSO Personnel").[2]

CPSO Personnel are required to comply with all CPSO policies, practices and guidelines regarding professional standards, conduct, employment and other issues raised in this Code of Conduct. This Code of Conduct does not supersede any CPSO policy, practice or guideline referenced under each section, but rather emphasizes the principles that guide the College and CPSO Personnel.

Ethical Framework

The College of Physicians and Surgeons of Ontario's mandate is to regulate the practice of medicine in the public interest. We must work to preserve the trust and confidence of the public and maintain respectful relations with the profession. Therefore we have a responsibility to adhere to the highest ethical standards and professional conduct in all our activities.

Regulatory Compliance

Underlying the College's commitment to professional standards and conduct is our obligation to follow legislative requirements and College By-laws. These may include:

- *The Regulated Health Professions Act, 1991*
- *College By-Laws*
- *The Medicine Act, 1991*
- *The Ontario Human Rights Code*
- *The Occupational Health and Safety Act*
- *Accessibility for Ontarians with Disabilities Act*

[1] This Code of Conduct applies to CPSO employees whether they are full-time or part-time, permanent or on contract.

[2] A separate Code of Conduct (the Council and Committee Code of Conduct) applies to Council and Committee members.

Expected Standards and Professional Conduct

1. General Expectations

1.1 Statement of Public Interest

It is the duty of the College to "serve and protect the public interest", therefore we must place the public interest in the forefront of our work.

1.2 Confidentiality and Representation[3]

At all times, we must represent the College with honesty, integrity and in good faith. We must maintain confidentiality regarding College-related information, unless an exception to the duty of confidentiality applies.[4] That is, with respect to information received in our capacity as employees, assessors and other CPSO Personnel, we:

a) are not to disclose or discuss such information with another person or entity; and
b) are not to use such information for our own purposes,

outside of our employment or CPSO business duties.

1.3 Conflict of Interest[5]

We are required to support and advance the interests of the College. We will declare all conflicts of interest (real or perceived, actual or potential, direct or indirect) between our personal or financial interests and the interests of the College. We shall not derive monetary benefit from our relationship with the College (other than reasonable remuneration, including fees, wages, honoraria and expense reimbursement in accordance with College policy).

1.4 Impartiality/Appearance of Bias

We will be fair and impartial in fulfilling our College obligations and will not participate in activities in a manner or circumstances that would give rise to an appearance of bias.

1.5 Communicating with the Media and Public

Media contact, responses and public discussion of the College's affairs should only be made through the authorized spokespersons. The President is the official spokesperson for the Council. The President represents the voice of Council to all

[3] Also see Confidentiality Policy and Best Practices – Privacy & Confidentiality.

[5] Also see Conflict of Interest Policy

stakeholders. The Registrar/CEO is the official spokesperson for the CPSO. All media requests are managed by communications staff who facilitate the approval process for interviews. No one shall speak or make representations on behalf of the College in any media (print, social media, in person) unless authorized by the President (or, in the President's absence, the Vice President) and the Registrar/CEO.

1.7 Whistle-blowing[6]

We will thoroughly investigate any reported claims of illegal or unethical behaviour on the part of any CPSO Personnel.

1.8 Guiding Principles of Service Delivery

- We are all representatives of the College and our individual actions collectively promote and enhance the College's image and reputation.
- We will make our services accessible to persons with disabilities consistent with our legal obligations and the principles of independence, dignity, integration and equality.
- Each one of us is responsible for performing our work in a timely manner.
- We will listen and work together to resolve matters.
- We will be courteous, respectful, and demonstrate interest in the issue at hand.
- We will make processes transparent and explain them clearly at the outset so that persons interacting with us have clear process expectations.
- We will set service standards and measure our performance.
- We will duly consider service improvement suggestions from all.

1.9 Environment

The College recognizes that exposure to harmful scents, fragrances or odours in the work environment can cause extreme discomfort and/or directly impact the health of some individuals. For this reason, the College asks that CPSO Personnel refrain from using, wearing or bringing harmful scented products and/or materials into the building.

1.10 Drugs and Alcohol[7]

The College prohibits the use, distribution, possession, or manufacture of drugs or alcohol on College premises, other than for events that are approved by the Registrar/CEO. CPSO Personnel are prohibited from being on the job while their ability to perform assigned duties safely and effectively is affected by the use of alcohol or drugs. The College has zero tolerance for driving while under the influence of alcohol or drugs.

[6] Also see Safe Disclosure Policy
[7] Also see Use of Drugs and Alcohol in the Workplace

1.11 Dress Code

The dress code for CPSO Personnel is "dress for the day". At a minimum, CPSO Personnel are expected to present in neat appearance in a manner that is appropriate for the work they are doing that day. CPSO Personnel are also expected to assure safe and sanitary working conditions. (See also Environment in 1.9.)

2. Individual Treatment

2.1 Harassment and Discrimination[8]

The College seeks to foster a positive environment, where all individuals are treated with respect and regarded as equals. This includes adopting and maintaining practices that comply with the *Human Rights Code,* respecting differences, being receptive to the specific needs of individuals and taking steps to accommodate those needs when required.

2.2 Protection from Violence and Harassment

The College is committed to minimizing risk and protecting any individual from violence, harassment and sexual harassment while the individual is fulfilling his or her role in the College's regulatory function. CPSO will not tolerate violence or unacceptable behaviour perpetrated by or against any CPSO Personnel.

2.3 Accessibility for Persons with Disabilities (AODA)

The College is committed to making all services and programs available and accessible to people with disabilities in a way that respects their dignity and independence.

2.4 Preferential Treatment/Nepotism[9]

To maintain confidentiality, avoid potential conflicts of interests, prevent favoritism and avoid harmful work related situations, CPSO has an anti-nepotism policy that limits the employment of certain persons related to employees or Council or committee members.

3. Information Management and Technology

3.1 Ownership and Use of Information and Technology[10]

We are provided with access to a wide variety of technology and electronic tools in order to support the work of the College. All information and data (including e-mail and

[8] Also see Harassment & Discrimination Policy
[9] Also see Nepotism Policy
[10] Also see Use of CPSO Technology Policy,

instant messaging) generated or stored by CPSO Personnel on devices, systems and associated computer storage media owned or provided by the College, or owned by CPSO Personnel that are used for College work, ("CPSO Technology") are the exclusive and confidential property of the CPSO. CPSO Personnel should have no expectation of privacy in their use of CPSO Technology or in any information or data generated or stored on CPSO Technology. The College may monitor and review the use of CPSO Technology and e-mail messages, instant messaging, internet activity and other information and data (including those of a personal nature) on CPSO Technology at any time without notice to CPSO Personnel.

We are expected to use CPSO Technology responsibly. It is appropriate to use CPSO Technology for the following:

- Communicating with CPSO Personnel or external stakeholders to exchange business information where there are no privacy or confidentiality concerns
- Acquiring or sharing information to accomplish assigned responsibilities
- Participating in education or professional development

It is unacceptable to use College Technology for any illegal, harmful, unauthorized or unlawful activity, including, but not limited to, the following:

- Spamming and invasion of privacy of others
- Infringement of intellectual property rights
- Accessing pornography or gaming sites

3.2 Information Practices

The College may collect, use, disclose or retain information, including personal information and personal health information, in order to perform its regulatory functions, fulfill its statutory objects, its obligations as an employer, or where it is permitted or required by law to do so. In doing so, the College will comply with its legal obligations, its Privacy Code, and any relevant corporate policies.

We are required to comply with obligations to keep information confidential as set out in the *Regulated Health Professions Act, 1991.* Specific guidance on how to comply with these obligations is contained in "Best Practices: Privacy and Confidentiality" and the "Working from Home" Policy. Should individuals become aware that confidential information has been shared inadvertently and that a privacy breach has or may have occurred, they must act in accordance with the CPSO's Information Breach Protocol.

Information Breach Protocol

Application of Protocol

This Protocol applies to all:

- CPSO employees (whether full-time or part-time, permanent or on contract);
- Council members;
- CPSO committee members; and
- other persons or stakeholders working on behalf of the CPSO,

(collectively, **"CPSO Personnel"**).

Confidentiality

The CPSO is committed to meeting high standards to protect the confidentiality and security of CPSO Confidential Information.

In this Protocol, **"Confidential Information"** means all information that is required to be kept confidential by Section 36 of the *Regulated Health Professions Act, 1991* (the **"RHPA"**)[1] or that is otherwise regulated by any other law, contract, court order or similar requirement. Confidential Information includes, but is not limited to, personal information and personal health information about members, CPSO employees and other individuals.

CPSO Personnel are required to limit access to and use of Confidential Information to what is necessary to fulfill their duties. CPSO Personnel are not permitted to disclose Confidential Information to any person, or to use Confidential Information for their own purposes, outside of their employment or CPSO business duties or except as permitted or required by law. This prohibition generally applies to disclosure to persons outside the CPSO, but it could also include disclosure to persons within the CPSO if the particular information or matter is confidential and limited to a particular group of people within the CPSO.

[1] Section 36 of the RHPA requires employees and other persons retained or appointed by CPSO (including Council members, committee members, assessors, consultants and other contractors) to keep confidential all information that comes to their knowledge in the course of their duties to the CPSO. Section 36 of the RHPA also prohibits CPSO Personnel from disclosing any such information unless one of the exceptions listed in that provision apply..

Information Breaches

For purposes of this Protocol, an **"information breach"** is:

(a) the loss or theft of Confidential Information; or
(b) the unauthorized access to or use or disclosure of Confidential Information,

whether intentional, inadvertent or in error.

Information Breach Protocol

This Protocol is important to enable CPSO to take a coordinated and consistent approach to information breaches.

All information breaches relating to CPSO are to be reported to the Privacy Officer in accordance with this Protocol.

The Incident Response Team is responsible for responding to information breaches in accordance with this Protocol. The Incident Response Team includes the Privacy Officer and applicable support staff, except that in the case of a data security breach (see below), the Incident Response Team includes the Chief Transformation Officer, the Director, Information Technology and the Privacy Officer.

CPSO Personnel are to comply with the following protocol if they know or suspect that a privacy breach has occurred:

Step 1: Notification & Initial Assessment

- Immediately notify the Privacy Officer by completing the Information Breach Report form and emailing it to the Privacy Group email address.
  - The information provided in the report will help the Incident Response Team assess how to respond to the breach.
  - Notification to the Privacy Officer can be made by: the individual who learns of or suspects the breach, or by a supervisor, manager or other senior staff responsible for the program area, department, Committee or Council.
- **CPSO Personnel are asked <u>not</u> to notify affected persons[2] or take remediating action or corrective measures before speaking with the Privacy Officer.**
- Where a laptop or smartphone (whether provided by the CPSO or a personal device that is used to access CPSO information) has been lost, also notify the IT Helpdesk so that immediate steps can be taken to remotely 'wipe' the device.

[2] Affected persons are those whose information was compromised or those who may be involved in unauthorized processing of CPSO Confidential Information.

- The Privacy Officer, supported by the Incident Response Team, will conduct an initial assessment to determine whether a breach has occurred, and if so, the nature and extent of the breach.

Step 2: Contain the Potential Breach

- The Incident Response Team will take steps to contain the situation and may ask the party who reported the breach or other person(s), as appropriate, to take steps to assist with containing the breach. The goal in doing so is to limit any ongoing unauthorized access to Confidential Information.
- CPSO Personnel are expected to cooperate with and assist the Incident Response Team to work through privacy breaches.
- The specific steps taken will depend on the circumstances in question but can include taking steps to recover the information, prevent further access to the information, locate lost devices and wipe devices (remotely) of confidential or private information.

Step 3: Information Gathering and Assessment of Situation

- The Incident Response Team will gather pertinent details for the purpose of determining what further action is required.
- This will include determination of the following:
    - what information has or may have been disclosed;
    - the nature and scope of the information in question: whether it is confidential information, personal information, public information, or other sensitive information;
    - the cause of the breach;
    - to whom the information in question has been or may have been disclosed; and
    - whether the information released would allow individuals access to any other confidential information.
- The Incident Response Team must engage or notify other stakeholders as necessary in light of the nature and seriousness of the information breach.
    - These other stakeholders may include (but are not limited to) the Chief Legal Officer, Human Resources, Communications and other senior management.
    - The Incident Response Team will consult with the Chief Legal Officer prior to retaining external counsel or other third party providers (e.g. forensics) in connection with the investigation.
    - The Legal Office can advise on legal strategy and risk, including measures to be taken to protect the organization's legal rights and privilege.

Step 4: Develop Strategy to Address Breach

- Based on the information available, the Incident Response Team will determine what steps are required to address the breach, including:
    - whether notification to the individuals affected by the breach is required along with whom the notification should come from; and
    - if any third parties need to be notified (for example insurers, regulators, law enforcement).

Step 5: De-brief & Preventive Steps

- Once the above steps have been taken, and the breach itself has been fully addressed, the Incident Response Team will review the circumstances and details to determine whether any steps can be taken to prevent similar breaches in the future.
- This may involve considering whether changes in processes or procedures are required, and whether any educational training for those involved (and others) is necessary.

Data Security Breaches

In the event that an information breach is caused by or involves a cybersecurity incident (such as ransomware or hacking) or technology system malfunction or misuse:

(a) where the information breach is reported to the Privacy Officer, the Privacy Officer will advise the Chief Transformation Officer and the Director, Information Technology of the breach; or

(b) where the information breach first comes to the attention of the Director, Information Technology and/or the Chief Transformation Officer, they shall advise the Privacy Officer and Legal Office of the breach.

The Director, Information Technology and/or the Chief Transformation Officer may lead the investigation and resolution of such a breach, and will keep the Privacy Officer informed and coordinating efforts with the Privacy Officer as appropriate in the circumstances.

PROTOCOL FOR ACCESS TO CPSO INFORMATION FOR MONITORING AND REVIEW

Background: CPSO's Code of Conduct, Use of CPSO Technology Policy, Email Management Policy, and other policies, provide that all information and data generated or stored on CPSO-supplied devices or CPSO systems are the exclusive and confidential property of CPSO and may be subject to monitoring and review at any time, without notice to the individual.

Definitions: For purposes of this Protocol the following terms have the following meanings:

CPSO Information means all information and data generated or stored on CPSO Technology, including, but not limited to, e-mail, instant messaging, internet activity and electronic files, and may include items of a personal nature;

CPSO Personnel means CPSO employees (whether full-time or part-time, permanent or on contract), Council members, CPSO committee members, and contractors who use or have access to CPSO Technology;

CPSO Technology means CPSO systems, CPSO-supplied devices and personal devices used by CPSO Personnel for CPSO activities (for greater certainty, including, but not limited to, computers, laptops, and phones) and associated computer storage media.

Purpose:

In the course of CPSO operations it is sometimes necessary to monitor or review the CPSO Information generated or stored by one or more CPSO Personnel on CPSO Technology and/or their use of CPSO Technology, without notice to the individual(s). The purpose of this Protocol is to provide a process and oversight for any such monitoring or review. Some examples where such monitoring or review may be necessary include, but are not limited to, the following:

- Formal or informal investigations (whether conducted internally or by an external party) of one or more CPSO Personnel where there are reasonable grounds to believe that there may have been a failure to comply with or a violation of applicable laws, regulations, or the Code of Conduct for CPSO Personnel, the Code of Conduct for Council and Committee Members, or policies.

- Review of CPSO Information of former CPSO Personnel for the purposes of business continuity, quality assurance and review of compliance with applicable laws, regulations or the Code of Conduct for CPSO Personnel, the Code of Conduct for Council and Committee Members or policies.

Protocol:

Where it is necessary to monitor or review CPSO Information generated or stored by one or more CPSO Personnel on CPSO Technology or their use of CPSO Technology, the following Protocol applies:

1. **Request for Access:** A request for access for the purpose of monitoring or review must be made to the Privacy Officer. Prior to requesting access from the Privacy Officer, permission to request access must be obtained from the Registrar/CEO. Please see exceptions below for particular circumstances.

2. **Who may make a request:** Only the Registrar/CEO or a member of the Senior Management Team who reports directly to the Registrar/CEO, may request access.

3. **Access Requests by Privacy Officer:** Where the Privacy Officer intends to make a request for access for the purpose of monitoring or review, this request shall be made to the Chief Legal Officer, after consultation with the Registrar/CEO.

4. **Access Requests re Privacy Officer or Chief Legal Officer:** Where the access request is for the purpose of the monitoring or review of either the Privacy Officer's or the Chief Legal Officer's CPSO Information generated or stored on CPSO Technology and/or their use of CPSO Technology, this request shall be made to the Registrar/CEO. The Registrar/CEO will seek external legal counsel in considering the request.

5. **Access Requests re Registrar/CEO:** Where the access request is for the purpose of the monitoring or review of the Registrar/CEO's CPSO Information generated or stored on CPSO Technology and/or their use of CPSO Technology, this request shall be made to the Privacy Officer after consultation with the Chief Legal Officer and the President or President's delegate.

6. **Access Requests re Council or Committee Members:** Where the access request is for the purpose of the monitoring or review of a Council or committee member's CPSO Information generated or stored on CPSO Technology and/or their use of CPSO Technology, permission to request access from the Privacy Officer must be obtained from both the CPSO President and the Registrar/CEO.

7. **Contents of Access Request:** Every request for access must include:

    - The reason for the request;
    - The specific CPSO Information to be accessed for monitoring or review;
    - How the specific CPSO Information to be accessed for monitoring or review is relevant to the reason for the request;
    - The individual responsible for monitoring or reviewing the CPSO Information (if not the member of the Senior Management Team making the request);
    - With whom (if anyone), in addition to the individual responsible for monitoring or reviewing the CPSO Information, the CPSO Information will be shared;
    - What steps will be taken to protect the privacy and confidentiality of the CPSO Information, if access is granted; and
    - To whom and how will the conclusions of the monitoring or review be communicated and used.

Upon receipt of a request for access, the Privacy Officer (or Chief Legal Officer or the Registrar/CEO, if applicable) will determine if there is a legitimate business need to access the CPSO Information for the purpose of monitoring or review and if this business need is reasonable and outweighs any privacy and confidentiality interests involved and other risks associated with accessing the requested information, in all of the circumstances. Legal privileges (including deliberative privilege) and restrictions will be considered and respected as appropriate in determining the response to the access request. This determination may also include consideration of the risks of not accessing the requested information.

Where the Privacy Officer (or Chief Legal Officer or Registrar/CEO, if the conditions in 3 or 4 above apply) determines that CPSO Information may be accessed, the Privacy Officer (or Chief Legal Officer or Registrar/CEO, if the conditions in 3 or 4 above apply) will direct:

- the specific CPSO Information that may be accessed and for what purpose;
- the individual responsible for the monitoring /or review;
- with whom the CPSO Information may be shared; and

- any steps that must be taken in the process of accessing and sharing the CPSO Information to protect the privacy and confidentiality of that information.

When a request for access is granted in accordance with this Protocol, the CPSO Information may be accessed without the consent of individual CPSO Personnel and without notice to individual CPSO Personnel.

Safe Disclosure Policy

Purpose

The purpose of this Policy is to facilitate the disclosure and investigation of significant and serious incidents at the College of Physicians and Surgeons of Ontario ("CPSO" or the "College") involving unlawful, unethical, or unprofessional conduct of CPSO Personnel, while creating and maintaining a culture of trust and respect at the College, where CPSO Personnel feel empowered to make good faith reports of such incidents based on reasonable grounds.

Application of Policy

This Policy applies to all:

- CPSO employees (whether full-time or part-time, permanent or on contract);
- Council members;
- CPSO committee members;
- CPSO contractors; and
- any other persons or stakeholders working on behalf of the CPSO,

(collectively, **"CPSO Personnel"**).

Safe Disclosure Incidents

An incident reportable under this Policy includes, but is not limited to, the following:

- Fraud or deliberate error in preparing, evaluating, reviewing or auditing financial statements;
- Fraudulent recording or reporting of financial records;
- Fraudulent classification of assets and/or liabilities or any deviation from full and fair reporting of the College's financial condition or results;
- Deliberate, unauthorized manipulation of or access to documents or records;
- Deliberate misuse of the College's funds;
- Unlawful conduct;
- Unprofessional or unethical conduct or business practices that result in violation of College internal policies such as the Code of Conduct; and
- Concealment of any of the above.

Reporting and Investigation Processes

Any CPSO Personnel who has reasonable grounds to believe that another CPSO Personnel working on behalf of the College has committed an act or is planning to commit an act that would constitute a reportable incident under this Policy should promptly report the incident.

All incidents should be reported directly to the Director, People, Organizational Development and Quality Programs (DPO) or the Corporate Services Officer (CSO). If the DPO or the CSO is involved in the incident or if the individual does not feel comfortable reporting this information to the DPO or the CSO, the individual should report the incident to the Registrar. If the incident is about the Registrar, the individual should report the incident to the President or the Chair of the Finance Committee.

The incident report should include as much information as possible, including the following:

- Reporter's full name;
- Reporter's contact information (whether at work or at home)
- The name of the CPSO Personnel alleged to be involved in the incident;
- A description of the alleged conduct with as much detail as possible including any witnesses, locations and dates; and,
- Reporter's signature.

Although complaints may be made on an anonymous basis, reporting individuals should be aware that maintaining anonymity may limit the College's ability to adequately investigate the report and confirm the good faith by the reporter.

The reporter is not required to prove the truth of the allegation but is required to make the report on reasonable grounds and to act in good faith in making the report.

No CPSO Personnel will be subject to reprisal or retribution (including termination, demotion, suspension, threats, harassment or other discrimination) as a result of making a good faith report of an incident or for participating in the investigation of an incident. If any CPSO Personnel is found to be engaging in reprisal or retribution in violation of this Policy, the College may take action against such person, up to and including dismissal or termination of engagement or appointment.

The CSO, Registrar and/or President, in consultation with the DPO and/or the Chief Legal Officer (CLO), (collectively, the Designated Officers) (excluding any of these persons if they are the subject of the report or involved in the alleged incident) will assess whether the report discloses a matter that is covered under this Policy. If it does, then the Designated Officers will review the information provided and either

investigate the report or designate an appropriate internal or external investigator to conduct the investigation. If the report relates to a privacy or data security concern, the Designated Officers will also consult with the Privacy Officer.

The College will endeavour to complete each investigation in a timely manner and will monitor investigations on an ongoing basis.

If it is determined after the investigation that the reported incident occurred or was planned, the Designated Personnel may determine the appropriate action or remedy, including but not limited to:

- Education and training for the individual(s) involved;
- Disciplinary action up to and including dismissal or termination of engagement or appointment;
- Other appropriate remedial steps or action in respect of the conduct of the individual involved; and
- Notification of appropriate law enforcement authorities or other regulatory entities.

In determining the appropriate action, the College will consider all the relevant circumstances, including the nature and seriousness of the conduct, any relevant history or record of the individual involved, the actual or potential impact of the conduct, and any mitigating circumstances.

Once any investigation has been completed, the Designated Officers will prepare an investigation report. Where appropriate, the Designated Officers will notify the reporting individual of the results of the investigation and any action taken as a result, subject to privacy and other legal obligations.

Confidentiality

All complaints under this Policy will be regarded as confidential to the extent possible. The College will take every reasonable measure to protect the identity of the reporting individual, although disclosure of the reporting individual's identity may be necessary in in order for the College to effectively investigate, to respond to the report or matters disclosed in the investigation, or if otherwise required by law. Depending on the nature of the complaint, the College may be required to report the matter to law enforcement officials, which may require a disclosure of the reporting individual's identity. The College will take reasonable steps to protect the reporter from reprisal or retaliation.

If an incident is also covered by another College policy (for example, Protection from Violence and Harassment Policy and Harassment and Discrimination Policy),the investigation may be conducted in accordance with that other policy and in accordance with the terms of that policy.

Council Briefing Note

March 2021

Topic:	Status Update on Council Decisions
Purpose:	For Information
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration, Continuous Improvement
Public Interest Rationale:	**Accountability:** Holding Council and the College accountable for the decisions made during the Council meetings.
Main Contact(s):	Laurie Cabanas, Director of Governance
Attachment(s):	N/A

Issue

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

Current Status

- Council held a meeting on December 3-4, 2020. The motions carried and the implementation status of those decisions are outlined in Table 1.

- A Special Meeting of Council was held on February 9, 2021. The motions carried and the implementation status of those decisions are outlined in Table 2.

Table 1: Council Decisions from December Meeting

Reference	Motions Carried	Status
01-C-12-2020	The Council approves the items outlined in the consent agenda, which include in their entirety: • Meeting agenda for Dec 3-4, 2020	Completed.

Reference	Motions Carried	Status
	• Meeting minutes of Council held on September 10-11, 2020 • For information items: o Discipline Committee Report o Executive Committee Report o Government Relations Report o Policy Report o Annual Committee Reports	
02-C-12-2020	The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 139: **By-law No. 139** (1) Paragraph 20(3) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted, effective January 1, 2021: (3) The amount payable to members of the council and a committee is, subject to subsections (4) and (8), (a) for attendance at, and preparation for, meetings to transact College business, $522 per half day, and (b) for transacting College committee business by telephone or electronic means of which minutes are taken, the corresponding hourly rate for one hour and then the corresponding half hour rate for the half hour or major part thereof after the first hour.	Completed. The Fees and Remuneration By-Law has been updated accordingly, operationalized and posted on CPSO's website.
03-C-12-2020	Council approve the "Budget for 2021" (a copy of which forms Appendix "B" to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2021.	Completed. The budget for 2021 has been operationalized accordingly.
04-C-12-2020	The Council approves the Overview of the eLearning Program, a copy of which forms Appendix "C" to the minutes of this meeting, as the basis for the education program to be undertaken by prospective physician	In Progress. Staff are finalizing the

Reference	Motions Carried	Status
	Councillors, elected and appointed Councillors and committee members.	eLearning Program for release in Summer 2021. In the interim, staff are also working on a format of the Program to be provided to the 2021 Council candidates.
05-C-12-2020	The Council approves the revised Declaration of Adherence, a copy of which forms Appendix "D" to the minutes of this meeting, and the revised Council and Committee Code of Conduct, a copy of which forms Appendix "E" to the minutes of this meeting.	Completed. The revisions have been made. Council and Committee members received the Declaration of Adherence the week of Feb. 22nd for signature.
06-C-12-2020	The College engage in the consultation process in respect of the draft Alternative Pathways to Registration policy (a copy of which forms Appendix "F and G" to the minutes of this meeting).	Completed. The policy was released for consultation.
07-C-12-2020	The Council exclude the public from the part of the meeting immediately after this motion is passed, under clause 7(2)(b) and (d) of the Health Professions Procedural Code.	N/A
08-C-12-2020	The Council adopts the following 2021 Key Performance Indicators (KPIs) to measure and report progress on the Strategic Plan: 1. Target of 735 active physicians assessed who are: (a) turning 70; or (b) are 71 or older and have not had an assessment in	Completed. The Key Performance Indicators have been operationalized

Reference	Motions Carried	Status
	the past five years 2. Target of 325 completed facility assessments 3. Respond to 90% of calls to Public Advisory Services within one business day 4. Target of 3000 Practice Improvement Plans submitted through Quality 5. Improvement Program 6. Target of 20 hospitals collaborating in Quality Improvement Partnership 7. Compliance with Ontario Government's new College Performance Measurement Framework 8. Staff to achieve target of 395 Continuous Improvements 9. Meeting Solis and Vault project timelines 10. Monitor and continue to achieve 2-day benchmark for contacting complainants 11. Target to complete all complaint files within 150 days 12. Target of one year or 365 days to complete a file from referral to discipline to the start of hearing date.	and data is being collected.
09-C-12-2020	The College engage in the consultation process in respect of the draft policy "Complementary and Alternative Medicine" (a copy of which forms Appendix "H" to the minutes of this meeting).	Completed. The policy was released for consultation.
10-C-12-2020	The Council approves the 2021 district election date set out below: Districts 6, 7, 8 and 9: June 22, 2021	Completed. The new date has been reflected in work processes and communications to physicians regarding the Council Elections.
11-C-12-2020	The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 140: **By-law No. 140**	Completed. The amendments were made to the General By-Law

Reference	Motions Carried	Status
	(1) Subsections 13(1)(f), (g), (h) and (i) of the General By-law are revoked and substituted with the following: **Eligibility for Election** **13.** (1) A member is eligible for election to the council in an electoral district if, on the date of the election, … (f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario or the Ontario Specialists Association; (g) the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization; (h) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis); (i) council has not disqualified the member from council or from one or more committees during the five years before the election date; (j) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees; (k) the member has completed and filed with the	and are available on CPSO's website.

Reference	Motions Carried	Status
	registrar a Conflict of Interest form by the deadline set by the registrar; and (l) prior to the member submitting a nomination form and nomination statement for the election, the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members. (2) Subsection 22(1)(i) of the General By-law is revoked and substituted with the following: **Disqualification of Elected Members** **22.** (1) An elected member is disqualified from sitting on the council if the member, … (i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association; (3) Subsections 24(3)(f), (g) and (h) of the General By-law are revoked and substituted with the following: **Academic Advisory Committee** **24.** (3) A member is eligible for appointment to the academic advisory committee if, on the date of the appointment, … (f) the member is not, and has not been within one year before the date of the election, a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association;	

Reference	Motions Carried	Status
	(g) the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if appointed to the Academic Advisory Committee, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization; (h) the member is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(a); (i) the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis); (j) council has not disqualified the member from council or from one or more committees during the five years before the election date; (k) the member has not resigned from council or from one or more committees during the five years before the election date where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the member from council or one or more committees; and (l) the member has completed the orientation program specified by the College relating to the business and governance of the College and the duties, obligations and expectations of council and committee members. (4) Subsection 27(1)(i) of the General By-law is revoked and substituted with the following: **Disqualification of Selected Councillors**	

Reference	Motions Carried	Status
	27. (1) A person selected as a councillor is disqualified from sitting on the council if the member, … (i) is or becomes a director or officer of the Ontario Medical Association, the Canadian Medical Association, the Coalition of Family Physicians and Specialists of Ontario, or the Ontario Specialists Association; or	
12-C-12-2020	The Council approves the revised policy "Advertising", (a copy of which forms Appendix "I" to the minutes of this meeting).	Completed. The policy has been updated on CPSO's website and physicians have been made aware of the policy through various communication channels.
13-C-12-2020	The Council approves the Committee Mentoring Guide, a copy of which forms Appendix "J" to the minutes of this meeting.	Completed. The Committee Mentoring Guide is being made available to all Committee Chairs/Vice-Chairs and newly appointed Committee members.
14-C-12-2020	The Council appoints the following people to the 2020-2021 Governance Committee for the term indicated below: Dr. Brenda Copps, Chair — 1 year Dr. Judith Plante, Vice Chair — 1 year Dr. Janet van Vlymen — 1 year Dr. Ian Preyra — 1 year	Completed. The appointment term of public member Mehdi Kanji, expired on Feb. 7, 2021. A discussion about

Reference	Motions Carried		Status
	Mr. Mehdi Kanji - Public Member of Council	1 year	how to fill the vacancy on the Governance Committee is on the Council meeting agenda for March.
	Mr. Pierre Giroux -Public Member of Council	1 year	
15-C-12-2020	Council approves the application of the exceptional circumstances clause in Section 37 (8) of the General By-Law in respect to Dr. Patrick Safieh, when his appointment to the Quality Assurance Committee expires at the Annual General Meeting of Council in December 2020.		Completed. The term information has been updated accordingly in CPSO's database and Dr. Safieh will be mentoring newer QAC members between now and the end of his term.
16-C-12-2020	The Council appoints the following committee members as Chairs of the following committees for the terms set out below as of the close of the Annual General Meeting of Council in December 2020, which terms supersede the terms previously approved by Council in September 2020 for Dr. Anil Chopra, Dr. Gillian Oliver and Dr. Janet van Vlymen: Discipline Committee: Mr. David Wright, Chair, 3 years Inquiries, Complaints and Reports Committee: Dr. Anil Chopra, Chair, 1 year Premises Inspection Committee: Dr. Gillian Oliver, Chair, 1 year Quality Assurance Committee: Dr. Janet van Vlymen, Chair, 1 year		Completed. The term information for these Chairs has been updated accordingly in CPSO's database.

Reference	Motions Carried	Status
17-C-12-2020	The Council appoints the following committee members as Vice Chairs/ICRC Specialty Panel Vice Chairs of the following committees for the following terms, as of the close of the Annual General Meeting of Council in December 2020: Discipline Committee: Dr. James Watters, Vice Chair, 2 years Executive Committee: Dr. Janet van Vlymen, Vice Chair, 1 year Finance and Audit Committee: Dr. Rob Gratton, Vice Chair, 2 years Fitness to Practise Committee: Dr. James Watters, Vice Chair, 2 years Governance Committee: Dr. Judith Plante, Vice Chair, 1 year Inquiries, Complaints and Reports Committee: Dr. Brian Burke, Vice Chair, ICRC, 1 year Dr. Dori Seccareccia, Specialty Panel Vice Chair, Settlement, 2 years Dr. Lydia Miljan, PhD, Specialty Panel Vice Chair, General, 2 years Dr. Elaine Herer, Specialty Panel Vice Chair, Obstetrical, 2 years Dr. Mary Jean Duncan, Specialty Panel Vice Chair, Surgical, 2 years Dr. Val Rachlis, Specialty Panel Vice Chair, Family Practise, 2 years Dr. Mary Bell, Specialty Panel Vice Chair, Internal Medicine, 2 years Dr. Daniel Greben, Specialty Panel Vice Chair, Mental Health & HIP, 2 years Premises Inspection Committee: Dr. James Watson, Vice Chair, 1 year Quality Assurance Committee:	Completed. The term information for these Chairs has been updated accordingly in CPSO's database.

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td></td><td>Dr. Sarah Reid, Vice Chair, 1 year

Registration Committee:
Dr. Bob Byrick, Acting Vice Chair, 1 year</td><td></td></tr>
<tr><td>18-C-12-2020</td><td>The Council appoints the following people to the following committees for the terms indicated below:
Discipline Committee:
PHYSICIAN COUNCIL MEMBERS:
Dr. Glen Bandiera — 3 years
Dr. Michael Franklyn — 3 years
Dr. Deborah Hellyer — 3 years
Dr. Paul Hendry — 3 years
Dr. Roy Kirkpatrick — 3 years
Dr. Camille Lemieux — 3 years
Dr. Ian Preyra — 3 years
Dr. John Rapin — 3 years
Dr. Deborah Robertson — 3 years
Dr. Andrew Turner — 3 years
PUBLIC MEMBERS OF COUNCIL:
Mr. Jose Cordeiro — 1 year
Mr. Pierre Giroux — 2 years
Mr. Mehdi Kanji — 1 year
Mr. Paul Malette — 1 year
Mr. Rob Payne — 1 year
Mr. Peter Pielsticker — 2 years
Ms. Linda Robbins — 1 year
Ms. Shannon Weber — 1 year
NON-COUNCIL PHYSICIAN MEMBERS:
Dr. Ida Ackerman — 3 years
Dr. Philip Berger — 3 years
Dr. Steven Bodley — 1 year
Dr. Joanna Bostwick — 3 years
Dr. Pamela Chart — 1 year
Dr. Melinda Davie — 1 year
Dr. Paul Garfinkel — 1 year
Dr. Kristen Hallett — 3 years
Dr. Stephen Hucker — 3 years
Dr. Veronica Mohr — 3 years
Dr. Joanne Nicholson — 3 years
Dr. Terri Paul — 3 years
Dr. Dennis Pitt — 1 year</td><td>Completed.

The appointment term of public member, Mehdi Kanji, expired on Feb. 7, 2021.

The term information for these Committee members has been updated accordingly in CPSO's database.</td></tr>
</table>

Reference	Motions Carried		Status
	Dr. Peeter Poldre	2 years	
	Dr. Robert Sheppard	1 year	
	Dr. Eric Stanton	1 year	
	Dr. Yvonne Verbeeten	3 years	
	Dr. James Watters	3 years	
	Mr. David Wright	3 years	
	Dr. Susanna Yanivker	3 years	
	Executive Committee:		
	PUBLIC MEMBER OF COUNCIL:		
	Ms. Joan Fisk	1 year	
	Finance and Audit Committee:		
	PHYSICIAN COUNCIL MEMBERS:		
	Dr. Rob Gratton	3 years	
	Dr. Judith Plante	1 year	
	Dr. Janet van Vlymen	2 years	
	PUBLIC MEMBERS OF COUNCIL:		
	Mr. Pierre Giroux	1 year	
	Mr. Rob Payne	1 year	
	Mr. Peter Pielsticker	2 years	
	NON-COUNCIL PHYSICIAN MEMBER:		
	Dr. Thomas Bertoia	3 years	
	Fitness to Practise Committee:		
	PHYSICIAN COUNCIL MEMBER:		
	Dr. Glen Bandiera	3 years	
	Dr. Michael Franklyn	3 years	
	Dr. Deborah Hellyer	3 years	
	Dr. Paul Hendry	3 years	
	Dr. Roy Kirkpatrick	3 years	
	Dr. Camille Lemieux	3 years	
	Dr. Ian Preyra	3 years	
	Dr. John Rapin	3 years	
	Dr. Deborah Robertson	3 years	
	Dr. Andrew Turner	3 years	
	PUBLIC MEMBERS OF COUNCIL:		
	Mr. Jose Cordeiro	1 year	
	Mr. Pierre Giroux	2 years	
	Mr. Mehdi Kanji	1 year	
	Mr. Paul Malette	1 year	
	Mr. Rob Payne	1 year	

Reference	Motions Carried		Status
	Mr. Peter Pielsticker	2 years	
	Ms. Linda Robbins	1 year	

Table 2: Council Decisions from February Special Meeting of Council

Reference	Motions Carried	Status
01-C-02-2021	The Council exclude the public from the part of the meeting immediately after this motion is passed, under clause 7(2)(e) of the Health Professions Procedural Code.	Completed.
02-C-02-2021	The Council approves the agenda for the February 9, 2021 Special Meeting of Council.	Completed.
03-C-02-2021	The College engage in the notice and consultation process in accordance with section 22.21 of the Health Professions Procedural Code, in respect of the draft policy "Requirement For Successful Completion of Part 2 of the MCCQE – Pandemic Exemption" (a copy of which forms Appendix "A" to the minutes of this meeting).	Completed. CPSO provided notice and consultation process on Feb 10, 2021.

REGISTRAR'S REPORT

(No materials)

PRESIDENT'S REPORT

(No materials)

Council Motion

Motion Title	Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption
Date of Meeting	March 4, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the policy "Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption", (a copy of which forms Appendix "A", "B", "C" & "D" to the minutes of this meeting).

Council Briefing Note

March 2021

Topic:	Medical Council of Canada Qualifying Examination Part II
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services Amy Block, Senior Legal Counsel, Legal Office
Attachment(s):	Appendix A: Proposed Policy - *Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption* Appendix B: Feedback from serving notice under section 22.21 of the Health Professions Procedural Code Appendix C: Letter from the Medical Council of Canada Appendix D: Submission from Professional Association of Residents of Ontario (PARO)

Issue

- The proposed policy "Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption" was released for notice under section 22.21 (a) of the Health Professions Procedural Code by Council at its meeting on February 9, 2021.

- Section 22.21 (a) of the Health Professions Procedural Code requires that the College give notice of its intention to establish or amend occupational standards to:

  (i) The Minister of Health
  (ii) The co-ordinating Minister under the *Ontario Labour Mobility* Act, *2009*, and
  (iii) The bodies authorized to grant certificates of registration in other provinces or territories that are parties to the Canadian Free Trade Agreement (i.e. Medical Regulatory Authorities).

- The medical regulatory authorities are provided an opportunity to comment on the proposed change.

- Council is asked whether the draft policy can be approved.

Background

- The draft policy was approved for release for notice to the Ministry of Health, the coordinating Minister under the *Ontario Labour Mobility* Act, *2009*, and the medical regulatory authorities in Canada under Section 22.21 of the Health Professions Procedural Code at a Special Meeting of Council held on February 9, 2021

- The materials considered at that meeting can be accessed here.

Current Status

Proposal

- The proposed policy (*Appendix A)* provides that the Registration Committee may direct the Registrar to issue a certificate of registration authorizing independent practice to applicants who are lacking MCCQE Part II where:

  - The applicant demonstrates that they were eligible to challenge the Medical Council of Canada Qualifying Examination Part II at the May 2020, October 2020, and/or February 2021 sittings*;

  - The applicant is presently registered in Ontario or was registered in Ontario at the time that they were eligible to challenge the Medical Council of Canada Qualifying Examination Part II at the May 2020, October 2020, and/or February 2021 sittings;

  - The applicant was within 24 months from the completion of their postgraduate training at the time that they were eligible to challenge the Medical Council of Canada Qualifying Examination Part II at the May 2020, October 2020, and/or February 2021 sittings;

- The applicant otherwise meets the prescribed requirements for an Independent Practice Certificate of Registration; and

- The applicant satisfies the non-exemptible requirements set out in Section 2(1) of *Ontario Regulation 865/93***.

***Note:** The Policy may be extended to apply to future scheduled sittings of the Medical Council of Canada Qualifying Examination Part II as may be required during the pandemic.

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

In other words, the specific cohort who meets the above noted requirements will be issued an Independent Practice Certificate without the Medical Council of Canada Qualifying Examination Part II.

- The proposed policy was circulated to the Minister of Health and the Minister under the *Ontario Labour Mobility* Act, *2009,* and to the Federation of Medical Regulatory Authorities of Canada on February 10, 2021. The medical regulatory authorities were provided an opportunity to comment on the proposed policy. Responses are attached as Appendix B. If additional feedback is received prior to the meeting, the feedback will be presented at the meeting of Council.

- We have also received a letter from the Medical Council of Canada attached as Appendix C.

- Additionally, we have received a submission from Professional Association of Residents of Ontario (PARO) attached as Appendix D.

Next Steps

- Should Council approve the revised draft policy, it will be announced in Dialogue and added to the College's website.

Question for Council

1. Does Council approve the Proposed Policy - *Requirement for Successful Completion of Part 2 of the MCCQE – Pandemic Exemption*?

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

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

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

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

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

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

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

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

MCCQE2 Pandemic Exemption

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

i) The applicant demonstrates that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings*;

ii) The applicant is presently registered in Ontario or was registered in Ontario at the time that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings;

iii) The applicant was within 24 months from the completion of their postgraduate training at the time that they were eligible to challenge the MCCQE2 at the May 2020, October 2020, and/or February 2021 sittings;

iv) The applicant otherwise meets the prescribed requirements for an Independent Practice Certificate of Registration and,

v) The applicant satisfies the non-exemptible requirements set out in Section 2(1) of Ontario Regulation 865/93.

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

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

Response from the College of Physicians and Surgeons of British Columbia:

The College does not support the proposed policy change because the MCCQE Part II is an independent assessment of Canadian physicians which provides additional assurance to a regulatory College of a physician's readiness to be licensed, and to practice in British Columbia. Its independence from the educational and certification bodies is important.

To date, the College is in receipt of applications from residents where program directors have enabled a resident to graduate while noting competency concerns regarding that resident in the confidential reference form they provide to the College. Having an independent examination, administered by a body that is not directly involved with the training programs for residents provides the College with an additional impartial lens regarding a physician's competency for independent practice the focus of which includes medical knowledge and clinical skills.

The certification examinations of the two national Colleges, the College of Family Physicians of Canada ("CFPC") and the Royal College of Physicians and Surgeons of Canada ("RCPSC"), focus on medical expertise, but not on foundational aspects of practice such communication, collaboration, ethics and professionalism. The MCCQE Part II assesses these dimensions of care in every station included in its examination. As a regulator, we have observed that communication and professionalism problems tend to be the subject of many of the complaints received by the College. This underscores the importance of the MCCQE Part II which focuses on the assessment of these dimensions of care.

Additionally, the current MCCQE Part II exam incorporates elements of assessment related to cultural safety and humility. Given recent reports, including the *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Healthcare* report by Mary Ellen Turpell-LaFond, it is this College's position that the MCC must place additional emphasis on the assessment of physician behaviors related to cultural safety and humility in healthcare in future iterations of the MCCQE Part II. Given this, this examination will become even more critical in the determination of physician competency in non-medical expert dimensions of care in the health care system.

The proposed policy will create equity issues under the Canada Free Trade Agreement ("CFTA") when graduates who did not have to take the MCCQE Part II apply to other Canadian jurisdictions for a full unrestricted license.

The proposed CPSO policy is, at this time, limited to Ontario graduating residents who were not able to take MCCQE Part II exams from April 2020 to April 2021. If passed, even though envisioned to be temporary, the policy creates issues of fairness and human rights for any Canadian graduating resident applicant or International medical graduate ("IMG") applicant in Canada as well as for these groups and cohorts of Ontario graduating residents who graduate after April 2020. This may translate into a permanent, rather than a temporary change.

Rather than suspending the requirement for the MCCQE Part II it would be preferable for the CPSO to change its legislation to not require sponsorship or supervision in the provisional class for the same eligible applicants until such time that these applicants are able to sit the examination for the first time. This would mirror what many other Canadian jurisdictions did, including the BC College, to address the lack of availability of the MCCQE Part II. This approach requires these applicants to obtain the MCCQE Part II at the earliest available opportunity underscoring the continued importance of physicians obtaining the MCCQE Part II as part of demonstrating competency in the

dimensions of care to be licensed for independent practice and supporting health regulators mandate of supporting public safety in healthcare.

Corinne de Bruin, LLB, CAE
Executive Director
Registration
cdebruin@cpsbc.ca
Pronouns: she, her, hers

College of Physicians and Surgeons of BC
300-669 Howe Street
Vancouver, BC V6C 0B4
604-733-7758
www.cpsbc.ca
Twitter | Facebook | LinkedIn

Serving the public by regulating physicians and surgeons

The College is located on the unceded territory of the Coast Salish peoples, including the territories of the xʷməθkwəy̓əm, Skwxwú7mesh, and Səl̓ílwətaʔ/Selilwitulh Nations.

Appendix B

Response from the Collège des médecins du Québec

Bonjour Madame Tulipano,

Merci de nous donner cette opportunité comme membre du Registration Working Group de la Fédération des ordres des médecins du Canada de commenter les propositions du CPSO concernant l'exemption de réussite de la partie 2 de l'examen d'aptitude du Conseil médical du Canada (EACMC2) pour l'obtention d'un permis régulier. Si le CPSO va de l'avant, nous espérons que cette mesure sera une mesure exceptionnelle liée à la pandémie et non une mesure temporaire qui pourrait devenir permanent.

L'examen d'aptitude partie 2 du Conseil médical du Canada est un examen clinique oral structuré (ÉCOS) avec des patients simulés qui mesure les compétences générales propres à tout médecin. C'est l'un des seuls examens standardisés qui évalue le comportement professionnel et les habiletés de communication des candidats. Il permet à l'ordre professionnel d'assurer entre autres l'équité, l'objectivité, la cohérence et l'impartialité de son processus relatif à l'admission à la profession.

La réussite de l'EACMC partie 1 et partie 2 mène à l'obtention de la Licence du Conseil médical du Canada. Être titulaire du LCMC est l'une des exigences pour l'obtention du permis régulier et du certificat de spécialiste au Québec.

Malgré la pandémie, l'EACMC partie 1 a eu lieu, mais avec quelques mois de retard, au printemps 2020. L'EACMC partie 2 du printemps avait pour sa part été reporté à la mi-octobre 2020. En raison de la poursuite de la pandémie, cet examen ECOS en présentiel a dû être reporté de nouveau et se tiendra en mai 2021 en mode virtuel, à nouveau avec des patients simulés aussi en virtuel.

L'utilité des examens de certification, plus particulièrement ceux menant au LCMC, ont été discutés à plusieurs reprises au sein de notre ordre professionnel par les membres du comité d'admission à l'exercice, avec les universités et avec notre direction générale. Nous sommes d'avis que ces examens sont nécessaires pour s'assurer que nos finissants exerceront une médecine de qualité, ce qui assure la protection du public.

Rappelons que dès le tout début de la pandémie, en mars 2020, le Conseil d'administration du Collège des médecins du Québec a été proactif en créant un permis restrictif pour résident finissant, permettant à ceux qui ont terminé leur formation d'exercer sans supervision dans leur spécialité, en attendant de réussir les examens du Collège royal, du Collège des médecins de famille du Canada ou du Conseil médical du Canada. Ceux qui malheureusement échouent se voient retirer leur permis restrictif et doivent se réinscrire en formation postdoctorale. Vous trouverez-ci-joint copie de cette résolution qui nous allons modifier pour la prolonger exceptionnellement, puisque la pandémie sévit toujours. Peut-être le CPSO pourrait s'en inspirer pour adopter une résolution semblable qui ne mettrait pas en péril la pérennité des examens standardisés d'admission à la profession?

Malgré les pressions multiples pour abolir les examens du Collège royal, du Collège des médecins de famille du Canada ou du Conseil médical du Canada, le Collège des médecins du Québec compte maintenir l'exigence de réussite de ces examens et l'obtention du LCMC pour la délivrance du permis régulier.

Salutations distinguées,
Anne-Marie MacLellan

Anne-Marie MacLellan, MDCM, CSPQ, FRCPC
Secrétaire adjointe
Directrice, Direction des études médicales

Appendix B

Collège des médecins du Québec
1250, boulevard René-Lévesque Ouest, bureau 3500, Montréal (Québec) H3B 0G2
Téléphone : 514-933-4441, poste 5302 | 1-888-MEDECIN | Télécopieur : 514-933-5167
amaclellan@cmq.org | **www.cmq.org**

Hello Ms. Tulipano,
Thank you for giving us this opportunity as a member of the Registration Working Group of the Federation of Medical Regulatory Authorities of Canada to comment on the CPSO's proposals regarding the exemption from passing the Medical Council of Canada Qualifying Examination Part 2 (MCCQE2) for regular licensure. If the CPSO goes ahead with it, we hope that this will be an exceptional measure related to the pandemic, but not a temporary measure that could become permanent.
The Medical Council of Canada Qualifying Examination Part 2 is a structured oral clinical examination (OSCE) with simulated patients that measures general competencies required for any physician. It is one of the only standardized exams that evaluates candidates' professional behaviour and communication skills. It enables the professional college to ensure, among other things, the fairness, objectivity, consistency and impartiality of its process for admission to the profession.
Successful completion of the MCCQE Part 1 and Part 2 leads to the Licentiate of the Medical Council of Canada. Holding the LMCC is one of the requirements for obtaining the regular permit and specialist's certificate in Quebec.
Despite the pandemic, the MCCQE Part 1 was held, albeit two months late, in the spring of 2020. The spring MCCQE Part 2 has been postponed to mid-October 2020. Due to the continuing pandemic, this face-to-face OSCE examination had to be postponed again and will be held in May 2021 in virtual mode, again with simulated patients also in virtual mode.
The usefulness of the certification examinations, particularly those leading to the LMCC, has been discussed on several occasions within our professional order by members of the Admission to Practice Committee, with universities and with our Executive Director. We believe that these exams are necessary to ensure that our graduates will practice quality medicine, thereby ensuring the protection of the public.
It should be remembered that from the very beginning of the pandemic, in March 2020, the Board of Directors of the Collège des médecins du Québec [Quebec College of Physicians] was proactive in creating a restrictive permit for graduating residents, allowing those who have completed their training to practice without supervision in their specialty, while waiting to pass the examinations of the Royal College, the College of Family Physicians of Canada or the Medical Council of Canada. Those who unfortunately fail will have their restrictive license revoked and must re-enroll in postgraduate training. You will find a copy of this resolution attached, which we will modify to extend it exceptionally, as the pandemic is still raging.
Perhaps the CPSO could use this as a basis for a similar resolution that would not jeopardize the sustainability of standardized entry-to-practice exams?
Despite multiple pressures to abolish the examinations of the Royal College, the College of Family Physicians of Canada or the Medical Council of Canada, the Collège des médecins du Québec intends to maintain the requirement to pass these examinations and to obtain the LMCC for regular licensure.
Best regards,

Anne-Marie
Anne-Marie MacLellan, MDCM, CSPQ, FRCPC
Assistant Secretary
Director, Medical Education Branch
Collège des médecins du Québec
1250 René-Lévesque Boulevard West, Suite 3500, Montreal, Quebec H3B 0G2
Telephone: 514-933-4441, ext. 5302 | 1-888-MEDECIN | Fax: 514-933-5167
amaclellan@cmq.org | **www.cmq.org**
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Balises pour la délivrance des permis restrictifs pour résidents finissants

ATTENDU la situation exceptionnelle actuelle liée à la pandémie de la COVID-19, laquelledemande la prise de mesures permettant de déployer une offre de services optimale et laprésence de tous les effectifs médicaux disponibles afin d'enrayer la propagation du virus;

ATTENDU QUE dans ce contexte, le Collège royal des médecins et chirurgiens du Canada (Collège royal), le Collège des médecins de famille du Canada (CMFC) et le Conseil médical du Canada (CMC) ont décidé de reporter les examens de certification etl'examen d'aptitude partie I et partie II du CMC;

ATTENDU QUE conformément à l'article 12 du *Règlement sur les conditions et modalitésde délivrance du permis et des certificats de spécialiste du Collège des médecins du Québec*, la réussite de ces examens est nécessaire à la délivrance d'un permis visé à l'article 33 de la *Loi médicale* et d'un certificat de spécialiste;

ATTENDU QUE le Collège des médecins du Québec souhaite adopter une mesure exceptionnelle afin de permettre au résident finissant d'exercer comme médecin sans avoir réussi tous les examens prescrits par la réglementation;

ATTENDU QUE l'article 35 de la *Loi médicale* permet au Conseil d'administration de déterminer les conditions suivant lesquelles il accorde un permis à toute personne qui neremplit pas les conditions pour obtenir un permis régulier en application de l'article 33 de la *Loi médicale*;

ATTENDU la mission de protection du public du Collège des médecins du Québec;

Il est résolu,

CDA-20-24

1) d'utiliser les critères suivants pour la délivrance d'un permis restrictif pour résident finissant, lequel autorisera le résident à exercer uniquement les activités professionnelles comprises dans la discipline visée par sa formation postdoctorale, sera valide jusqu'au 30 juin 2021 et ne sera renouvelable qu'en cas d'un autre report ou d'annulation à nouveau des examens :

1. Délivrance

1.1 être titulaire d'un diplôme de médecine décerné par une université canadienne ou des États-Unis agréée par le Liaison Committee on Medical Education (LCME) ou avoir obtenu du Collège la reconnaissance de l'équivalence du diplôme;

1.2 avoir réussi l'examen d'aptitude partie I du CMC (EACMC-I);

…/2

1.3 avoir achevé une formation postdoctorale en médecine de famille (24 mois)ou une formation postdoctorale dans l'une des 59 autres spécialités (48 à 96 mois) dans un programme agréé par le Canadian Excellence in Residency Accreditation (CanERA) ou l'Accreditation Council for Graduate Medical Education (ACGME), pour laquelle le Collège devra avoir reçu la confirmation de cette fin de formation par l'université;

1.4 avoir participé à l'activité de formation portant sur les aspects légaux, déontologiques et organisationnels de la pratique médicale au Québec (ALDO-Québec);

2. Retrait

En plus des autres mécanismes prévus au *Code des professions* et à la *Loi médicale*, l'échec à une ou plusieurs composantes de l'examen final donnant ouverture au permis d'exercice (examens du Collège royal, du CMFC ou du CMC), après la délivrance du permis restrictif pour résident finissant, entraînerale retrait immédiat du permis restrictif, sans aucune autre formalité.

2) d'autoriser la docteure Anne-Marie MacLellan, à titre de secrétaire adjointe, à délivrer les permis restrictifs pour résidents finissants, compte tenu du contexte d'urgence sanitaire.

Le secrétaire,

Yves Robert, M.D.

Appendix B

Response from the College of Physicians & Surgeons of Manitoba

Thank you for the opportunity to provide feedback.

Prior to moving away from an independent examination, which has been broadly validated, regulators need to be assured that there will be no lowering of standards for residents exiting training. Aspects of care such as communication, professionalism, and ethics need to be assessed and currently MCCQE II is the exam which addresses these in the greatest depths.

At this point in time it seems inappropriate to move away from the MCCQE II as there is no clear pathway to replace assessing these elements of care which are central to safe care.

We have a national standard for full registration, I wonder about the impact for physicians who do not meet the national standard when attempting to register across the jurisdictions in Canada.

Regards

Anna M. Ziomek, MD
Registrar/CEO
College of Physicians & Surgeons of Manitoba
1000 – 1661 Portage Avenue
Winnipeg MB R3J 3T7
Ph 204 774 4344
Fax 204 774 0750

Appendix B

Response from the College of Physicians & Surgeons of Nova Scotia

COLLEGE OF PHYSICIANS & SURGEONS OF NOVA SCOTIA

Registration Department
Suite 400 - 175 Western Parkway
Bedford, Nova Scotia
Canada B4B 0V1
Phone: (902) 422-5823
Toll-free: 1-877-282-7767
Fax: (902) 422-7476
www.cpsns.ns.ca

February 22, 2021

To: Council of the College of Physicians and Surgeons of Ontario (CPSO)

Thank you for allowing the College of Physicians and Surgeons of Nova Scotia (CPSNS) the opportunity to provide comment on the proposed new policy regarding a pandemic-related exemption to the Medical Council of Canada Qualifying Examination (MCCQE) Part II. The CPSNS has a similar approved policy in place since December 2020.

Like all Medical Regulatory Authorities (MRAs), our mission is to licence competent physicians, not licence incompetent physicians and licence a physician to their full competence. Licensing begins with a decision which involves the question of whether we presume competence. We all have ways of delving into a practice with possible competence concerns, but we don't do that for every licensing application. If there were just the first two options, licensing would be fairly easy. However, with option 3 on the table, we must embrace being flexible.

Some MRAs are bound in legislation in decision-making regarding the MCCQE Part II and some have discretion. In Nova Scotia, we have broad licensing authority. The discretion offered in the Nova Scotia Medical Act allows us to be nimble and flexible. And with this, we have put together a governance structure to shape such discretionary decisions.

In 2018, we separated our operational decision-making and governance decision-making Committees in Registration. The Registration Committees are comprised of elected physicians and appointed public members with a cross-section of academic and clinical practitioners. The newer Registration Policy Committee reviews, develops and retires all policies related to licensing. We have taken a deep dive into current policies to ensure they align with the Medical Act, other CPSNS policies and with the strategic plan of the CPSNS in mind. An ongoing strategic theme is access to care. Then along came COVID, and the Committee was tasked with closely examining the licensure requirement for the MCCQE Part II.

Our view is that licensing decisions were, and should be, constantly evolving.

It is within our mandate to develop policies that would align with our desire to be fair, defensible, and flexible and would address concerns for access to care, public safety, and fairness to International Medical Graduates (IMGs).

The MCCQE Part II was designed and focused on a certain point of time. We defer to the scientists at the MCC who designed the exam. We know that faculties of medicine train with that exam in mind. Given the high pass rate for Canadian graduates, one can place much more value on a failed result than on a pass. We also know that IMGs fail more often but are unable to offer an explanation for that. It is

tempting to say that it is because they are not well trained. But maybe it's because it is written at the wrong time in the physician's career. We could allow the natural experiment with the new Canadian graduates to see if the exam is written later than it's designed to be written to determine if this has an impact on overall pass rates.

The classic formula to obtain a Full licence is a Medical Degree, the Licentiate of the Medical Council of Canada (LMCC) designation, and Canadian certification.

In 1991, the (now) Association of Faculties of Medicine of Canada and the Federation of Medical Regulatory Authorities of Canada (FMRAC) issued a joint statement indicating as of 1994, the MCCQE Part II would be a licensing requirement across Canada.

It is likely that all MRAs have seen licensing applications missing the LMCC though we know it still makes sense to licence the physician. We all struggle with these scenarios.

The MCCQE Part II has evolved over time to include communication skills, patient safety, professional behaviors, and foundational clinical skills. The competencies assessed by the MCCQE Part II are directly mapped to the CanMEDS and CanMEDS – FM frameworks. The competencies are assessed within various dimensions of care including health promotion, illness prevention, acute and chronic care and psychosocial care. There is no doubt that all of these are valuable and important competencies to test.

We have struggled with the Right Touch for IMG physicians. Often the applicants are mid-career and many agree that this examination would be difficult with too broad a focus for this group. Legislation in Nova Scotia allows for Acceptable Alternatives to the LMCC. Because of the concern that this point-in-time exam was designed to be challenged during postgraduate training, the CPSNS developed a policy in 2018 for acceptable alternatives to the LMCC. The existing policy allows for recognition of years in independent practice in lieu of the MCCQE Part II. It also recognizes the United States Medical Licensing Examination (USMLE) as a reasonable equivalent for American trained physicians.

Then along came COVID. The pandemic lead to 3 sittings of the MCCQE Part II being postponed which led to a backlog of candidates. The CPSNS felt compelled to review the licensing requirement for the LMCC in the setting of the pandemic. The prevailing reasons for the review were consideration of fairness, pass rates, inaccessibility to the examination and inapplicability to a mid-career physician.

The MCCQE Part II was designed to be challenged after 12 months of postgraduate training. The pandemic-related postponements will cause delay and some physicians will have completed their postgraduate training program and certification.

We know that a high percentage of Canadian trained, newly graduated physicians pass the MCCQE Part II on their first attempt. Internationally trained physicians have long questioned the value of this exam at mid-career. With this information in mind, the Registration Policy Committee considered written submissions from the Medical Council of Canada, the Deans of the Undergraduate and Postgraduate Faculty of Medicine at Dalhousie University and Maritime Resident Doctors.

The Registration Policy Committee considered three main options: no change, temporary change or permanent change. They decided on a temporary change focusing on pandemic-related postponements of the MCCQE Part II.

The new CPSNS policy is entitled the Pandemic-related Exceptions to the Requirement for the Medical Council of Canada Qualifying Examination (MCCQE) Part II. The purpose of the new policy is to describe temporary exceptions to the licensure requirement for the MCCQE Part II. Specifically, the new CPSNS

policy applies only to physicians affected by the postponements in May 2020, October 2020 and February 2021. The policy provides for a temporary expansion of the acceptable alternatives to the LMCC. The exception is only in the setting of no previous unsuccessful attempts at the MCCQE Part II.

For graduates of Canadian postgraduate programs, the CPSNS will accept certification with the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC) as an acceptable alternative to the LMCC for those who were eligible to challenge the MCCQE Part II in May 2020, October 2020 or February 2021.

For physicians on the Conditional Register on a Defined licence, the CPSNS will accept 2 years of satisfactory supervised practice in NS as an acceptable alternative to the LMCC for Defined licensees who were eligible to challenge the MCCQE Part II for May 2020, October 2020 and February 2021 and who meet all other criteria for a Full licence (i.e. Canadian certification).

For postgraduate trainees who wish to moonlight, the requirement for the LMCC is waived for those who were eligible to challenge the MCCQE Part II in May 2020, October 2020 or February 2021.

In summary, the MCCQE Part II tests valuable competencies as a point-in-time examination that is not currently accessible. The licensure requirement for the MCCQE Part II has been temporarily waived in some circumstances.

This policy is going to be re-considered by the Registration Policy Committee in April 2021 as it is a temporary policy. The Committee will look at the context at that time including the availability of the MCCQE Part II and the plan of the MCC to address the current backlog.

The CPSNS clearly supports the direction of the new policy being contemplated at the CPSO. This is a progressive response to a difficult situation.

Yours,

Keri McAdoo, MD, CCFP, FCFP
Deputy Registrar
KM/sh

Appendix B

Questions from Alberta – sent through the Ministry of Health:

Hello Sam,

I'm sure you are very busy getting ready for the March Council meeting, but I hope you were able to find some time to enjoy the long weekend.

I understand from our labour mobility coordinator that Alberta has some questions regarding the College's proposed Policy. Would you be able to provide a response to the following four questions that I can share by **noon, Friday, February 19**?

1. Will physicians in Ontario that were eligible to write the second MCCQE2 be given a full license to practice (with no limitations or requirements to write the MCCQE2)?
2. What is the rationale for providing a full license rather than a limited license?
3. Is the CPSO's intent that these physicians (who are fully certified but have not written the MCCQE2 exam) have mobility to other provinces? Would ON be willing to indicate on the physician's letter of good standing that he/she has not written the MCCQE2 exam for registration?
4. Would you be able to provide the number of physicians that have been fully licensed in ON without writing the MCCQE2 exam to date?

Thank you very much in advance,
Doug

Doug Ross
Senior Policy Analyst | Regulatory Oversight and Performance Unit
Health Workforce Regulatory Oversight Branch | Ministry of Health and Ministry of Long-Term Care
438 University Avenue, 10th floor | Toronto, ON M5G 2K8
Ph: 437-221-6538

Appendix B

CPSO response to the Ministry of Health:

Hi Doug,

Please see the responses below:

1. **Will physicians in Ontario that were eligible to write the second MCCQE2 be given a full license to practice (with no limitations or requirements to write the MCCQE2)?**

   The applicants who meet the requirements set out in the proposed policy will be given an independent practice certificate, without restrictions and without the requirement to write the MCCQE2.

   Please note, the proposed policy applies to a limited cohort of individuals who meet the following criteria:

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

   We also note that an applicant who previously attempted and failed the examination will be referred to the Registration Committee for review under section 2 of the Registration Regulation.

   The Council material, including the proposed policy, is accessible here: : https://www.cpso.on.ca/CPSO/media/Documents/about-us/council/council-meetings/council-materials-2021feb.pdf

2. **What is the rationale for providing a full license rather than a limited license?**

   The rationale for the proposed policy is set out in detail in the Council materials, accessible here: https://www.cpso.on.ca/CPSO/media/Documents/about-us/council/council-meetings/council-materials-2021feb.pdf

   The concern is that physicians who were on a pathway to full registration in Ontario have had their path disrupted as they have been prevented from sitting the examination in the normal course

   As indicated above, Council will consider feedback from the CPSA at its upcoming meeting.

3. **Is the CPSO's intent that these physicians (who are fully certified but have not written the MCCQE2 exam) have mobility to other provinces? Would ON be willing to indicate on the**

physician's letter of good standing that he/she has not written the MCCQE2 exam for registration?

An applicant who is registered under the proposed policy will have a independent practice certificate (i.e. a full license without restrictions) .

Information with respect to the MCCQE2 is not included as a matter of course in a Certificate of Professional Conduct ("CPC", sometimes referred to by other regulators as a letter of good standing). The contents of the CPC are determined at the discretion of the Registrar. We note that section 36 of the *Regulated Health Professions Act* permits the Registrar to share information with other medical regulators outside of Ontario, so there is no obstacle to sharing this information if requested.

We also note each jurisdiction may have their own application and credential requirements that would likely confirm whether a candidate completed this examination.

4. **Would you be able to provide the number of physicians that have been fully licensed in ON without writing the MCCQE2 exam to date?**

   The policy has not yet been approved by Council, therefore we have not been exempting individuals from this requirement under this route. It will be considered by Council for approval at its meeting March 4-5, 2021.

   We note that It is possible that we have individuals in Ontario practicing without MCCQE2 who have obtained registration through a variety of routes/pathways including: CFTA, Alternative Pathways to Registration policy, Acceptable Qualifying Examinations and Alterative to the MCCQE 2 policy. These policies are available on our website at the following link: https://www.cpso.on.ca/Physicians/Registration/Registration-Policies

Sincerely,

Samantha Tulipano
Director | Registration & Membership Services
T: 416-967-2600 | ext. 709

Appendix C

MEDICAL COUNCIL OF CANADA | LE CONSEIL MÉDICAL DU CANADA

CONFIDENTIAL

MCC Submission to CPSO Council - February 19, 2021

Medical Council of Canada Qualifying Examination Part II

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

CPSO Briefing Note to their Council, Feb. 2021

This submission seeks to:

Inform the CPSO Council's discussion related to the proposal of the CPSO Registration Committee to temporarily exempt Ontario licensure applicants from the requirement of the Medical Council of Canada Qualifying Examination (MCCQE) Part II.

Clarify information circulating publicly about the Medical Council of Canada (MCC) included in documents provided to the CPSO Council at its February 9 special meeting as well as in various form letters being sent to numerous individuals and organizations.

Provide the CPSO Council with information about MCC's response to the COVID-19 challenges and about the upcoming resumption of the MCCQE Part II (via an online platform) planned for May 2021, announced on February 18, 2021.

Encourage CPSO Council to recommend that, in keeping with the approach in other provinces (excluding Nova Scotia) and given that the virtual delivery model is expected to clear the current backlog of affected candidates by end of calendar year, temporary provisional licenses for Ontario candidates remain in place until the MCCQE Part II requirement is met.

MCC's mandate: Protecting the public by ensuring competency of physicians in Canada

MCCQE Part II Pass Rates

The CPSO briefing note states:

"Being mindful that CPSO does not wish to create additional burden for those impacted by the multiple postponements of the exam, and considering that the pass rate on the first try is very high…"

The MCCQE Part II standard for **"Pass"**, as established by expert external clinical faculty, **is the minimally competent physician** demonstrating core clinical performance, communication skills and professional behaviours required of all physicians. It does not examine for excellence.

- In May 2019, for total first-time Canadian trained medical school candidates (1447 candidates), the overall pass rate was 88% - 165 did not pass.

- The overall pass rate for total postgraduate candidates in Canadian training programs (1850 candidates) was 84% - 296 did not pass.
- In October 2019, for total first-time Canadian trained medical school candidates (1371 candidates) the overall pass rate was 91% - 123 did not pass.
- The overall pass rate for total postgraduate candidates in Canadian training programs (1807 candidates) was 88% - 216 did not pass.

These results demonstrate the value of the MCCQE Part II as an important screening function to identify candidates who do not meet the standard of a minimally competent physician as determined by a standardized, objective and independent examination developed, administered and scored by hundreds of practicing physicians in Canada.

Predictive outcomes research

Detailed research, including work done in partnership with CPSA and CPSO has demonstrated the predictive value of MCC exams on future practice performance including:

Exam performance is linked to practice assessment outcomes[1]

Exam performance is predictive of future performance in practice including complaints and prescribing practices (opioids and benzodiazepines)[2]

MCC examinations assist regulators to identify candidates for licensure who may require or benefit from ongoing support or tailored supervision.

Assessments during COVID-19

The CPSO briefing note states that the MCC:

"did not offer an alternate means for completing their examination" and further asserts a *"lack of planning for an alternate means to complete the examination (the Medical Council of Canada continues to plan for an in-person examination)"*

This is inaccurate. The MCC teams have worked diligently since the onset of the pandemic to both plan and execute robust and standardized qualifying exams. The MCC has demonstrated flexible and adaptive planning in the past year, in rapid response to the serious constraints applied by the evolving nature of the pandemic in connection to both the MCCQE Part I and Part II.

The MCC is progressing toward the virtual delivery of the MCCQE Part II as was communicated:

- December 22 2020 – MCC communicated its intention to shift to a virtual exam to *stakeholders*
- February 3, 2021 – *MCC publicly announced* its contract with EMS to deliver a virtual MCCQE Part II in Spring 2021
- February 18,2021 – MCC communicated to stakeholders that the exam will commence on May 18.
- Week of February 22 – registration details will be provided to candidates
- May - June 2021 – using a semi-continuous delivery model, the MCC anticipates that 2400 candidates will have an opportunity to complete the assessment by end of June
- End of 2021– MCC anticipates having administered the examination to all remaining eligible candidates

MCCQE Part I

In the first six weeks of the pandemic, responding to candidate and Faculty input, MCCQE Part I moved from a written examination delivered only in test centres, to a remote proctored examination.

- Close to 2500 candidates completed their MCCQE Part I requirement between June and September, the majority doing this prior to the start of residency training July 1.
- Extensively scrutinized, remote proctored exams were demonstrated to provide a valid and defensible examination process.

Exam delivery continues using the option of remote proctoring or test centres (now re-opened but limited capacity) and over 5000 candidates have now been tested.

MCCQE Part II

The clinical performance requirement of the MCCQE Part II posed a greater challenge.

- Initially changes were made to increase capacity for the deferred candidates from May 2020, to meet specific public health requirements, reduce travel and costs for candidates and to allow safe, in-person delivery in October 2020.
- Cancellation in October resulted from the very late withdrawal of several local sites under contract to the MCC. The MCC was prepared to and could have safely administered this assessment to over 1000 candidates in October; however, the remaining small pool of sites and candidates reduced the reference group candidates below the baseline required to ensure psychometric validation; this would have resulted in a non valid administration and nullified results.
- February 2021 dates had been proposed as an “add-on” date; however, escalating pandemic concerns and our desire to avoid the disruption to candidates of another potential late cancellation by local sites compelled the MCC to abandon this option.

The MCC has been exploring the use of virtual delivery of clinical performance examinations for some time. Since October we have rapidly accelerated this work, such that:

- With extensive work by our external physician expert committees, drawn from Faculties of Medicine across the country, the MCCQE Part II content has been adapted for virtual delivery.
- An extensive and very detailed RFQ process to identify a suitable platform was completed.
- Recruitment for examiners and standardized patients is underway.
- Delivery has switched from specific dates twice per year to a semi-continuous delivery model to allow more flexibility for candidates and for schools in not having a large group of resident candidates away at the same time.
- Exam dates will be offered beginning May 18, 2021.

The MCC, from the outset of the pandemic, has safely administered the MCCQE Part I to more than 5000 candidates, the NAC examination to more than 1200 candidates in a manner that is efficient, reliable and compliant with public health imperatives, and is creating capacity for the delivery of MCCQE Part II to 6000 candidates by the end of 2021.

Looking to the future

In November 2020, the MCC implemented an Assessment Innovation Task Force with a 12-month mandate to provide recommendations on specific assessment requirements for licensure. The MCC’s objective is to gather the insights to lead conversations about change – offering forethought and options to MRAs and our stakeholders.

An abrupt change to qualifying requirements could lead to a number of unintended consequences for students, faculties, residency programs and MRAs. The recent changes to the USMLE clinical skills[3] examination in the US has raised serious questions and generated much uncertainty.

The extensive literature on "*failure to fail*" regarding Faculties of Medicine, and the fact that some medical schools have suspended their clinical performance examinations due to pandemic restrictions, should also be considered when assessing the value and relevance of a standardized, objective assessment tool

The MCC respectfully submits that the MCCQE Part I and Part II serve a well-established and vital function in the Canadian medical education system and are the assessment requirements necessary to protect the public prior to the privilege of independent licensure being granted. Any significant changes to the current pan-Canadian standardized evaluation of practice readiness warrant careful consideration and broad consultation amongst stakeholders.

Impact of MCC on licensure

There have been suggestions in various forums that that the postponement of the MCCQE Part II is creating or amplifying a national shortage of physicians. We disagree. While the pandemic has posed never seen or anticipated challenges, the MCC has and continues to work with its stakeholders in developing innovative solutions while maintaining its key objectives of offering a reliable, pan-Canadian objective standard of assessment.

A permanent exemption from the MCCQE Part II is not necessary, advisable, or indicated. It would deprive the CPSO of a valuable assessment tool and set Ontario licensees apart from the vast majority of their contemporaries thereby raising mobility issues from one jurisdiction to another.

The MCC respectfully submits that continuing to offer temporary provisional licenses is consistent with allowing individuals to provide health care delivery support pending the successful completion of the soon to be resumed MCCQE Part II and is a preferable approach.

We appreciate the opportunity to provide this information.

Respectfully submitted,

Jay Rosenfield, MD, MEd, FRCPC
President

Maureen Topps, MB ChB, MBA, FCFP, FRCPC (Hon)
Executive Director and CEO

1 *https://mcc.ca/media/IAMRA-2018Poster-Fang.Tian_.pdf*

2 *https://meridian.allenpress.com/jmr/article/106/4/17/454057/Does-Pass-Fail-on-Medical-Licensing-Exams-Predict*
3 *What the elimination of a major medical licensing exam — Step 2 CS — means for students and schools | AAMC*

Submission from PARO

Briefing Note on MCCQE2

In the early 1990s with the end of the rotating internship and licensure after one-year, the MCCQEII was developed and became a requirement for licensure in some provinces in addition to certification by the CFPC.

For graduates of Canadian Medical Schools, training in Canadian residency programs, the pass rate on the first try is very high – reflecting the quality and ability of our Canadian residency programs to provide training in basic clinical skills as well as specialty-specific training.

CMG Pass Rates

• Stats are taken from the MCC's Technical Reports, except for the * 2018 Total, which was calculated based on figures in those reports.

	CMGs 1st Try
2019	89.5
October 2019	91.0
May 2019	88.1
2018 *	93.8
October 2018	89.4
May 2018	98.2
2017	97.2
2016	91.6
2015	92.2
2014	93.5

Note:
• There is a notable drop in the pass rate from May 2018 to October 2018 – Dr. Topps (President and CEO of the MCC) has explained that this drop was expected given there is historical precedence for similar drops when the MCC introduces a new exam blueprint. The subsequent exams pass rates are trending up.

Throughout medical school and residency, trainees are subject to rigorous testing and consistent iterative feedback. All trainees enrolled in Canadian postgraduate medical training programs are held to stringent national standards governed by national accreditation bodies.

It is notable that some regulatory authorities in Canada do not require the MCCQE2 for registration for graduates of Canadian Medical Schools who are also graduates of Canadian Residency Programs. In addition, there are other jurisdictions currently reviewing their requirements related to the MCCQE2.

Not all provinces require MCCQE2. Below is a quick overview of the conditions for provinces who do not require it or who are considering not requiring it in some measure.

Regulatory Authorities Who Have No Requirement of MCCQE2

New Brunswick - – *Independent Registration*
A physician may be eligible for registration with a Regular, or Regular Locum, licence if they are a graduate of a medical or osteopathic medical school approved by Council and are:
(a) Certified in Family Practice by the CFPC or le Collège des médecins du Québec;
(b) Certified in a specialty by the RCPSC or le Collège des médecins du Québec.
(c) Registered under the previous Regulation with a Full or Locum licence.

Quebec - – *Independent Registration*
For independent registration, Quebec requires that applicants to have:
• A Doctor of Medicine degree from a medical school in Canada or the United States that is accredited by the Liaison Committee on Medical Education (LCME) or by the Commission on Osteopathic College Accreditation (COCA) of the American Osteopathic Association (AOA),
• Completed of postgraduate training in Canada in a program accredited by the CFPC, the RCPSC or the American Board of Family Medicine and must satisfy all the requirements.
• Completed postgraduate training in family medicine (24 months) or postgraduate training in one of the 59 other specialties (48 to 96 months).

Regulatory Authorities Currently Considering Amendments to MCCQE2 Requirement

At this juncture in time, two Regulatory Authorities are already reviewing the relevance of QE2 in their provinces.

Nova Scotia – *Independent Registration*
The College of Physicians and Surgeons of Nova Scotia is currently doing a review process to assess the relevance of the MCCQE2 as it pertains to licensing physicians in Nova Scotia for independent registration.

British Columbia - *Resident Clinical Associate*
The CPSBC has a proposed amendment to the CPSBC Bylaws Article 2-26 (3) (h) if passed it will allow the Registrar to grant a *Resident Clinical Associate* licence without having passed the MCCQE2.

Council Briefing Note

March 2021

Topic:	Council Award Recipient
Purpose:	For Information
Relevance to Strategic Plan:	Quality Care Continuous Improvement
Public Interest Rationale:	**Quality Care:** Ensuring that the care provided by individual regulated health professions is of high quality and that the standard of care provided by each regulated health professional is maintained and/or improved
Main Contact(s):	Janet Eide, Governance Coordinator
Attachment(s):	N/A

Issue

- At the March 4, 2021 meeting of Council, **Dr. Mihaela Nicula** from Toronto, will receive the CPSO Council Award.

Background

- The CPSO Council Award recognizes physicians who demonstrate the ideal qualities that are required to effectively meet the health care needs of the people they serve. These abilities are articulated in the Royal College of Physicians and Surgeons of Canada's CANMEDS Framework which consist of seven roles:

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

- A competent physician seamlessly integrates the competencies of all seven CPSO Council Award qualities.

Current Status and Analysis

- Council member, Dr. Mary Bell, will present the award.

Council Motion

Motion Title	In Camera Motion
Date of Meeting	March 4, 2021

It is moved by_____, and seconded by_____, that:

The Council exclude the public from the part of the meeting immediately following the lunch break, under clause 7(2)(b) and (e) of the Health Professions Procedural Code.

Council Motion

Motion Title	Discipline Committee Enhancements
Date of Meeting	March 4, 2021

It is moved by_____, and seconded by_____, that:

1) The Council of the College of Physicians and Surgeons approves the recruitment of four to five experienced adjudicators to be put forward to Council for appointment to the Discipline Committee.

2) The Council of the College of Physicians and Surgeons of Ontario makes the following by-law No. 141, to take effect on a date to be determined by the Executive Committee:

   By-law No. 141

   (1) The General By-law is amended by adding the following:

   Discipline Committee

   40b. The Discipline Committee shall be known as the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) in English and Tribunal de discipline des médecins et chirurgiens de l'Ontario (TDMCO) in French, and each reference to the Ontario Physicians and Surgeons Discipline Tribunal or the Tribunal de discipline des médecins et chirurgiens de l'Ontario, whether orally or in writing, shall be deemed to be a reference to the Discipline Committee of CPSO as specified in the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, 1991.

Council Briefing Note

March 2021

Topic:	Discipline Committee Enhancements
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	**Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection:** Ensuring the protection of the public from harm in the delivery of health care services **Fairness:** Ensuring that regulatory processes are fair, independent and neutral and perceived to be so by the public, members and other stakeholders.
Main Contact:	David Wright, Tribunal Director and Chair, Discipline Committee
Attachments:	Appendix A: Recruitment Advertisement and Member Position Description from the Law Society Tribunal

Issue

- Council is asked to consider two proposed enhancements to the Discipline Committee:
  - adding four to five experienced adjudicators, selected through a merit-based competitive process, as members of the Discipline Committee;
  - changing to the name by which the Discipline Committee is known to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) (in English) and Tribunal de discipline des médecins et chirurgiens de l'Ontario (TDMCO) (in French).

Background

The Committee

- The Discipline Committee is established in the Health Professions Procedural Code (the Code), being Schedule 2 to the *Regulated Health Professions Act, 1991*. It decides allegations of professional misconduct and incompetence referred by the Inquiries, Complaints and Reports Committee, as well as applications for reinstatement by revoked physicians referred by the Registrar.

- In 2020, the Committee opened 27 files and closed 35 files. Both are a drop from previous years, in which the Committee opened as many as 82 files (in 2017).

- Members of the Committee are appointed by Council. There are currently 39 members: ten physicians who are members of Council, seven public members who are members of Council, 21 physicians who are not members of Council and the Chair, who is a lawyer and full-time College employee. The by-laws permit the appointment of non-physician members of the public to committees.

- The Committee is a quasi-judicial administrative tribunal whose rules and processes are similar to those of courts. It holds formal hearings in which the civil rules of evidence apply, and often must decide complex legal questions. To promote settlement and efficient proceedings, it conducts mediation and case management meetings called pre-hearing conferences and case management conferences.

- The parties to a proceeding before the Committee are the College, which is the prosecutor, and the member. The College may be represented by a lawyer from the College's Legal Office or an outside lawyer. Members may be represented by a lawyer retained by the Canadian Medical Protective Association, a lawyer they have privately retained, or be self-represented.

- After each hearing, whether on liability, penalty or motions, the panel must prepare reasons similar to the reasons for judgment of a court. The reasons are published on the CPSO website and in various legal databases.

- The Committee's decisions may be appealed to the Divisional Court by either party. As a result of the Supreme Court's decision in late 2019 in *Canada (Minister of Citizenship and Immigration) v. Vavilov*, the Divisional Court will apply a more intensive review than previously to some aspects of the Committee's decisions. Prior to *Vavilov*, the decisions, including those on questions of law, would be upheld so long as they were reasonable. Now, the Committee's decisions on questions of law must be found to be correct or they will be overturned. The Court's review involves a careful consideration of the reasons given by the panel.

- The Committee is neutral and independent of the College. It sometimes may not be perceived as such because of its integration into the College, the same organization prosecuting the physician. For example, letters to the parties are on the same letterhead as those of the lawyer that is prosecuting the case; and information about the Committee and its rules is found on the CPSO's website.

Panel Composition

- The Committee Chair selects the members of each panel. Under the Code, the panel may be composed of three to five Committee members, two of whom must be public members of Council and one of whom must be a physician member of Council. If the panel is composed of five members, there are no requirements for the final two members other than that they be members of the Committee.

- The practice at the College has generally been to have a five-member panel, including two physicians who are not on Council in addition to those required by the Code.

Administrative Justice in Ontario

- In addition to professional discipline bodies like the Discipline Committee, administrative tribunals include organizations as diverse as the Human Rights Tribunal, Labour Relations Board, Workplace Safety and Insurance Board, Immigration and Refugee Board, Environment Review Tribunal and Copyright Board. Administrative tribunals make vastly more decisions than courts and are most people's only interaction with the justice system. Their strengths include their expertise in a particular subject matter and ability to adapt process to the particular context.

- In recent years, there has been a growing professionalization of administrative tribunals. In many tribunals, these developments have led to formal, merit-based recruitment processes, a robust education program, written position descriptions and performance assessment of adjudicators, among other things. For many, being a tribunal member is now a career rather than a short term or part-time position. Many individuals, once they develop strong adjudicative skills, sit on various tribunals at the same time and/or throughout their careers.

The Goudge Report

- In 2015, the Ministry of Health and Long-Term Care retained Stephen Goudge, a former justice of the Court of Appeal for Ontario, to make recommendations about the complaint and hearing processes at the College. His report recommended, among other things:

    - that non-physician members with advanced dispute resolution skills be appointed to the Discipline Committee to deal with cases where a physician pre-

hearing conference chair is not required, or where a non-physician pre-hearing conference chair might be more effective.

- that legally trained persons, experienced in running hearings, be appointed to the Discipline Committee to chair hearing panels in non-standards cases. He noted that would eliminate the need for Independent Legal Counsel at those hearings.

Other Regulators

- The Colleges of Physicians and Surgeons of Nova Scotia and Quebec have legally-trained members sit on all panels and chair their discipline hearings. They do not use Independent Legal Counsel. The Newfoundland College has lawyer members of its Disciplinary Panel and uses Independent Legal Counsel.

- In recent years, the Immigration Consultants of Canada Regulatory Council and the Electrical Safety Authority have moved from using Independent Legal Counsel to having an experienced adjudicator chair their panels. The Coroner's Office recently recruited a group of experienced lawyers and adjudicators to preside at inquests.

- Beginning in 2013, the Law Society of Ontario implemented significant enhancements to its hearing process. This included establishing the Law Society Tribunal as a body with a separate identity from the Society. The Tribunal has its own premises, website and logo. There has been considerable positive feedback about the distinguishing of the Tribunal from the Law Society, in particular from representatives of lawyers and paralegals, and it has led to a clearer perception by the media and public of the Tribunal's role.

- The Law Society of Ontario has appointed individuals with adjudicative experience to the Tribunal as part-time members. There are currently ten appointee lawyer members, who chair many but not all hearing panels and conduct most pre-hearing conferences. Except for certain special circumstances, appointed adjudicators are recruited through a competitive process that includes providing writing samples, interviews and, in the most recent competition, writing reasons for a mock hearing. Attached as Appendix B are the Law Society Tribunal's 2016 advertisement for part-time lawyer adjudicators and member position description.

Current Status and Analysis

- There is now an opportunity to review the current member composition of the Discipline Committee and explore improvements consistent with best practices and the recommendations in the Goudge Report.

Merit-Based Recruitment of Adjudicators

- The Committee Chair proposes to conduct a competitive, merit-based recruitment process for four to five experienced adjudicators with strong hearing management, writing and mediation skills. They would work part-time, being assigned and paid *per diems* like the physician members of the Committee. While it would not be a prerequisite to be legally trained, most applicants with the relevant skill set are likely to be lawyers. We will apply an equity, diversity and inclusion lens to the recruitment and competition process.

- Most hearings, it is expected, would be chaired by one of the new adjudicators as would pre-hearing conferences. A hearing panel would be composed of the panel chair, one Council physician, one non-Council physician and two public members of Council. No Independent Legal Counsel would be required due to the knowledge and experience of the chair. The chair would assist the other members of the panel with legal issues during the deliberations. Independent legal counsel may still be used to assist the Committee with certain functions and perhaps certain hearings.

- It is expected that the appointment of experienced adjudicators to the Committee would:

    - lead to fairer and more efficient hearings, including through the greater use of active adjudication and case management;

    - lead to more and earlier settlements through the application of mediation skills;

    - improve the quality of reasons and reduce the amount of time taken to draft and edit them; and

    - reduce legal costs, as ILC would not be needed in hearings or pre-hearing and case management conferences chaired by experienced adjudicators.

- Making such appointments would reflect developments at other administrative tribunals and mirror innovative changes that have successfully been implemented by other regulators.

- There may be concerns raised about this proposed change:

    - Panels would no longer be composed of a majority of physicians. Some stakeholders may say that members of the profession should have more votes than others on a panel even though this is not required by the legislation. Ideally, an adjudicative panel brings together various perspectives, all of which collectively contribute to a better decision. The physician perspective will be well provided by the physicians on the panel.

- A second concern that may be raised is that the experienced adjudicator may have too much influence over the other panel members because of their training. On legal issues, the chair's views may be given strong weight by the other panel members. However, that is likely the case now in relation to the advice given by Independent Legal Counsel. There are many issues, including credibility determinations and the length of penalty, in relation to which legal or adjudicative training would give little advantage. The members of the Committee can be expected to fulfil their duty to listen to all the evidence and argument and make their own, independent decision.

- It will remain important for all Committee members to receive ongoing training in adjudication and reason writing so they can take an active part in all aspects of the hearing process, including writing reasons where appropriate.

New Name

- The purposes of changing the name of the Discipline Committee are twofold: 1) to advance the public and member perception of the independence of the tribunal from the College itself, and 2) to make the purpose of the tribunal clear to the public and the profession.

- Changing the name will allow the tribunal to more clearly define itself as independent of the College, enhancing the confidence of the public and members. At the same time as the new name takes effect, the tribunal will establish its own branding including a logo. A separate website, linked to the College's website, will be created.

- The word "tribunal" much better reflects the work the body does and the nature of its procedures than "committee."

- It is important that the new tribunal act in an independent manner and be treated as independent and distinct from other college committees by the College and Council. Otherwise, the differentiation may be perceived as merely cosmetic.

Next Steps

- If approved, a recruitment process for new members will begin, as will the amendment of the rules and forms, development of a logo and drafting of key policies.

Questions for Council

1. Does Council agree that this issue supports the strategic plan and our role in serving the public interest?

2. Does Council approve the recruitment, through a competitive process, of four to five experienced adjudicators and the passage of a by-law to change the Discipline Committee's name to the Ontario Physicians and Surgeons Discipline Tribunal/Tribunal de discipline des médecins et chirurgiens de l'Ontario as set out in the motion that follows?

MEMBER – POSITION DESCRIPTION

INTRODUCTION

The Law Society Tribunal is an independent adjudicative tribunal within the Law Society of Ontario. As regulator of the legal and paralegal professions, the Law Society of Ontario governs Ontario's lawyers and paralegals in the public interest. Members of the Tribunal hear and make independent decisions about Ontario lawyers and paralegals. They apply legislation, policies, jurisprudence and rules and act in accordance with the mission and core values of the Tribunal.

Members work under the leadership of the Chair. They are expected to uphold and embody the Tribunal's core values of fairness, quality, transparency and timeliness. Members may be assigned by the Chair or, in the absence of the Chair, a Vice-Chair, to carry out their adjudicative responsibilities as a single adjudicator or as a member of a hearing or appeal panel, pre-hearing conference or proceeding management conference adjudicator.

All members, with the exception of the Chair, are part-time and remunerated on a per diem basis. Reasonable expenses are reimbursed.

APPOINTMENT AND REAPPOINTMENT

Members are appointed to the Tribunal by Convocation on recommendation of the Chair. Elected and appointed benchers are eligible to be appointed to an initial term by virtue of their position. Appointee adjudicators are appointed following a competitive process. Ability to conduct hearings in English and French is an asset.

Reappointment by Convocation of all members for subsequent terms is based on the recommendation of the Chair following a formal performance evaluation, based on the competencies and duties set out in this position description.

KEY COMPETENCIES AND DUTIES

1. Fairness and Collegiality

- Acts with impartiality and balance, maintaining an open mind at all times;
- Acts with dedication, professionalism and collegiality;
- Values diversity and upholds the right to equal treatment without discrimination under the *Human Rights Code* throughout the adjudicative process;
- Acts in accordance with the principles of procedural fairness;
- Maintains decorum and professional conduct at all times, inside and outside the hearing room;
- Engages in respectful and courteous interactions with hearing participants, staff, and other Tribunal members;
- Employs active listening techniques, seeking clarification, reflecting understanding of others' views, and valuing diverse perspectives.

2. Quality and Continuous Improvement:

- Understands and applies administrative law principles; the *Law Society Act*; Ontario Regulation 167/07; the *Statutory Powers Procedure Act*; Rules of Professional Conduct; Paralegal Rules of Conduct; Rules of Practice and Procedure; and other relevant law, rules, practice directions and jurisprudence;
- Attends and actively participates in all required adjudicator training and education programs;
- Participates actively in self-evaluation and performance development with commitment to continuous development of adjudicative skills;
- Reflects on experiences and is open to feedback, striving for continuous improvement;
- Works to promote quality and consistency in the Tribunal's jurisprudence.

3. Transparency

- Complies with all policies and guidelines of the Law Society Tribunal;
- Adheres to the Law Society Adjudicator Code of Conduct, and manages issues of reasonable apprehension of bias or conflict of interest, identifying potential conflicts at the earliest opportunity;
- Respects and promotes the independence of the Law Society Tribunal;
- Determines transparency issues involving access to a hearing, non-public treatment of materials and publication bans with an understanding of the relevant principles and rules;
- Acts in a manner that bears the closest scrutiny.

4. Timeliness

- Collaborates with Tribunal staff to promote effective administration of Tribunal processes;
- Is regularly available for hearings throughout the calendar year and holds the time committed, absent exceptional circumstances;
- Balances the need to be prompt and decisive with consideration of the views and positions of others;
- Prepares for proceedings by reviewing all materials sent in advance;
- Prioritizes the scheduling of continuation dates.

5. As a panel member in a hearing or appeal:

- Reaches procedural rulings, findings of fact, and decisions that are balanced, reflect a solid grasp of the issues, evidence and submissions advanced; and interpret the relevant law, rule or jurisprudence;
- Participates actively in panel deliberations, works collegially with other panel members to share views, knowledge and expertise, and considers and is open to the feedback of others;
- Listens actively and takes detailed notes of the hearing;
- Asks questions where appropriate, respecting the principles of procedural fairness;
- Aims for consensus among panel members where possible, while respecting the value of dissenting or concurring reasons where panel members have differing views.

6. When assigned as a panel chair:

- Promotes the effective use of hearing time through skillful and fair management of the hearing process, the application of the *Rules of Practice and Procedure* and principles of evidence;
- Balances control of the hearing with openness to the parties' positions and concerns;
- Consults with other panel members and concisely and clearly conveys the panel's procedural rulings;
- Ensures that hearings start at the time set and all scheduled hearing time is used until the matter is concluded, absent extenuating circumstances;
- Promotes prompt continuation dates and the accurate estimate of further hearing time;
- Ensures that all panel members' views are heard and valued in deliberations and promotes consensus where possible;
- Ensures that written reasons are prepared as appropriate;
- Ensures that the Tribunal's core values of fairness, quality, transparency and timelines are demonstrated throughout the process

7. When authoring reasons:

- Prepares reasons that are clear, concise, well organized and fully justify the decision;
- Prepares reasons using the Tribunal reasons template, minimizing typographical and grammatical errors in drafts;
- Prepares reasons within the established timeline, absent extenuating circumstances;
- Considers and incorporates the comments and views of other members of the panel;

8. When assigned to conduct pre-hearing conferences or proceeding management conferences:

- In pre-hearing conferences, assists the parties in reaching joint submissions and/or agreed statements of facts, offers opinions on the merits of a case, the applicable law, rules and jurisprudence;
- Actively case manages the matter to ensure issues are defined early, timelines are set to deal with pre-hearing issues, and the matter is ready for a hearing in a timely manner;
- Promotes consistency of procedural approaches within the Tribunal;
- Where appropriate, monitors cases to ensure preliminary issues are resolved or determined without delay and the hearing can proceed on the dates set.

Law Society Tribunal
Tribunal du Barreau

Part Time Adjudicator (Lawyer), Law Society Tribunal

The Law Society Tribunal is an independent adjudicative tribunal within the Law Society of Upper Canada, consisting of staff and appointed adjudicators. Adjudicators include benchers and other lawyer, paralegal and lay appointees.

The Tribunal is seeking several qualified lawyers for appointment to the Tribunal as part-time members for a term of two years. Remuneration and travel expenses are paid.

Previous experience as an adjudicator or completion of an adjudicator-training course is a strong asset. Successful applicants must:

- be currently licensed as a lawyer by the Law Society of Upper Canada with no restrictions on their right to practise, be called to the bar for a minimum of 10 years and have no disciplinary record in any jurisdiction.
- be available throughout the calendar year for hearings and to set prompt continuation dates.
- have excellent hearing management and reason writing skills.
- have knowledge and understanding of principles of legal ethics and procedural fairness.
- be comfortable with independent use of web-based applications and word processing software.
- participate in performance assessment by the Chair.

Among those appointed, we hope to include candidates: (1) who can conduct hearings in French; (2) with expertise on Indigenous issues; and (3) with experience handling mental health matters.

More information about the Law Society Tribunal and a detailed position description can be found on our website at www.lawsocietytribunal.ca. An application package consists of a cover letter, curriculum vitae and two writing samples, preferably decisions the candidate has authored. The package must be sent by email, including “Adjudicator Application” in the subject line.

The deadline for applications is December 15, 2017.

David A. Wright, Chair
Law Society Tribunal
402-375 University Avenue
Toronto, Ontario M5G 2J5

vramsukh@lsuc.on.ca

The Law Society Tribunal strives to reflect the population of Ontario and the diversity of the legal professions among its members. We encourage applications from members of equality-seeking communities, including those based on race, ancestry, ethnic origin, place of origin, citizenship, language, disability, age, creed, sex, gender identity, gender expression and sexual orientation.

Council Briefing Note

March 2021

Topic:	Member Topic
Purpose:	For Discussion
Relevance to Strategic Plan:	Meaningful Engagement
Main Contact(s):	Judith Plante, President
Attachment(s):	Appendix A: Executive Committee Terms of Reference

Issue

- A member topic has been raised for discussion at the upcoming Council meeting, which relates to better understanding the role of the Executive Committee.

Background

- As part of efforts to strengthen CPSO's governance, an initiative was started in 2020 to establish a Terms of Reference for every Committee reporting into Council.

- The Executive Committee Terms of Reference is attached as Appendix A. It is informed by relevant legislation and our by-laws, and clearly defines the Committee's mandate, roles and responsibilities of Committee members.

- It helps to align the Committee members on shared objectives and also serves as a tool to inform the Committee's annual self-assessment to evaluate whether the Committee was effective in fulfilling its mandate.

Executive Committee
Terms of Reference

CPSO

Authority
The Executive Committee is a statutory committee. [HPPC, s. 10(1)]

Mandate, Duties and Powers
The Executive Committee may exercise all the powers and duties of the Council with respect to any matter that, in the opinion of the Executive Committee, requires attention between meetings of the Council, except that the Executive Committee does not have the power to make, amend or revoke a regulation or by-law. [General By-law, s. 30; HPPC[1], s. 12(1)]

In addition to the duties set out above, the Executive Committee is required to:

- review the performance of the Registrar and set the compensation of the Registrar, which includes:
  - consulting with Council in respect of the performance of the Registrar and with respect to setting performance objectives in accordance with a process approved by Council;
  - ensuring that the appointment and re-appointment of the Registrar are approved by Council; and
  - approving a written agreement setting out the terms of employment of the Registrar; [General By-law, s. 39(3(a) and (4)]
- oversee and assist CPSO staff with the development and delivery of major communications, government relations and outreach initiatives to the profession, the public and other stakeholders, consistent with CPSO's strategic plan; [General By-law, s. 39(3(b))]
- oversee the review and development of policies for the medical profession; and
- making recommendations to Council where appropriate.

The Executive Committee may make appointments to fill any vacancies which occur in the membership of a committee. The Executive Committee is required to make such appointments if it is necessary for a committee to achieve its quorum. [General By-law, s. 37(4)]

Reporting
If the Executive Committee has exercised a power of the Council, the Executive Committee shall report on its actions to the Council at the Council's next meeting. [HPPC, s. 12(2)]

Composition
The Executive Committee shall be composed of the following 6 persons :

- the President;
- the Vice-President;
- the Past President[2] (unless the Past President is unwilling or unable to serve on the Executive Committee); and
- three CPSO Council members (or four if the Past President is unwilling or unable to serve on the Executive Committee). [General By-law, s. 39(1)]

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[1] *Health Professions Procedural Code* ("HPPC"), Schedule 2 to the *Regulated Health Professions Act, 1991* ("RHPA")

[2] The past president position is typically filled by the immediate past president. However, if the immediate past president is not willing or able to serve in this role, the role may be filled by another past president, preferably one who is still on Council.

The Executive Committee must have a minimum of two members of CPSO (i.e. physician Council members) and a minimum of two public members appointed to the Council by the Lieutenant Governor in Council.

In the event of a vacancy in the office of the President and/or Vice-President, Council shall fill the vacancy(ies) as per the process outlined in the General By-law. [General By-law, s. 32]

Term of Appointment

The term of office of an Executive Committee member is one year, beginning at the Annual General Meeting of Council[3] and ending at the next Annual General Meeting of Council. [General By-law, s. 37(2.1)]

Chair

The President is the Chair of the Executive Committee. [General By-law, s. 39(2)]

Meetings

- The Executive Committee will meet at least 6 times per year.
- Meetings of the Executive Committee may, in the discretion of the Chair, be held in any manner that allows all the persons participating to communicate with each other simultaneously and instantaneously. [General By-laws, s. 38(7)]
- Members of the Executive Committee are expected to regularly attend and actively participate in meetings.
- The Chair, or his/her appointee for this purpose, will preside over meetings of the Executive Committee. [General By-law, s. 38(5)]
- The Chair, or his/her appointee, is responsible for recording the meeting deliberations in writing (i.e. minutes). The minutes will be brought to a subsequent Executive Committee meeting for acceptance (and corrections, if any) so that the minutes are conclusive proof that they accurately reflect the deliberations at the prior Executive Committee meeting. [General By-law, s. 38(8-9)]

Quorum

A majority (4) of the members of the Executive Committee constitutes a quorum. [General By-law, s. 38(4)]

Decision-Making

Questions before the Executive Committee may be decided by a majority of the votes cast at the meeting (including the presiding officer at the meeting). If there is an equality of votes, the question is deemed to have been defeated. [General By-law, s. 38(6)][4]

[3] The Annual General Meeting is the Council meeting that takes place between November and December each year. [General By-law, s. 28(1)]
[4] For example, where there are only 4 Committee members present, a majority of the votes is 3. [General By-law, s. 38(6)]

Compensation

Committee members who are physicians are compensated for committee work and travel time, and are reimbursed for expenses incurred in the conduct of committee business, in accordance with section 20 of CPSO By-Law No. 2 (Fees and Remuneration By-Law).

Committee members who are public members are compensated by the Minister of Health for expenses and remuneration as determined by the Lieutenant Governor in Council. [HPPC, s. 8]

Committee Staff Support

The Executive Committee will receive administrative support from the staff within the Governance and Policy division and the Executive Office of CPSO. Administrative support includes scheduling meetings, preparing and distributing meeting materials and assistance with organization and notice of each meeting.

Declaration of Adherence

Each member of the Executive Committee must sign a Declaration of Adherence in the form provided by CPSO, which requires committee members to comply with, among other things, conflict of interest, confidentiality obligations and CPSO policies.

Acknowledgement

I, the undersigned, acknowledge that, as a member of the Executive Committee, I have read and understand the Terms of Reference of the Executive Committee. The RHPA, including the HPPC, any other applicable legislation or regulations and the CPSO By-laws prevail over these Terms of Reference to the extent of any inconsistencies or conflicts with these Terms of Reference. I hereby confirm my commitment to fulfilling my duties as a member of the Executive Committee in accordance with the Terms of Reference, applicable legislation and the CPSO By-laws.

Printed Name:	
Signature:	
Date:	

Council Motion

Motion Title	Alternative Pathways to Registration
Date of Meeting	March 4, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the revised policy *"Alternative Pathways to Registration"*, (a copy of which forms Appendix " " & " " to the minutes of this meeting).

Council Briefing Note

March 2021

Topic:	Alternative Pathways to Registration
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services
Attachment(s):	Appendix A: Current "Pathways" Policy Appendix B: Proposed *Policy "Alternative Pathways to Registration"*

Issue

- The existing Council Policies on *Alternatives Pathways to Registration* ("Pathways" Policy) is under review.

- Section 22.21 (a) of the Health Professions Procedural Code ("Code") requires that the College give notice of its intention to establish or amend occupational standards to:

  (i) The Minister of Health;
  (ii) The co-ordinating Minister under the *Ontario Labour Mobility Act, 2009;* and
  (iii) The bodies authorized to grant certificates of registration in other provinces or territories that are parties to the Canadian Free Trade Agreement (i.e. Medical Regulatory Authorities).

- The Medical Regulatory Authorities are provided with an opportunity to comment on the proposed changes.

- Council is asked whether the draft policy can be approved.

Background

- The Pathway policies were last approved by Council in September 2008.

- The draft revised policy was approved for release for notice to the Ministry of Health, the coordinating Minister under the *Ontario Labour Mobility Act, 2009*, and the medical regulatory authorities in Canada under Section 22.21 of the Code at a Council meeting held on December 3, 2020.

- The materials considered at that meeting can be accessed here.

Current Status

- The proposed policy was circulated to the Minister of Health and the coordinating Minister under the *Labour Mobility Act, 2009,* and to the Federation of Medical Regulatory Authorities of Canada on February 3, 2021. The medical regulatory authorities were provided an opportunity to comment on the proposed policy.

- A summary of the consultation feedback is outlined below:

    - As of the Council submission deadline, one response was received as part of this external consultation from the College of Physicians and Surgeons of New Brunswick (CPSNB);
    - CPSNB inquired why Pathway B was excluding applicants currently registered in another Canadian province.
    - The explanation provided was that this pathway is intended for US-trained physicians and that individuals registered in another Canadian province are eligible for registration under various alternate routes in Ontario including eligibility under the Registration Regulation and the Canadian Free Trade Agreement.

- Based on this feedback we are not recommending any changes to the proposed policy.

- If further feedback is received prior to the meeting, it will be presented at the meeting of Council.

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Question for Council

1. Does Council approve the revised draft *Alternative Pathways to Registration* policy as a policy of the College?

Appendix A

PATHWAY 1 – CANADIAN MEDICAL DEGREE AND POSTGRADUATE TRAINING WITHOUT RCPSC OR CFPC CERTIFICATION

Approved by Council: September 2008; February 2010

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the CFTA and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

1. Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See details below.
2. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See Pathway 2.
3. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification. See Pathway 3.
4. IMGs with US postgraduate training and certification. See Pathway 4.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 1: Canadian Medical Degree and Postgraduate Training without RCPSC or CFPC Certification

Appendix A

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who has a medical degree from a medical school in Canada accredited by the Council on Accreditation of Canadian Medical Schools, if the applicant has:

1. successfully completed:
    1. a Canadian residency program; or
    2. acceptable pre-1993 training;
2. successfully completed:
    1. the Medical Council of Canada Qualifying Examinations; or
    2. an acceptable qualifying examination; and
3. practised for five or more continuous years in Canada or the United States (US), while holding an independent or full license or certificate of registration without restrictions but does not currently hold a certificate in a Canadian jurisdiction. [1]

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC and do not currently hold a certificate in a Canadian jurisdiction. (See footnote [1]). Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Endnote

[1] If you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under the CFTA. To find out more, please see Registration Requirements for out-of-province licence holders.

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Appendix A

PATHWAY 2 – IMG WITH CANADIAN POSTGRADUATE TRAINING WITHOUT RCPSC OR CFPC CERTIFICATION

Approved by Council: September 2008; February 2010

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the AIT and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

1. Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See Pathway 1.
2. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See details below.
3. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification. See Pathway 3.
4. IMGs with US postgraduate training and certification. See Pathway 4.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 2: IMG with Canadian Postgraduate Training without RCPSC or CFPC Certification

Appendix A

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who is an IMG, if the applicant has:

1. successfully completed:
    1. a Canadian residency program; or
    2. acceptable pre-1993 training;
2. successfully completed:
    1. the Medical Council of Canada Qualifying Examinations; or
    2. an acceptable qualifying examination; and
3. practised for five or more continuous years in Canada while holding an independent or full license or certificate of registration without restrictions but do not currently hold a certificate in a Canadian jurisdiction.[1]

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC and do not currently hold a certificate in a Canadian jurisdiction. (See endnote 1). Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Endnote

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Appendix A

PATHWAY 3 – U.S. OR CANADIAN MEDICAL DEGREE OR DOCTOR OF OSTEOPATHY WITH U.S. POSTGRADUATE TRAINING

Approved by Council: September 2008; February 2010

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the AIT and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

1. Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See Pathway 1.
2. International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See Pathway 2.
3. Physicians with a U.S. or Canadian medical degree or Doctor of Osteopathy degree with U.S. postgraduate training and certification. See details below.
4. IMGs with US postgraduate training and certification. See Pathway 4.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 3: US or Canadian Medical Degree or "Doctor of Osteopathy" Degree with US Postgraduate Training and Certification

Appendix A

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who has a medical degree from a medical school in the US which is accredited by the Liaison Committee of Medical Education, or a medical degree from a medical school in Canada accredited by the Council on Accreditation of Canadian Medical Schools or a "doctor of osteopathy" degree granted by an osteopathic medical school in the US that was, at the time the degree was granted, accredited by the American Osteopathic Association, if the applicant has:

1. successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education;
2. been certified by a US Specialty Board;
3. successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying examination; and
4. an independent or full license or certificate of registration to practise without restrictions in the US.

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC. Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Unlike the College's policy for ACGME-trained specialists,[1] this pathway does not require that the ACGME residency be comparable in content and duration to a Canadian training program in the same discipline.

Endnote

[1] The policy for ACGME-trained specialists was rescinded by CPSO Council in November 2008 because applicants now have access to licensure under Pathway 3

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Registration Committee FAQ

Common questions and answers relating to the Registration Committee process.

Appendix A

PATHWAY 4 – IMG WITH US POSTGRADUATE TRAINING AND CERTIFICATION

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways.

Approved by Council: September 2008

In an effort to improve access and reduce barriers for qualified physicians, the College's Council approved groundbreaking policy in September 2008 that established four new registration pathways. The four approved pathways came into effect on December 1, 2008. Subsequently, Pathways 1, 2 and 3 were amended in February 2010 to comply with the AIT and the FMRAC National Standard. These new registration requirements vary depending on the source of the applicant's medical degree, where the applicant is currently practising and where the applicant received postgraduate training.

The Pathways are applicable to the following groups of physicians:

- Physicians with a Canadian medical degree and postgraduate training without RCPSC or CFPC certification. See Pathway 1.
- International medical graduates (IMGs) with Canadian postgraduate training without RCPSC or CFPC certification. See Pathway 2.
- Physicians with a US or Canadian medical degree or "Doctor of Osteopathy" Degree with US postgraduate training and certification. See Pathway 3.
- IMGs with US postgraduate training and certification. See details below.

Preamble

The College's registration regulation sets out the requirements which must be met in order for an applicant to be issued a certificate of registration.

If an applicant does not meet the requirements set out in the regulation it may still be possible for an applicant to qualify pursuant to one of the exemption policies.

Please note that if you currently hold a certificate of registration in any Canadian jurisdiction except Nunavut you may be eligible for registration in Ontario under new provisions of the *Health Professions Procedural Code*. See Legislation and By-Laws for more detail.

All applicants must be able to demonstrate that their past and present conduct indicates that they are mentally competent to practise medicine; will practise with decency, integrity and honesty and in accordance with the law; have sufficient knowledge, skill and judgment to engage in the kind of practice authorized by the certificate and can communicate effectively; and will display an appropriately professional attitude.

In addition to the registration regulation and policies, all applicants will also be subject to other CPSO policies and regulations which apply to current registrants. In particular, the Changing Scope of Practice and Re-entering Practice policies, and the regulation pertaining to the use of specialist titles may have relevance for new applicants. All applicants will also be subject to the College's expectations with respect to continuing professional development.

All registrants qualified under this policy will undergo an assessment after completing a minimum of one year of practice in Ontario. Assessments ensure that physicians are practising competently and safely. All physicians in Ontario undergo assessments and it is part of the College's vision of quality professionals that all physicians will be assessed every 10 years.

Pathway 4: IMG with US Postgraduate Training and Certification

Appendix A

The Registration Committee may direct the Registrar to issue a certificate of registration to an applicant who is an IMG, if the applicant has:

1. successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education;
2. been certified by a US Specialty Board;
3. successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying examination; and
4. an independent or full license or certificate to practise without restrictions in the US or is eligible to apply for an independent or full license or certificate of registration to practise without restrictions in the US.

The following conditions will be placed on the certificate of registration:

1. The physician must practice with a mentor and/or supervisor until he or she has successfully completed an assessment.
2. The physician must undergo an assessment after completing a minimum of one year of practice in Ontario. The certificate of registration automatically expires 18 months from the date of issuance, but may be renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

How Barriers are Reduced

This policy adds another pathway to licensure for applicants who are not certified by the RCPSC or CFPC. Under this policy, eligible candidates now have a route to a certificate of registration to practice medicine independently limited to their scope of practice, subject to an initial one-year period of practice under supervision (or a mentor) and successful completion of an assessment after the first year of practice. Unsuccessful completion of an assessment would result in expiry of the certificate of registration unless it is renewed by the Registration Committee, with or without additional or other terms, conditions and limitations.

Unlike the College's policy for ACGME-trained specialists,[1] this pathway does not require that the ACGME residency be comparable in content and duration to a Canadian training program in the same discipline.

Endnote

[1] The policy for ACGME-trained specialists was rescinded by CPSO Council in November 2008 because applicants now have access to licensure under Pathway 3 and Pathway 4.

Related Information

Guidelines for College-Directed Supervision

The CPSO provides guidance for physicians required to take part in supervised practice by our policies or committees.

Registration Committee FAQ

Common questions and answers relating to the Registration Committee process.

1. Alternative Pathways to Registration

We are committed to improving access for qualified doctors looking to practice medicine in Ontario.

The CPSO offers two alternative pathways for physicians looking to gain licensure in the province of Ontario but who are applying outside of our regular registration requirements.

If you gain licensure under one of these pathways, you will undergo an assessment after completing a minimum of one year of supervised practice in Ontario. Upon satisfactory completion of the assessment, you will be issued a certificate of registration to practice independently in the area that was assessed. Your initial certificate automatically expires 18 months from the date of issuance, but the Registration Committee may renew it with or without terms, conditions and limitations.

Pathway A

We may issue you a certificate if you have:

- One of the following degrees:
  - an acceptable medical degree as defined in Ontario Regulation 865/93 under the *Medicine Act, 1991*; **or**
  - a "doctor of osteopathy" degree granted by an osteopathic medical school in the US that was accredited by the American Osteopathic Association at the time it granted you your degree;
- successfully completed a residency program accredited by the ACGME;
- been certified by a US Specialty Board;
- successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying exam; and
- an independent or full licence to practise without restrictions in the US or are eligible to apply for such a licence.

How we've reduced barriers

This adds another pathway to licensure if you are not certified by the RCPSC or CFPC. Under this policy, you now have a route to a certificate of registration to practice medicine independently, limited to your scope of practice.

Unlike our previous policy for ACGME-trained specialists, this pathway does not require that the ACGME residency be comparable in content and duration to a Canadian training program in the same discipline.

Pathway B

The CPSO may issue you a certificate if you have a medical degree from a medical school in Canada accredited by the Council on Accreditation of Canadian Medical Schools, or an acceptable international medical degree. To qualify, you must have:

- successfully completed a Canadian residency program or acceptable pre-1993 training;
- successfully completed the Medical Council of Canada Qualifying Examinations or an acceptable qualifying exam;
- practised for five or more continuous years in Canada or the United States (US) while holding an independent or full license or certificate of registration without restrictions but does not currently hold a certificate in a Canadian jurisdiction.

How we've reduced barriers

This adds another pathway if you are not certified by the RCPSC or CFPC and do not currently hold a certificate in a Canadian jurisdiction. You now have a route to practice medicine independently, limited to your scope of practice.

Council Motion

Motion Title	Delegation of Controlled Acts – Revised Policy for Final Approval
Date of Meeting	March 4, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the revised policy "Delegation of Controlled Acts", (a copy of which forms Appendix "…" to the minutes of this meeting).

Council Briefing Note

March 2021

Topic:	Delegation of Controlled Acts – Revised Draft Policy for Final Approval
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement System Collaboration
Public Interest Rationale:	Promotes patient safety while facilitating more timely and efficient access to care.
Main Contact(s):	Tanya Terzis, Senior Policy Analyst
Attachment(s):	Appendix A: Revised Draft *Delegation of Controlled Acts* Policy Appendix B: Revised Draft *Advice to the Profession: Delegation of Controlled Acts* Document

Issue

- The College's *Delegation of Controlled Acts* policy is currently under review. A new draft policy was released for external consultation in September 2020 along with a companion *Advice to the Profession* document (*Advice*). The draft policy and *Advice* have been revised in light of the feedback received through this engagement activity.

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

Background

- The current *Delegation of Controlled Acts* policy was last reviewed and approved by Council in 2012. Following extensive research[1] and a preliminary consultation[2], a new draft policy was developed with direction from the Policy Review Working Group, at the time consisting of Brenda Copps (Chair), Ellen Mary Mills, and Janet van Vlymen as well as Medical Advisors Angela Carol and Keith Hay. Additional support was provided by Jessica Amey (Legal Counsel).
    - The draft policy was approved for external consultation by Council in September 2020. The accompanying *Advice* was also released at this time.
    - A total of 128 responses were received as part of this external consultation[3]. The majority of respondents were physicians, along with 11 organizational stakeholders.[4]
    - Overall, feedback on the draft policy was largely positive. Respondents described the draft policy as clear and reasonable and a majority of survey respondents agreed that the draft policy clarifies when and how to delegate appropriately. All feedback received has been posted on a dedicated page of the College's website.[5]

Current Status and Analysis

- Revisions have been made to both the draft *Delegation of Controlled Acts* policy (Appendix A) and *Advice to the Profession* (Appendix B), predominantly in response to feedback obtained during the external consultation.
- The revisions were developed based on feedback and direction from the new Policy Review Working Group which is now comprised of Brenda Copps, Janet van Vlymen, Lydia Miljan, Peter Pielsticker, Sarah Reid, Karen Saperson, and Keith Hay. Medical Advisor, Angela Carol and Legal Counsel, Jessica Amey have continued to support this review.

[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian medical regulatory authorities and Ontario health profession regulators; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee; and feedback on the current policy from the College's Public and Physician Advisory Service (PPAS).
[2] 888 responses were received in total (83 through the online discussion page, and 805 via the online survey). An overview of the feedback was provided to Council in May 2019 as part of the Policy Report.
[3] 15 responses were received through the online discussion page, and 113 through the online survey. 77% of the respondents were physicians, 3% were members of the public, 9% were other health care professionals, 2% preferred not to say, and 9% were organizations.
[4] Organizational respondents included: Huron County Paramedic Service, Toronto Paramedic Services, Ontario Association of Paramedic Chiefs, Information and Privacy Commissioner of Ontario, Canadian Medical Protective Association, Ontario Medical Association, Professional Association of Residents of Ontario, College of Nurses of Ontario, Ontario Trial Lawyers Association, Ontario Homeopathic Medical Association, and weinject.
[5] A preliminary overview of the feedback was provided to Council in the December 2020 Policy Report.

- The revised draft policy expectations are largely consistent with those of the current policy as well as the draft policy that went out for consultation, while updates have been made to enhance clarity and reflect the realities of practice and that delegation occurs in a variety of contexts.

- An overview of the key issues considered by the Working Group along with any corresponding revisions is set out below.

Key Revisions in Response to Feedback

Definitions: Clarifying Delegation and Assignments of Tasks

- To clarify the scope of the policy and what is considered delegation as defined by the policy, additional content has been included in the revised draft policy's definition of delegation. The new content highlights assignments of tasks that would not be captured by the policy and that do not require delegation to perform (e.g., tasks that do not involve the performance of controlled acts, such as history taking, obtaining informed consent, taking vitals, etc.) (Lines #21-23).

- Notwithstanding the above, recognizing that the delivery of care often involves the performance of both controlled acts and non-controlled acts and the importance of both in the provision of care, updates were made in the *Advice* to better address this relationship.

    - More specifically, the revised draft *Advice* highlights that while the policy is focused on delegating controlled acts exclusively, physicians are ultimately responsible for all the care that is being provided on their behalf and for ensuring those providing the care can safely, effectively and ethically deliver all assigned components of care (Lines #75-87).

Performing controlled acts in an emergency (i.e., lay person first responders)

- In response to feedback about a gap in the current and draft policies, updates have been made in both the revised draft policy and *Advice* to clarify the policy's application to lay person first responders who may perform controlled acts in an emergency (e.g., lifeguards, ski patrol, wilderness first responders, occupational first aid providers, etc.).

- In particular, revisions in the *Advice* clarify that lay person first responders who perform controlled acts in emergency scenarios require delegation to do so and physicians acting in the capacity of Medical Directors for these initiatives must comply with the policy. However, in keeping with the other exceptions captured in the policy, a traditional physician-patient relationship would not be required in these instances (Lines #50-74).

- These revisions give lay person first responders a clear enabling mechanism to do this important public safety work, provide a framework to regulate this otherwise unregulated space, and hold physicians accountable for their decision to delegate in these circumstances.

Unregistered practitioners and health professionals who are suspended or revoked

- In keeping with the current expectation of not delegating to health professionals whose certificate of registration is suspended or revoked at the time of the delegation, the revised draft policy includes a new expectation that physicians not delegate to unregistered practitioners (i.e., individuals who have inappropriately claimed to be or have posed as a physician) (Provision #3b).

    - Where an unregistered practitioner is identified by the CPSO, information about the unregistered practitioner and any associated undertaking or order is now publicly available and posted on the CPSO's website, providing a mechanism by which physicians can identify these individuals.

- In response to feedback from the Ontario Medical Association, additional guidance has been added to the *Advice* regarding the actions that physicians can take to ensure they are not delegating to a health professional whose certificate of registration has been suspended or revoked. The guidance acknowledges that these actions will look different depending on the practice setting where the delegation is occurring (e.g., hospitals versus other practice settings) (Lines #89-102).

Delegating within a Physician-Patient Relationship

- In response to consultation feedback, the requirement to delegate in the context of a physician-patient relationship has been revised to now capture existing *or anticipated physician-patient relationships*, unless patient best interests dictate otherwise (Provision #7). This revision maintains the requirement for delegation to generally occur in the context of a physician-patient relationship while providing flexibility for the physician-patient relationship to be established prior to or soon after the delegation has occurred.

- This was an area of significant focus and discussion for the Working Group, recognizing that the policy needs to be flexible enough to permit appropriate practices occurring in hospital and family practice clinics while avoiding the creation of a loophole that could be used to circumvent the need for physicians to see and assess patients when delegating. The revision is meant to have patient best interests drive these decisions.

    - The draft policy sought to clarify the existing expectations by specifying when it would be appropriate to delegate in *advance* of a physician-patient relationship (i.e., when in a patient's best interest) and in the *absence* of a physician-patient relationship altogether (i.e., public health and public safety measures and in

hospital settings for routine protocols). However, some consultation feedback suggested a more principled approach.

- The revisions reflect the use of delegation in a variety of different contexts and in particular, the delegation that frequently occurs in hospital emergency department settings whereby the physician-patient relationship is often established after the delegation (e.g., ordering of tests prior to assessment by the physician).

Exceptions to the Physician-Patient Relationship Requirement

- The current and draft policies provide explicit examples of scenarios where delegation in the absence of a physician-patient relationship is permissible. The existing examples have been broadened to permit community paramedicine programs and *all* public health programs to operate in the absence of a traditional physician-patient relationship.

    - The revisions reflect the fact that many public health measures take place outside of the purview of the Medical Officer of Health and that paramedics play a role both in traditional 911 response, as well as in primary care and public health (i.e., assisting with chronic conditions, palliative care, influenza immunization and COVID-19 testing, often in remote or rural communities).

Ongoing Delegation

- Expectations in the draft policy regarding ongoing delegation received broad support. Minor revisions were made in response to feedback to clarify that these expectations do not apply in those instances where delegation is permitted in the absence of a physician-patient relationship (e.g., in the delivery of care by community paramedics) (Provision #9).

- The revised draft policy now permits re-assessments to take the form of a chart review or consult with the delegate rather than an in-person assessment, where delegation is occurring on an ongoing basis.

    - This revision provides greater flexibility with respect to re-assessments by a physician, while still requiring appropriate physician involvement in the care being provided.

<u>Minor Revisions in Response to Feedback</u>

Informed Consent

- While there was broad support for the existing expectation that informed consent be obtained for any treatments that are delegated and not the delegation itself, some stakeholders felt that the policy should require both consent for treatment and the delegation. While the Working Group was not of the view that this would be practical,

possible, or necessary in many instances of delegation, they felt that the draft could benefit from additional content to signal that informed consent includes the provision of information about who will be providing the treatment, including their role and/or credentials (Provision #10).

Identifying and Mitigating Risk

- To enhance clarity regarding the specific risks that must be mitigated when delegating, the revised draft policy has been updated to require physicians to mitigate *significant* or *common* risks associated with the delegation (i.e., not *all* risks) and to the extent that patient safety is at no greater risk than had the act not been delegated (Provision #11).

Knowing Who and When to Ask for Assistance

- A draft provision which required physicians to ensure an individual implementing a directive is able to identify the physician responsible for the care of the patient has been removed as it was felt to be impractical for emergency departments where delegation often occurs prior to a physician-patient relationship being established. The existing requirement for physicians to be satisfied that delegates know when and who to ask for assistance, if necessary, is felt to sufficiently address this issue and set an appropriate minimum standard (Provision #16(b)).

Adverse Events

- While the expectations related to adverse events have been largely retained, the expectation requiring physicians to ensure any adverse events that occur are managed appropriately has been revised to require physicians to have *protocols in place* to appropriately manage adverse events (Provision #18). The revision effectively creates a more tangible action for physicians to ensure appropriate management of adverse events.

<u>Expectations Retained in Response to Consultation Support</u>

Supervision and Support of Delegates

- In response to widespread support during the consultation, the provisions related to appropriate supervision have been retained in the revised draft policy (Provision #16 and 17). These provisions were a primary focus of the Working Group throughout the review and they wished to focus attention on them during the consultation to determine whether the right balance had been struck.

    - Survey respondents generally supported the factors included in the draft for assessing risk and determining an appropriate level of supervision, agreed that there are instances where onsite supervision is necessary and instances where it is

not, and felt that if onsite supervision was required in all instances it would negatively impact the delivery of care (i.e., hinder access and efficiency).

- Ultimately the Working Group is of the view that tying the level of risk associated with the delegation to the level of supervision required in each instance provides an appropriate framework for physicians to determine the type of supervision required in each instance of delegation (e.g., whether they need to be onsite).

Next Steps

- Should Council approve the revised draft policy, it will be announced in *Dialogue* and added to the College's website.

Question for Council

1. Does Council approve the revised draft *Delegation of Controlled Acts* policy as a policy of the College?

Delegation of Controlled Acts

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

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

Definitions

Controlled Acts[1]: Controlled acts are specified in the *Regulated Health Professions Act, 1991 (RHPA)* as acts which may only be performed by authorized regulated health professionals.[2]

Delegation: Delegation is a mechanism that allows a regulated health professional (e.g., a physician) who is authorized to perform a controlled act to temporarily grant that authority to another person (whether regulated or unregulated) who is not legally authorized to perform the act independently.

For the purposes of this policy, delegation does **not** include:

- Assignments of tasks that do not involve controlled acts (e.g., taking a patient's history, obtaining informed consent, administering a test that does not involve a controlled act, taking vitals, etc.); or
- Orders that authorize the initiation of a controlled act that is within the scope of practice of another health care professional (e.g., nurses are legally authorized to "administer a substance by injection" when the procedure has been ordered by a specified regulated health professional (e.g. a physician). Therefore, a nurse would require an order to perform this procedure, but this would not be considered delegation).[3]

[1] See Appendix A for a list of controlled acts defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 *(RHPA)*.
[2] Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it permits performing controlled acts if the person performing the act is doing so to render first aid or temporary assistance in an emergency, or if they are fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is performed under the supervision or direction of a member of the profession (*RHPA*, s. 29(1)(a,b)).
[3] For additional information about what is not considered "delegation" as defined in the policy, see the *Advice to the Profession: Delegation of Controlled Acts* document.

Direct Order: Direct orders are written or verbal instructions from a physician to another health care provider or a group of health care providers to carry out a specific treatment, procedure, or intervention for a specific patient, at a specific time. Direct orders provide the authority to carry out the treatments, procedures, or other interventions that have been directed by the physician and generally take place after a physician-patient relationship has been established.

Medical Directive[4]**:** Medical directives are written orders by physician(s) to other health care provider(s) that pertain to any patient who meets the criteria set out in the medical directive. When a medical directive calls for acts that need to be delegated, it provides the authority to carry out the treatments, procedures, or other interventions that are specified in the directive, provided that certain conditions and circumstances exist.

Policy

Delegation is intended to provide physicians with the ability to extend their capacity to serve patients by temporarily authorizing an individual to act on their behalf. Delegation is intended to be a physician extender, not a physician replacement. Physicians remain accountable and responsible for the patient care provided through delegation.

When to Delegate

In the patient's best interest

1. Physicians **must** only delegate controlled acts when doing so is in the best interest of the patient. This includes only delegating when the act can be performed safely, effectively, and ethically. Therefore, physicians **must** only delegate when:

    a. the patient's health and/or safety will not be put at risk;
    b. the patient's quality of care will not be compromised by the delegation; and
    c. delegating serves at least one of the following purposes:
        i. promotes patient safety,
        ii. facilitates access to care where there is a need,
        iii. results in more timely or efficient delivery of health care, or
        iv. contributes to optimal use of health-care resources.

When not to delegate

2. Physicians **must not** delegate where the primary reasons for delegating are monetary or physician convenience.

[4] For examples of prototype medical directives, please consult the Emergency Department Medical Directives Implementation Kit which has been developed jointly by the Ontario Hospital Association (OHA), the Ontario Medical Association, and the Ministry of Health and is available on the OHA website.

3. Physicians **must not** delegate the performance of a controlled act to:

    a. a health professional whose certificate of registration is revoked or suspended at the time of the delegation[5]; or
    b. unregistered practitioners[6] (i.e., individuals who have claimed to be or have posed as a physician).

4. Physicians **must not** delegate the controlled act of psychotherapy.[7]

What to Delegate

5. Physicians **must** only delegate the performance of controlled acts that they can personally perform competently (i.e., acts within their scope of practice).[8]

How to Delegate

Use of direct orders and medical directives

6. Physicians **must** delegate either through the use of a direct order or a medical directive that is clear, complete, appropriate, and includes sufficient detail to facilitate safe and appropriate implementation (see the *Documentation* section of this policy for more information).

In the context of a physician−patient relationship

7. Physicians **must** only delegate in the context of an existing or anticipated physician-patient relationship, unless a patient's best interest dictates otherwise (e.g., public health or public safety measures).[9]

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[5] For additional information about determining the status of a health professional's certificate of registration, see the *Advice to the Profession: Delegation of Controlled Acts document*.
[6] For a list of individuals identified by the CPSO see the CPSO's website.
[7] This does not prohibit health care professionals who are authorized to perform the controlled act of psychotherapy from doing so, including nurses of all classes, psychologists, occupational therapists, social workers, and registered psychotherapists.
[8] O. Reg. 865/93, *Registration*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30, s. 2(5) requires physicians to only practise in the areas of medicine in which they are trained and experienced. For more information see the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy and the *Delegation of Controlled Acts*: *Advice to the Profession* document.
[9] Generally, a patient's best interests will be served by delegation that occurs in the context of an existing or anticipated physician-patient relationship. However, in some instances a patient's best interests might be served by receiving care in the absence of a traditional physician-patient relationship. For example, in instances where access would otherwise be compromised to the point of risking patient safety, or where patient or public safety might be otherwise compromised. Examples of appropriate circumstances in which delegation may occur in the absence of a traditional physician-patient relationship include, but are not limited to:

8. Physicians **must** perform a clinical assessment prior to delegating or as soon as possible afterward, unless a patient's best interest dictates otherwise.

9. Where, in the context of a physician-patient relationship, delegation is occurring on an ongoing basis, physicians **must:**

    a. ensure that patients are informed of who the delegating physician is and that they can make a request to see the physician if they wish to; and
    b. periodically re-assess[10] the patient to ensure that delegation continues to be in the patient's best interest (e.g., when there is a change in the patient's clinical status or treatment options).

Ensure consent to treatment is obtained

10. Physicians **must** ensure informed consent is obtained and documented, in accordance with the *Health Care Consent Act, 1996* and the College's *Consent to Treatment* policy, for any treatments that are delegated.[11]

    a. In circumstances where the delegation takes place pursuant to a medical directive, physicians **must** ensure the medical directive includes obtaining the appropriate patient consent.[12]

- the provision of care by paramedics under the direct control of base hospital physicians or within community paramedicine programs;
- the provision of primary care in remote and isolated regions of the province by registered nurses acting in expanded roles;
- the provision of public health programs, such as vaccinations;
- post-exposure prophylaxis following potential exposure to a blood borne pathogen or the provision of the hepatitis B vaccine in the context of occupational health medicine;
- hospital emergency departments for routine protocols; and
- lay person first responders performing controlled acts for the purposes of first aid in an emergency.

[10] In some circumstances, an assessment might take the form of a chart review or consultation with the delegate rather than an in-person assessment.

[11] Please see the *Health Care Consent Act, 1996* and the College's *Consent to Treatment* policy for more information.

[12] Obtaining informed consent includes providing the patient with information about the individual who will be providing the treatment and their role and/or credentials. Obtaining informed consent also includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate.

Quality Assurance

Identifying and mitigating risks

11. Prior to delegating, physicians **must** identify significant or common risks associated with the delegation and mitigate them such that patient safety is at no greater risk than had the act not been delegated.

    a. Physicians **must** only delegate controlled acts if the necessary resources and environmental supports are in place to ensure safe and effective delegation.

Evaluating delegates and establishing competence

12. Physicians **must** be satisfied that individuals to whom they delegate have the knowledge, skill, and judgment to perform the delegated acts competently and safely. Prior to delegating physicians **must**:

    a. review the individual's training and credentials, unless the physician is not involved in the hiring process and it is reasonable to assume that the hiring institution has ensured that its employees have the requisite knowledge, skill, and judgment[13]; and
    b. observe the individual performing the act, where necessary (e.g., where the risk is such that observation is necessary to ensure patient safety).

Ensuring delegates can accept the delegation

13. Physicians **must** only delegate to individuals who are able to accept the delegation.[14] In particular, physicians **must not:**

    a. delegate to an individual if they become aware the individual is not permitted to accept the delegation; or
    b. compel an individual to perform a controlled act they have declined to perform.

[13] In some cases, the physician may not personally know the individual to whom they are delegating. For example, medical directors at base hospitals delegating to paramedics or in hospital settings, where the hospital employs the delegates (nurses, respiratory therapists, etc.) and the medical staff is not involved in the hiring process. For additional guidance about ensuring competence when a physician has not personally employed a delegate, see the *Advice to the Profession: Delegation of Controlled Acts* document.

[14] In addition to the limitations set out in the *RHPA*, some regulatory colleges in Ontario place limits on the types of acts that their members may be authorized to carry out through delegation. The delegate is responsible for informing the delegating physician of any regulations, policies, and/or guidelines of their regulatory body that would prevent them from accepting the delegation.

Supervision and support of delegates

14. Physicians **must** provide a level of supervision and support that is proportionate to the risk associated with the delegation and that is reflective of the following factors:

    a. the specific act being delegated;
    b. the patient's specific circumstances (e.g., health status, specific health-care needs);
    c. the setting where the act will be performed and the available resources and environmental supports in place; and
    d. the education, training and experience of the delegate.

15. If on the basis of the risk assessment onsite supervision is not necessary, physicians **must** be available to provide appropriate consultation and assistance (e.g., in person, if necessary, or by telephone).

16. Physicians **must** be satisfied that the individuals to whom they are delegating:

    a. understand the extent of their responsibilities; and
    b. know when and who to ask for assistance, if necessary.

17. Physicians **must** ensure that the individuals to whom they are delegating accurately identify themselves and their role in providing care to patients and that patients with questions about the delegate's role are provided with an explanation.

Managing adverse events

18. Physicians **must**:

    a. have protocols in place to appropriately manage any adverse events that occur;
    b. be available to provide assistance in managing any adverse events, if necessary;
    c. be satisfied that the delegate is capable of managing any adverse events themselves, if necessary; and
    d. have a communication plan in place to keep informed of any adverse events that take place and any actions taken by the delegate to manage them.

Ongoing monitoring and evaluation

19. Where acts are routinely delegated, physicians **must** have a reliable and ongoing monitoring and evaluation system for both the delegate(s) and the delegation process itself.

20. As part of this system, physicians **must**:

    a. confirm currency of the delegate's knowledge and skills; and
    b. evaluate the delegation process to ensure it is safe and effective; and
    c. review patient medical records to ensure the care provided through delegation is appropriate and meets the standard of practice.
        i. What is necessary will depend on the specific acts being delegated and the other quality assurance processes in place to ensure safe and effective delegation.

Documentation

Medical Directives

21. Physicians **must** ensure the following information is included in the medical directive[15]:

    a. The name and a description of the procedure, treatment, or intervention being ordered;
    b. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
    c. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
    d. A comprehensive list of contraindications to implementation of the directive;
    e. Identification of the individuals authorized to implement the directive;[16]
    f. A description of the procedure, treatment, or intervention itself that provides sufficient detail to ensure that the individual implementing the directive can do so safely and appropriately;[17]
    g. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and
    h. A list of the administrative approvals that were provided to the directive, including the dates and each committee (if any).

[15] A comprehensive guide and toolkit was developed by a working group of the Health Profession Regulators of Ontario (HPRO) in 2006 and is posted on their website.
[16] The individuals need not be named but may be described by qualification or position in the workplace.
[17] The directive may call for the delegate to follow a protocol that describes the steps to be taken in delivering treatment if one has been developed by the physician or the institution.

22. Each physician responsible for the care of a patient who may receive the proposed treatment, procedure, or intervention **must** review and sign the medical directive each time it is updated.[18]

Medical Records

23. Physicians **must** ensure that:

    a. the care provided through delegation is documented in accordance with the College's *Medical Records Documentation* policy, including that each entry in the medical record is identifiable and clearly conveys who made the entry and performed the act;
    b. it is clear who the authorizing physician(s) are (e.g., the name(s) of the authorizing physician(s) are captured in the medical record); and
    c. verbal direct orders are documented in the patient's medical record by the recipient of the direct order and are reviewed or confirmed at the earliest opportunity by the delegating physician.[19]

[18] It is acceptable for physicians working at institutions with multiple directives to receive copies of each directive and sign one statement indicating that they have read and agreed with all the medical directives referred to therein. This can be done as part of the annual physician reappointment process.
[19] Physicians practising in hospitals may be subject to additional requirements under the *Public Hospitals Act, 1990*.

Appendix A

Controlled Acts under the *RHPA*

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
    i. beyond the external ear canal,
    ii. beyond the point in the nasal passages where they normally narrow,
    iii. beyond the larynx,
    iv. beyond the opening of the urethra,
    v. beyond the labia majora,
    vi. beyond the anal verge, or
    vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the *RHPA*.
8. Prescribing, dispensing, selling or compounding a drug as defined in the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.[20]
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.
14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

[20] This is the only controlled act that physicians are not authorized to perform.

Advice to the Profession: Delegation of Controlled Acts

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

Introduction

Under Ontario law, certain acts, referred to as "controlled acts," may only be performed by authorized regulated health professionals. Of the 14 controlled acts, physicians are authorized to perform 13 of them and under appropriate circumstances, physicians may delegate these acts to others.[1] While the term "delegation" can have multiple meanings, for the purposes of the policy, "delegation" is defined as a mechanism that allows a regulated health professional (e.g., a physician) who is authorized to perform a controlled act to temporarily grant that authority to another person (whether regulated or unregulated) who is not legally authorized to perform the act independently. Delegating controlled acts in appropriate circumstances can result in more timely delivery of health care, promote optimal use of healthcare resources and personnel, and increase access to care where there is a need.

The *Delegation of Controlled Acts* policy sets expectations for physicians about when and how they may delegate controlled acts, through either direct orders or medical directives. This companion *Advice* document is intended to help physicians interpret their obligations as set out in the *Delegation of Controlled Acts* policy and provide guidance around how these expectations may be effectively discharged.

Delegation Fundamentals

What should I do if I'm not sure whether a procedure, treatment, or intervention requires the performance of a controlled act?

Controlled acts are defined in the *Regulated Health Professions Act, 1991*[2] *(RHPA)* and are set out in the appendix of the policy. Physicians with questions about whether a procedure, treatment or intervention involves the performance of a controlled act can obtain a legal opinion.

What are some examples of instances that would not require delegation? In what circumstances does the policy not apply?

[1] Physicians are not permitted to delegate the controlled act of psychotherapy.
[2] Controlled acts are defined under subsection 27 (2) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 *(RHPA).*

"Delegation" occurs only when a physician directs an individual to perform a controlled act that the individual has no statutory authority to perform. However, the term "delegation" is often used liberally to refer to instances that would not require delegation as defined in the policy. For example, the following would not require delegation as defined in the policy:

1) Assigning tasks to staff or other health care professionals that do not involve the performance of controlled acts (e.g., history-taking, administering a test that does not involve a controlled act, taking vitals, or obtaining consent).

2) Performing a controlled act in one of the permissible circumstances listed under the *RHPA*[3] (e.g., when providing first aid or temporary assistance in an emergency or when fulfilling the requirements to become a member of a health profession (e.g., medical students)).

3) Ordering the initiation of a controlled act that is within the scope of practice of another health professional (e.g., an order for a nurse to "administer a substance by injection" is not delegation as nurses are legally authorized to perform this act when ordered to do so by a physician).[4]

In what circumstances can the emergency exception under the RHPA be relied upon to perform controlled acts and when is delegation required?

The emergency exception under the *RHPA* allows individuals to perform controlled acts when providing first aid or temporary assistance in an emergency. The exception allows individuals who come across a scenario requiring immediate action and assistance to perform controlled acts where necessary. For example, a bystander who encounters someone experiencing anaphylaxis and requiring administration of an epinephrine auto injector (e.g., EpiPen™). The individual would be permitted under the exception to perform the controlled act of administering the injection, an act that would otherwise require legal authority to perform.

The exception does not enable individuals who are otherwise unauthorized to perform controlled acts, to do so in circumstances where there is an *anticipated* emergency.

[3] The *RHPA* sets out a number of exceptions that allow individuals who are not members of a regulated health profession to perform some controlled acts, in certain circumstances. A comprehensive list of the exceptions can be found under Section 29 (1) (2) of the *RHPA*.

[4] In order to determine whether an act requires delegation, physicians need to be aware of the scope of practice of the individual who will perform the act and whether it includes the controlled act in question. Regulated health professions have their own professional statutes (e.g., the *Nursing Act, 1991*), that define their scopes of practice and the controlled acts they are authorized to perform. Physicians with additional questions can consult the CMPA or obtain an independent legal opinion.

For example, circumstances requiring trained emergency or first aid personnel to be on site in the event of an injury. In scenarios where first responders, including lay person first responders (e.g., lifeguards, ski patrol, wilderness first responders, occupational first aid providers, etc.) are hired to provide emergency services that might require the performance of controlled acts, the policy expectations *do* apply.

Delegation is the authorizing mechanism enabling lay person first responders to perform controlled acts when providing first aid in an emergency. The policy permits these instances of delegation in the absence of a physician-patient relationship, however, it still requires the other expectations to be satisfied, including ensuring a delegate's competence, and that appropriate supervision and supports are in place to ensure safe and effective delegation (e.g., oversight by a Medical Director). Appropriate documentation is also required while recognizing that the nature of the care provided in these instances would not result in a typical patient medical record.

Performing tasks such as history-taking can be as important to the care provided as the performance of controlled acts. Why does the policy not apply to assignments of tasks that are not controlled acts?

Delegation is an enabling mechanism for the performance of acts that are otherwise restricted and thus a framework for delegation is necessary to provide clarity about how this can be done appropriately. Despite the policy's focus on the delegation of controlled acts, physicians remain responsible for all the care that is provided on their behalf, and for ensuring those providing care can safely, effectively and ethically deliver all assigned components of care. The general principles set out in the policy to ensure that delegation is done appropriately can similarly guide physician judgment when determining the appropriateness of assigning tasks to others. As with all decisions related to the provision of care, patient best interests can be used as the guiding principle.

Considering and Evaluating Delegates

The policy requires that physicians not delegate to a health professional whose certificate of registration is revoked or suspended at the time of the delegation. What actions do I need to take to ensure compliance with this expectation?

The actions that physicians need to take to ensure compliance with this expectation are case specific and are generally dependent on a physician's practice setting and their role in hiring. For physicians practising in institutional settings such as hospitals, unless there are reasonable grounds to believe otherwise, it would generally be acceptable to assume that the hiring institution has done their due diligence in this regard. All other physicians can confirm the status of a delegate's certificate of registration by checking the health profession regulator's registry or contacting the

regulator directly for confirmation of whether the delegate's practice certificate is in good standing. If a physician were to learn that an individual to whom they had been delegating had become suspended or their certificate of registration was revoked they would be expected to cease delegating to that individual immediately.

Can I delegate to individuals who are not members of a regulated health profession?

Yes. The policy permits delegating to individuals who are not members of a regulated health profession, provided the policy requirements are met. For example, Physician Assistants and paramedics are skilled health care providers who regularly provide safe and effective care entirely through delegation.

Physicians are ultimately responsible for the acts they delegate and must be satisfied that the individual to whom they are delegating has the requisite knowledge, skill, and judgment to perform the act(s).

Where can I find information about delegating to Physician Assistants (PAs)?

The Canadian Medical Association and the Canadian Association of Physician Assistants have developed a Physician Assistant Toolkit for Canadian physicians looking to delegate to PAs. The CMPA's article *Working with physician assistants: Collaborating while managing risks* also contains helpful information.

How do the policy expectations apply when delegating to International Medical Graduates (IMGs) who have credentials or licences obtained in other jurisdictions but who do not have certificates of registration in Ontario?

The same protocols that apply when delegating to any other individuals apply to IMGs. In particular, physicians cannot rely exclusively on credentials or licences obtained in other jurisdictions to ascertain whether an IMG has the requisite knowledge, skill, and judgment to safely perform a controlled act and must be equally diligent in evaluating and establishing the IMG's competence to perform the controlled acts as they would for any other delegate.

What are my responsibilities for ensuring competence if I am not involved in the hiring of the individual to whom I will be delegating (e.g., in an institutional setting)?

As part of establishing and ensuring a delegate's competence the policy requires physicians to review the delegate's training and credentials, unless the physician is not involved in the hiring process and it is reasonable to assume that the hiring institution has ensured that its employees have the requisite knowledge, skill, and judgment. It is reasonable to rely on the diligence of the institution's process for hiring unless there are

reasonable grounds to believe otherwise. If a physician becomes aware that an individual to whom they are delegating does not have the knowledge, skill, or judgment to perform the delegated acts competently and safely they need to take appropriate action to inform the person or authority to whom the delegate is accountable.[5]

Scope of Practice

What does it mean to only delegate acts which are in my scope of practice? If I have a practice restriction, am I permitted to delegate?

Physicians are required by the policy to only delegate acts that they are competent to perform personally (i.e., those within their scope of practice). This means that physicians must only delegate acts that are within the limits of their knowledge, skill and judgment and any terms, limits and conditions of their practice certificate. Physicians are not permitted to delegate acts that contravene their practice restrictions.

Delegating in the Context of a Physician-Patient Relationship

Is it appropriate to delegate a cosmetic procedure (e.g., botulinum toxin (Botox™) and fillers) without first establishing a physician-patient relationship?

Generally, no. As the policy states, delegation must occur within the context of a physician-patient relationship, unless a patient's best interest dictates otherwise. It is generally in a patient's best interest for a physician to conduct a clinical assessment and gather the necessary clinical information prior to delegating, so they can determine whether delegation is appropriate, including in the context of cosmetic procedures. As in all instances of delegation, a physician would have to justify why delegating in the absence of a physician-patient relationship is in a patient's best interest.

Assessment of Risk

What are the risks involved in delegating? How does risk factor into decisions related to delegation?

By law, controlled acts may only be performed by authorized regulated health professionals due to the potential harm that could result if performed by someone who does not have the knowledge, skill, and judgment to perform them. As such, the performance of any controlled act has been identified by the legislature as carrying some risk.

[5] For additional information see the College's *Mandatory and Permissive Reporting* policy.

Risks vary depending on the specific acts being performed and the circumstances under which they are performed and thus must be considered prior to each instance of delegation and mitigated appropriately. Physicians must then only delegate if the patient's health and/or safety will not be put at risk by the delegation. Physicians who require additional assistance determining the appropriateness of delegating in a specific circumstance can contact the CMPA or obtain independent legal advice.

Appropriate Supervision and Support

Delegation is intended to be a physician extender, not a physician replacement. What does this mean and how can I apply this principle when delegating?

Delegation is intended to provide physicians with the ability to extend their capacity to serve patients by temporarily authorizing an individual to act on their behalf. It is meant to be a tool to extend physician services, where appropriate, as opposed to replacing the physician altogether. In accordance with the policy, this requires physicians to appropriately supervise and support delegates, and not allow a delegate to practise independently without any physician involvement or beyond the scope of their individual knowledge, skills, and judgement. Ensuring appropriate parameters are placed around what a delegate is permitted to do, that are based on the individual's education, training and experience is vital for safe and effective delegation.

I am required to appropriately supervise individuals to whom I am delegating. Am I required to be onsite when supervising a delegate?

Generally speaking, by fulfilling the requirements in the policy physicians will often already be onsite to supervise delegates. For example, when establishing a physician-patient relationship, providing an appropriate clinical assessment, re-assessing a patient as a result of a change in clinical status or treatment options, or when a patient has requested to see the physician.

Notwithstanding the above, the requirement to be onsite is case specific and dependent on the circumstances of the delegation. Supervision must be proportionate to the risks associated with the delegation and physicians need to be available to provide whatever support is required by the delegate. In some instances this will require you to be onsite, or to be available to come onsite if necessary, and in other instances you can provide assistance remotely, provided the right supports are in place in the setting where the delegation is occurring. Physicians need to carefully consider whether it is safe and appropriate to delegate while offsite and only do so where robust protocols are in place to ensure patient safety.

It is not appropriate for physicians to leave a delegate to manage a practice or their patient population on their own. Onsite supervision will help ensure the policy expectations are met.

What are some examples of circumstances where it might be appropriate to be offsite when supervising a delegate?

It may be appropriate for physicians to supervise delegates while offsite where the risk of the delegation is low, and/or the circumstances make it impractical or impossible to be onsite. For example, where delegation is occurring for the purpose of facilitating access to care where there is a need, it may not be possible for supervising physicians to be physically present at the location in which a delegate is providing care. Additionally, paramedicine is structured in a way that permits Base Hospital physicians to provide remote assistance where necessary and does not require onsite supervision. Lastly, physicians delegating in the context of long-term care homes may not always be onsite.

Ultimately, whether it is appropriate to be offsite at any given moment is case specific and physicians must be available to provide assistance to delegates, when necessary.

Quality Assurance

What are some best practices for monitoring and evaluating the delegation process?

Tracking or monitoring when medical directives are being implemented inappropriately or are resulting in unanticipated outcomes can help monitor the effectiveness of the delegation process.

Delegating Prescribing

Am I permitted to delegate the controlled act of prescribing?

Yes, where appropriate. As with the delegation of all controlled acts, physicians must consider whether it is in the patient's best interest to delegate prescribing, in the circumstances. Factors for consideration include the risk profile of the drug, the patient's specific condition, whether the drug has been previously prescribed (repeats or renewals), whether the prescription requires adjustment, etc.

Can medical directives be used to implement orders for prescriptions?

Yes. Medical directives can be used to implement orders for prescriptions. Any prescriptions completed pursuant to a medical directive need to specifically identify the medical directive (name and number), the individual responsible for implementing the

directive (name and signature), and the name of the prescribing physician, along with contact information to clarify any questions. If a request is received, a copy of the medical directive can be forwarded to further demonstrate the integrity of the order.

Documentation

How do I ensure appropriate documentation of delegation?

Medical records can provide indication of whether delegation is being done appropriately and in accordance with the policy. Therefore, in keeping with the principles and expectation of the College's *Medical Records Documentation* policy, it is important for the medical records of patients who received care through delegation to accurately and comprehensively reflect the care that was provided (e.g., evidence of an appropriate history-taking, any relevant assessments that were done, informed consent in accordance with the policy, etc.). Additionally, where medical directives are implemented, physicians may wish to capture the name and number of the directive in the medical record.

Liability and Billing

Are there liability issues that arise from delegation?

Physicians are accountable and responsible for the acts that they delegate. In particular, they are responsible for making the choice to delegate, and for ensuring that the delegation is taking place safely, effectively, and in accordance with the policy expectations.

Physicians with questions about liability or liability protection can consult the CMPA.

If I am fulfilling the CPSO's expectations with respect to the delegation of controlled acts does that mean I have fulfilled the Ontario Health Insurance Plan (OHIP) billing requirements for delegated services?

No. Fulfilling the College's expectations with respect to the delegation of controlled acts does not entail that physicians have fulfilled Ontario Health Insurance Plan (OHIP) billing requirements for delegated services. Physicians who bill OHIP and who are considering delegating performance of controlled acts to others need to carefully review the provisions of the OHIP Schedule of Benefits. The Ontario Medical Association (OMA) and the Provider Services Branch at OHIP can answer questions and give advice about such matters and a joint bulletin developed by the Ministry of Health and the OMA provides additional information on Payment Requirements for Delegated Services.

GUEST PRESENTATION

“Anti-Indigenous Racism”

Guest Speaker: Dr. Lisa Richardson

Council Motion

Motion Title	Council Profile
Date of Meeting	March 5, 2021

It is moved by_____, and seconded by_____, that:

The Council approves the adoption of the Council Profile (a copy of which forms Appendix "…" to the minutes of this meeting).

Council Briefing Note

March 2021

Topic:	Council Profile
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	**Equity:** Ensuring that all individuals are treated with sensitivity and respect in their dealings with health professionals and CPSO **Quality Care:** Ensuring that the care provided by individual regulated health professions is of high quality and that the standard of care provided by each regulated health professional is maintained and/or improved **Accountability:** Holding regulated health professionals accountable to their patients/clients, the College and the public **Protection:** Ensuring the protection of the public from harm in the delivery of health care services
Main Contact(s):	Brenda Copps, Chair, Governance Committee Laurie Cabanas, Director of Governance Miriam Barna, Senior Government Relations Advisor Danna Aranda, Government Relations Coordinator
Attachment(s):	Appendix A: Proposed Council Profile Appendix B: Citizen Advisory Group Survey Results

Issue

- The Ministry of Health's College Performance Measurement Framework requires that health regulatory colleges have a pre-defined set of skills and competencies for Council members; and a process for ensuring that professional members wishing to stand for election meet these pre-defined skills and competencies.

- To enable CPSO to meet this requirement, staff have augmented and further refined the Diversity and Skills Matrix – now called the Council Profile. Council is being asked to adopt it.

Background

- Under the Governance Committee's direction, a Skills and Diversity Matrix was developed last summer to support CPSO Council and Committee diversification and help move CPSO towards a competency-based Council and Committee selection process.

- This matrix was shared with Council at its December 2020 meeting for discussion. Council provided feedback on the proposed tool including a suggestion that input be sought from the Citizen Advisory Group[1] regarding the value of assessing the skills and diversity of Council.

- In December 2020, government finalized its College Performance Measurement Framework which includes a governance-related measure which states: prior to becoming a member of Council and Statutory Committee, an individual must demonstrate that they have the necessary knowledge, skills, and commitment.

- The evidence that the Ministry is requesting from health regulatory colleges in support of this measure includes a requirement that professional members only be eligible to stand for election to Council after meeting pre-defined competency/suitability criteria.

- The adoption of the Council Profile will fulfill the Ministry's requirement in time for the College to include in its report to government by March 31, 2021.

Current Status and Analysis

Incorporating Council's Feedback

- Since December, staff have incorporated Council's feedback to validate and refine the Diversity and Skills Matrix which included:

    - Providing clearer definitions for the technical skills and knowledge (Appendix A)

    - Seeking feedback from the Citizen Advisory Group to validate the importance of diversity on Council and gain insight on what they felt were the attributes of diversity for Council

[1] The Citizen Advisory Group supports a partnership of 18 regulated health professional colleges and is consulted on issues to help bring patient voice and perspectives to healthcare regulation in Ontario.

- In response to Council's suggestion to consult with the Citizen Advisory Group regarding the proposed Diversity and Skills Matrix, CPSO staff developed an online survey that was sent to 21 Citizen Advisory Group members in January. A summary of the survey results is available in Appendix B.

- The survey explored issues including:

    - the importance of CPSO Council being both demographically diverse and comprised of individuals with a range of skills

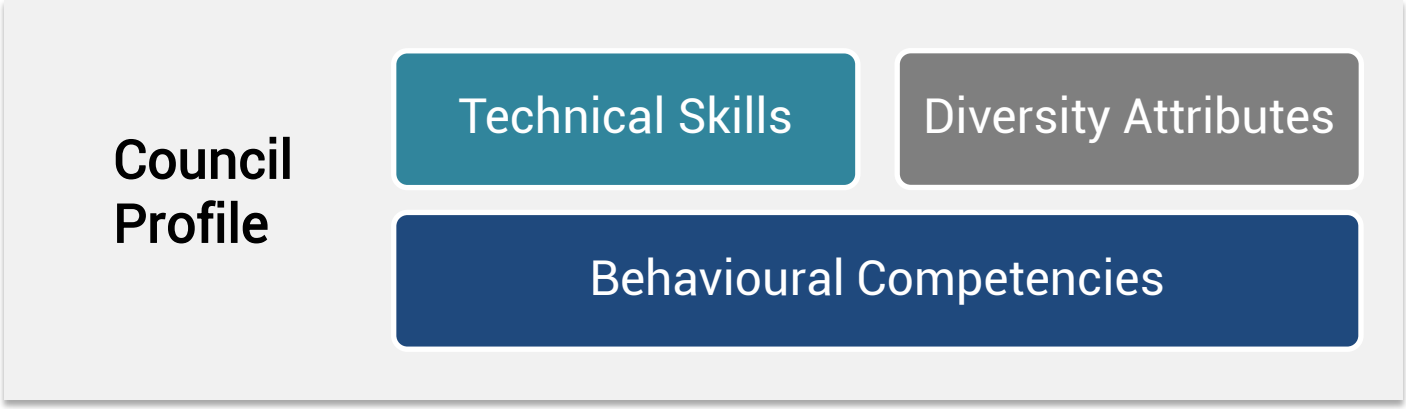
    - whether a more diverse Council and one with a broad range of skills would impact their confidence in CPSO's work; and

    - the value of undertaking a skills and diversity assessment process notwithstanding the elections-based governance model currently in place.

- Citizen Advisory Group participants were universally supportive of capturing the skills and diversity of Council member and underscored the value of such a tool to Council including increasing public trust and confidence in CPSO.

- You may recall that Council has already adopted a set of desired behavioural competencies, which all Council and Committee members are expected to demonstrate. These competencies have been embedded in the Governance Process Manual [note: see page 12].

- Recognizing these skills are important when working in a group and interacting with Council members as well as staff, these behavioural competencies have been combined with the skills and diversity attributes to create a Council Profile.



Using the Council Profile

- If Council approves of the proposed Council Profile, all Council members will be asked to complete an online survey where they can anonymously provide information regarding their identity/demographics and their existing skills in order to get an overall sense of the range of diversity and skills currently on Council.

- The results of this survey and any gaps in diversity or skills, will be used to inform outreach efforts (for professional members), conversations with government (for public members), guidance for the Deans of medical schools (for academic representatives) and Council education/training sessions.

- Recognizing that the accurate assessment of behavioural competencies can be more complex and often involves multiple sources of input over a prolonged period, a process for assessing behavioural competencies will be developed in the context of enhancing Committee member performance.

Next Steps

- Should Council approve the adoption of the Council profile, a survey will be sent to all members of Council to gather the required information.

- The results of the survey will be reviewed by the Governance Committee and aggregated information will be presented to Council in June.

Questions for Council

1. Does Council agree that this issue supports the strategic plan and our role in serving the public interest?

2. Are there any additional diversity, equity or inclusion issues to consider that have not been addressed?

3. What feedback does Council have regarding next steps?

4. Does Council support the adoption of the proposed Council Profile*?*

Council Profile

The Council Profile outlines the diversity attributes, technical skills, and behavioural competencies that should be represented in Council to effectively set strategic direction, develop policies, and provide oversight of CPSO's performance. The Council Profile will also provide a basis for assessing where there may be gaps in the diversity attributes, skills, and behaviour of current Council members and inform CPSO's outreach efforts for Council elections, and the learning/training needs of current members.

While individual Council members are not expected to possess all the technical skills and diversity attributes outlined in the Profile, Council can assess the current competence and diversity of its collective members and, through training and recruitment, work towards an appropriate composition of Council based on these requirements.

Diversity Attributes	Technical Skills	Behavioural Competencies
• Race/Ethnicity • Indigenous • Gender • LGBTQ2S+ • Age • Disability • Practice Setting • Practice Specialty	• Financial Literacy • Governance • Knowledge of Anti-racism and Anti-oppression • Legal and Fiduciary Knowledge • Technological Proficiency • French • Health Systems Knowledge • Human Resources • Leadership • Policy Development	• Continuous Learning • Creativity • Effective Communication • Planning & Initiative • Relationship Building • Results Oriented • Stakeholder Focused • Strategic Thinking • Teamwork

Appendix A: Council Profile

Descriptions of Technical Skills and Behavioural Competencies

Technical Skills	
Financial Literacy	Ability to understand conceptually the financial position of CPSO as presented in its financial statements and generally accepted accounting principles; can read, interpret, and ask questions about financial statements.
Governance	Demonstrated experience of governance principles and practices.
Knowledge of Anti-racism and Anti-oppression	Awareness of the impacts of racism and oppression on the individual, institutional, and societal levels. Builds awareness to create more just, equitable, and inclusive environments.
Legal and Fiduciary Knowledge	Understanding of one's legal and fiduciary duties and responsibilities including loyalty, good faith, trust, preparedness, participation.
Technological Proficiency	Ability to use software and digital platforms that CPSO uses to conduct its business.
French	Demonstrated capacity to comprehend and articulate complex materials in both spoken and written format.
Health System Knowledge	Understanding of the health care system in Ontario and Canada and the roles and responsibilities of health sector actors, including the different levels of government and other health organizations. A familiarity with historical and current trends in improvements to health services delivery, access to care and health outcomes.
Human Resources	Demonstrated experience in planning human resource strategies.
Leadership	Demonstrated experience in leadership positions.
Policy Development	Knowledge and understanding of the purpose of policy at CPSO and engagement in the policy development process.

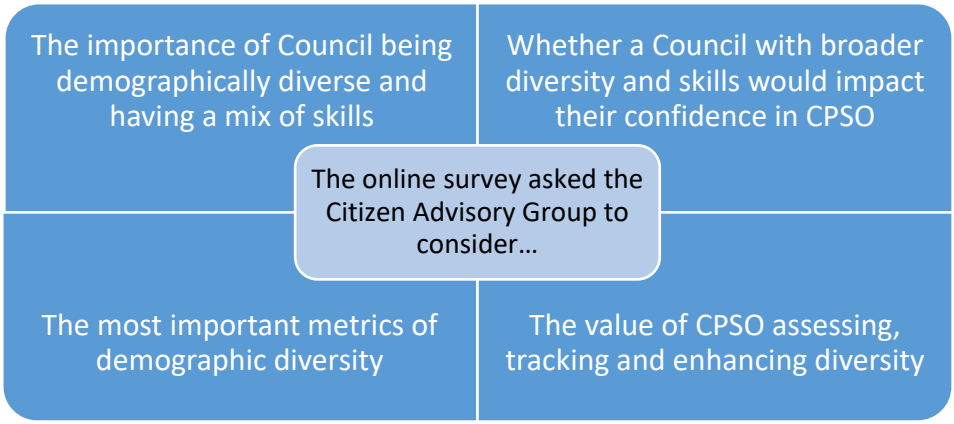
Appendix A: Council Profile

Behavioural Competencies	
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.
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

Appendix B: Citizen Advisory Group Survey Results

Background

Per Council's suggestion at the December 2020 meeting, the Citizen Advisory Group (CAG)[1] was consulted regarding the value of assessing the skills and diversity of Council.



Results

CAG participants were almost universally supportive of the Skills and Diversity Matrix and the tool's value to Council. Respondents articulated numerous reasons for why this tool would increase their confidence in CPSO as a health professions regulator

- Participants saw value in having Council be demographically diverse and possess a range of skills/knowledge.
- Participants were also supportive of assessing, tracking, and enhancing diversity.
- Participants placed more importance on demographic diversity than skills/knowledge diversity.

Of the participants surveyed, **96%** indicated that demographic diversity in Council is either extremely or very important. Moreover, **90%** of participants had expressed that a demographically diverse Council would increase their confidence in CPSO, while the remaining **10%** indicated that it would have no impact on their confidence. Characteristic comments included:

- *As an Indigenous Person, I would feel like my needs and perspectives were represented.*
- *The CPSO Council is a key part of the power structure of the health system and that power structure needs to reflect the society served.*

When asked to consider which demographic groups should be the greatest focus for Council representation, the most important characteristics identified by participants were Race/Ethnicity, Gender, Disability, Indigenous Status, Age, and LGBTQ2S+.

Concerning skills/knowledge diversity, **85%** of respondents indicated that it is extremely or very important that Council be comprised of individuals with a range of skills and knowledge.

[1] The Citizen Advisory Group supports a partnership of 18 regulated health professional colleges and is consulted on issues to help bring patient voice and perspectives to healthcare regulation in Ontario.

They also unanimously agreed that CPSO should assess the current board's skills and diversity and advocate for changes that would increase skill and demographic diversity on Council.

Council Motion

Motion Title	College Performance Management Framework Report
Date of Meeting	March 5, 2021

It is moved by_____, and seconded by_____, that:

the Council approves CPSO's College Performance Management Framework Report, as presented, for submission to the Ministry of Health by March 31, 2021.

Council Briefing Note

March 2021

Topic:	College Performance Measurement Framework
Purpose:	For Decision
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Continuous Improvement, System Collaboration, Meaningful Engagement
Public Interest Rationale:	The Ministry's new College Performance Measurement Framework aims to improve the performance of health regulatory colleges and enhance transparency and accountability to the public
Main Contact(s):	Brenda Copps, Chair of the Governance Committee Susan Klejman, Director of Information Management and Business Analytics Laurie Cabanas, Director of Governance
Attachment(s):	Appendix A: Draft CPSO College Performance Measurement Framework Report

Issue

- In December 2020, the Ministry of Health released its new College Performance Measurement Framework, which sets out expectations and reporting requirements for all health regulatory colleges in Ontario.

- CPSO has completed a draft report outlining its activities during the reporting period of October 1, 2020 to March 31, 2021; Council is provided with the draft report for approval.

Background

The College Performance Measurement Framework

- For the past couple of years, the Ministry of Health has been attempting to capture the work of health regulatory colleges with a significant degree of granularity; CPSO as well as

other health regulatory colleges provided input and feedback into the development process of a College Performance Measurement Framework.

- On December 1, 2020, Assistant Deputy Minister Sean Court sent a letter to health regulatory colleges sharing the final version of the College Performance Measurement Framework as well as details regarding the reporting timeframe and requirements (Appendix A).

- The goal of the College Performance Measurement Framework is to answer the question: "How well are Colleges executing their mandate which is to act in the public interest?"

- It is anticipated that the information provided in the report will strengthen accountability and oversight of Ontario's health regulatory Colleges and help Colleges improve their performance.

- The College Performance Measurement Framework consists of seven domains which are illustrated in Figure 1.

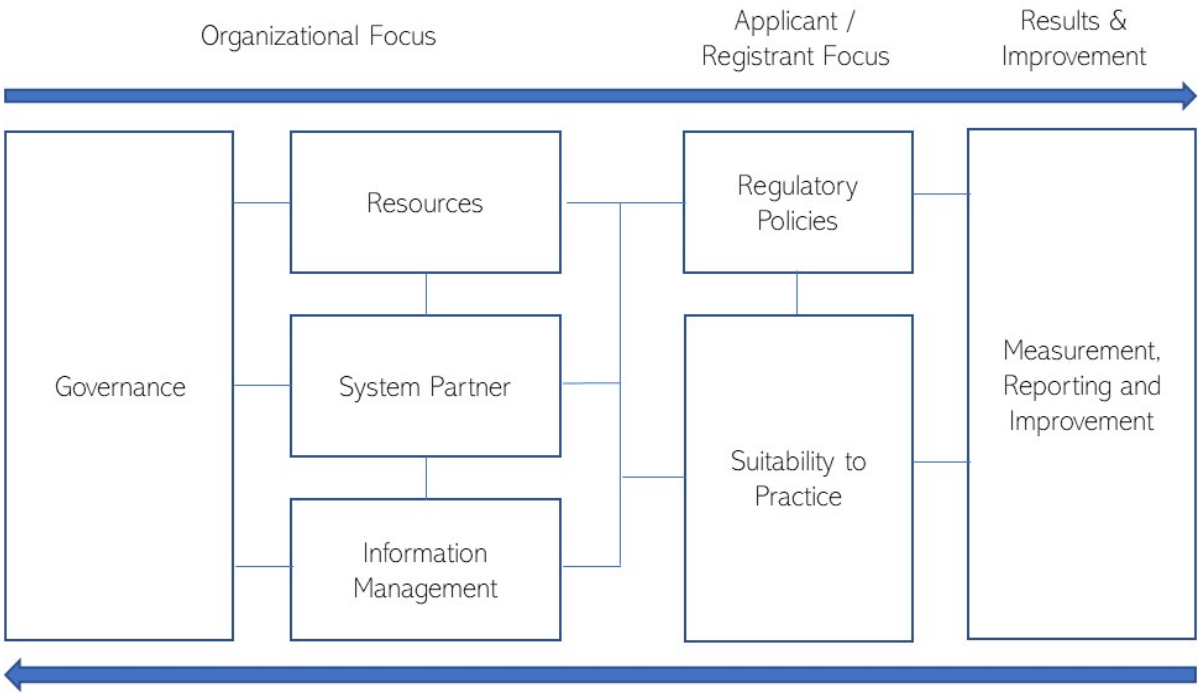


Figure 1: College Performance Measurement Framework Domains

- Within each domain, there are five components:

    - *Standards:* best practices of regulatory excellence that a college is expected to achieve and against which a college will be measured

- *Measures:* further specifications of the standard that will guide the evidence a college should provide and the assessment of a college in achieving the standard

- *Evidence:* decisions, activities, processes or the quantifiable results that are being used to demonstrate and assess a college's achievement of a standard

- *Context measures:* statistical data colleges report that will provide helpful context about a college's performance related to a standard

- *Planned improvement activities:* initiatives a college commits to implement over the next reporting period to improve its performance on one or more standards, where appropriate

- All health regulatory colleges will be required to submit their completed report to the Ministry of Health no later than March 31, 2021, as well as post it on their websites for the public to access.

Highlights of CPSO's Key Accomplishments

- In 2018, Council began the process of reviewing its governance structure and processes with the goal of modernizing them to be reflective of leading governance practices. As a result of the review and with the courage to demonstrate leadership among health regulatory Colleges, Council approved a number of changes to strengthen its governance:

    - Developed a Strategic Plan focused on Right-Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration and Continuous Improvement;

    - Implemented term limits for Committees;

    - Strengthened succession planning within Committees through the Chair/Vice-Chair model and the development of a Mentoring Program;

    - Established a cooling off period for prospective physician Council members prior to putting their name forward for election; and

    - Required a mandatory orientation session for prospective physician Council members prior to putting their name forward for election.

- Furthermore, since the arrival of CEO/Registrar Dr. Nancy Whitmore, she has led CPSO in making significant strides to improve its processes, outcomes and relationships with stakeholders.

- Applying the Right-Touch Regulation lens to all aspects of CPSO's work through the Strategic Plan;

- Developing and implementing an Alternate Dispute Resolution process to address complaints in an effective manner while improving the experience of both the physician and the complainant;

- Fostering effective relationships with organizations across the health system during the Covid-19 pandemic, including government, health regulatory Colleges, professional associations and other stakeholders;

- Establishing new relationships with organizations that represent equity-seeking groups and/or are furthering the work to promote diversity, equity and inclusion across the system;

- Creating a Quality Improvement Program for Physicians, which ensure Ontario's physicians are engaging in self-reflection, self-improvement and meeting their quality requirements in five-year cycles throughout their practice;

- Developing a Quality Improvement Partnership Program, which offers hospitals the opportunity to work with CPSO to deliver a single quality oversight program and relieve administrative burden on physicians by streamlining quality requirements for hospital-based physicians; and

- Developing and implementing a new enterprise management system and data management system to improve productivity of staff as well as interactions with members of the profession.

Current Status and Analysis

- Staff have prepared the draft report and circulated it to Council for review and feedback in advance of it being submitted to the Ministry of Health (Appendix B).

- As outlined in Table 1, CPSO is fully meeting the Ministry's requirements of health regulatory Colleges in all domains except for one, which requires that:

    - professional members are eligible to stand for election to Council only after meeting pre-defined competency/suitability criteria and attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities

- Currently, our process for Council elections includes mandatory attendance at an orientation training session outlining the College's mandate and Council member expectations; however, at the time of writing this briefing note, Council has not yet adopted pre-defined competencies/suitability criteria.

- Council will be asked to consider adopting the Council Profile, which consists of a set of diversity attributes, technical skills and behavioural competencies. Should Council adopt the Council Profile, it will be incorporated as part of the eligibility requirements outlined in the General By-Law.

- CPSO would then be in a position to submit a report that states the organization is fully meeting all requirements of health regulatory Colleges set out by government.

Table 1: Overview of CPSO College Performance Measurement Framework Report

Domain	Standard	Is CPSO Meeting Requirements
Governance	• Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.	Yes (pending approval of Council Profile)
	• Council decisions are made in the public interest.	Yes
	• The College acts to foster public trust through transparency about decisions made and actions taken.	Yes
Resources	• The College is a responsible steward of its (financial and human) resources.	Yes
System Partner	• The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.	Yes
	• The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.	Yes
	• The College responds in a timely and effective manner to changing public expectations.	Yes
Information Management	• Information collected by the College is protected from unauthorized disclosure.	Yes

Domain	Standard	Is CPSO Meeting Requirements
Regulatory Policies	• Policies, standards of practice and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations and where appropriate aligned with other Colleges.	Yes
Suitability to Practice	• The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.	Yes
	• The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.	Yes
	• The complaints process is accessible and supportive.	Yes
	• All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.	Yes
	• The College complaints process is coordinated and integrated.	Yes
Measurement, Reporting and Improvement	• The College monitors, reports on, and improves its performance.	Yes

Limitations of the College Performance Measurement Framework

- While CPSO is meeting the requirements set out by the Ministry of Health, there are some considerations worth noting:
    - There is a lot of confusion regarding the interpretation of some of the measures and how health regulatory colleges may be compared when they are drastically different;
    - The requirements don't address the importance of diversity, equity and inclusion in the context of a health regulatory college's work;
    - CPSO's governing legislation and regulations currently limit the ability to modernize our governance in a manner that allows CPSO to operate in an effective manner. Examples include but are not limited to:

- the legislated process by which Council members are elected or appointed to Council does not enable Council to apply a competency-based framework; and

- critical aspects of effective governance such as the size of Council, diversity of Council members and parity between public and professional members are not included in the Ministry's requirements.

Ministry of Health Response to the Health Regulatory Colleges' Reports

- The Ministry of Health has shared that in the first year, it does not intend to assess whether a College meets or does not meet the standards, rather the first iteration of the report is to provide the public, government and other stakeholders with baseline information respecting a Colleges activities and processes regarding best practices of regulatory excellence. Where relevant, commitments to performance improvement have been included as well.

- The Ministry of Health will use the results to help lay a foundation upon which expectations and benchmarks for regulatory excellence can be refined and improved. The results may stimulate discussions about regulatory excellence and performance improvement among Council members and College staff, as well as between Colleges, the public, government, registrants and other stakeholders.

- Based on the reports submitted from all health regulatory Colleges, the Ministry of Health will develop a summary report highlighting key findings regarding best practices, areas for improvement and the various commitments Colleges have made to improve their performance in serving and protecting the public. The report will be posted publicly and will focus on the performance of the regulatory system rather than the performance of each individual College.

- The Ministry of Health intends to evaluate and refine the College Performance Measurement Framework process for the second year's cycle.

Next Steps

- Based on feedback and decisions made by Council at the March meeting, staff will incorporate any changes as appropriate and prepare the report for final submission to government.

- The final report will also be shared with Council and will be posted on CPSO's website for the public and stakeholders to access.

Question for Council

1. Does Council approve the draft report that will be submitted to the Ministry of Health by March 31, 2021?

CPSO

Serving the people of Ontario through effective regulation of medical doctors

College Performance Measurement Framework (CPMF) Reporting Tool

March 31, 2021

INTRODUCTION

THE COLLEGE PERFORMANCE MEASUREMENT FRAMEWORK (CPMF)

A CPMF has been developed by the Ontario Ministry of Health in close collaboration with Ontario's health regulatory Colleges (Colleges), subject matter experts and the public with the aim of answering the question "how well are Colleges executing their mandate which is to act in the public interest?". This information will:

1. strengthen accountability and oversight of Ontario's health regulatory Colleges; and
2. help Colleges improve their performance.

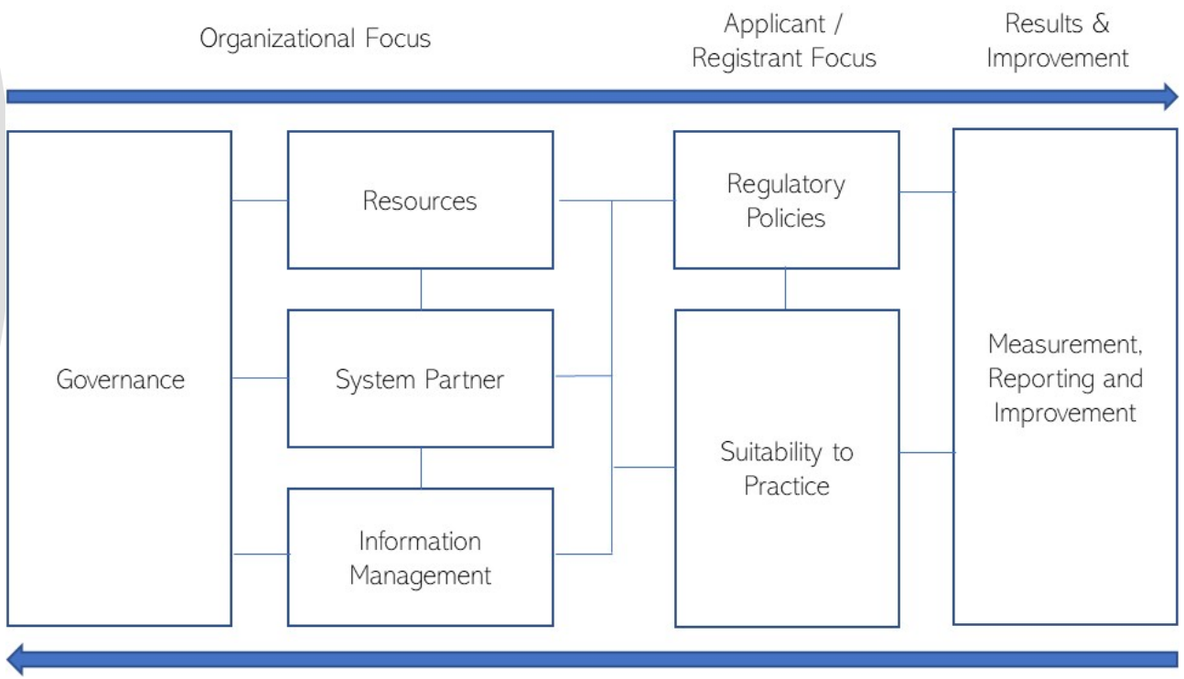
a) Components of the CPMF:

1	**Measurement domains**	→	Critical attributes of an excellent health regulator in Ontario that should be measured for the purpose of the CPMF.
2	**Standards**	→	Best practices of regulatory excellence a College is expected to achieve and against which a College will be measured.
3	**Measures**	→	Further specifications of the standard that will guide the evidence a College should provide and the assessment of a College in achieving the standard.
4	**Evidence**	→	Decisions, activities, processes, or the quantifiable results that are being used to demonstrate and assess a College's achievement of a standard.
5	**Context measures**	→	Statistical data Colleges report that will provide helpful context about a College's performance related to a standard.
6	**Planned improvement actions**	→	Initiatives a College commits to implement over the next reporting period to improve its performance on one or more standards, where appropriate.

b) Measurement domains:

The proposed CPMF has seven measurement domains. These domains were identified as the most critical attributes that contribute to a College effectively serving and protecting the public interest (Figure 1). The measurement domains relate to Ontario's health regulatory Colleges' key statutory functions and key organizational aspects, identified through discussions with the Colleges and experts, that enable a College to carry out its functions well.

Figure 1: CPMF Model for measuring regulatory excellence



The seven domains are interdependent and together lead to the outcomes that a College is expected to achieve as an excellent regulator. Table 1 describes what is being measured by each domain.

Table 1: Overview of what the Framework is measuring

	Domain	Areas of focus
1	**Governance**	• The efforts a College undertakes to ensure that Council and Statutory Committees have the required knowledge and skills to warrant good governance. • Integrity in Council decision making. • The efforts a College undertakes in disclosing decisions made or is planning to make and actions taken, that are communicated in ways that are accessible to, timely and useful for relevant audiences.
2	**Resources**	• The College's ability to have the financial and human resources to meet its statutory objects and regulatory mandate, now and in the future.
3	**System Partner**	• The extent to which a College is working with other Colleges and system partners, where appropriate, to help execute its mandate in a more effective, efficient and/or coordinated manner and to ensure it is responsive to changing public expectation.
4	**Information Management**	• The efforts a College undertakes to ensure that the confidential information it deals with is retained securely and used appropriately in the course of administering its regulatory activities and legislative duties and objects.
5	**Regulatory Policies**	• The College's policies, standards of practice, and practice guidelines are based on the best available evidence, reflect current best practices, are aligned with changing publications and where appropriate aligned with other Colleges.
6	**Suitability to Practice**	• The efforts a College undertakes to ensure that only those individuals who are qualified, skilled and competent are registered, and only those registrants who remain competent, safe and ethical continue to practice the profession.
7	**Measurement, Reporting and Improvement**	• The College continuously assesses risks, and measures, evaluates, and improves its performance. • The College is transparent about its performance and improvement activities.

c) Standards, Measures, Evidence, and Improvement:

The CPMF is primarily organized around five components: **domains**, **standards**, **measures**, **evidence** and **improvement**, as noted on page 3. The following example demonstrates the type of information provided under each component and how the information is presented within the Reporting Tool.

Example:

Domain 1: Governance			
Standard →	**Measure** →	**Evidence** →	**Improvement**
1. Council and Statutory Committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.	1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria. By-laws will be updated to reflect the screening criteria as a component of the election process to determine professional registrant eligibility to run for a Council position.
		b. Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria.
		c. Prior to attending their first meeting, public appointments to Council undertake a rigorous orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	Nil
	2. Council and Statutory Committees regularly assess their effectiveness and address identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	Nil
		b. The framework includes a third-party assessment of Council effectiveness at minimum every three years.	Nil

THE CPMF REPORTING TOOL

For the first time in Ontario, the CPMF Reporting Tool (along with the companion Technical Specifications for Quantitative CPMF Measures document) will provide comprehensive and consistent information to the public, the Ministry of Health ('ministry') and other stakeholders by each of Ontario's health regulatory Colleges (Colleges). In providing this information each College will:

1. meet with the ministry to discuss the system partner domain;
2. complete the self-assessment;
3. post the Council approved completed CPMF Report on its website; and
4. submit the CPMF Report to the ministry.

The ministry will not assess whether a College meets or does not meet the Standards. The purpose of the first iteration of the CPMF is to provide the public, the ministry and other stakeholders with baseline information respecting a College's activities and processes regarding best practices of regulatory excellence and, where relevant, the College's performance improvement commitments. Furthermore, the reported results will help to lay a foundation upon which expectations and benchmarks for regulatory excellence can be refined and improved. Finally, the results of the first iteration may stimulate discussions about regulatory excellence and performance improvement among Council members and senior staff within a College, as well as between Colleges, the public, the ministry, registrants and other stakeholders.

The information reported through the completed CPMF Reporting Tools will be used by the ministry to strengthen its oversight role of Ontario's 26 health regulatory Colleges and may help to identify areas of concern that warrant closer attention and potential follow-up.

Furthermore, the ministry will develop a Summary Report highlighting key findings regarding the best practices Colleges already have in place, areas for improvement and the various commitments Colleges have made to improve their performance in serving and protecting the public. The focus of the Summary Report will be on the performance of the regulatory system (as opposed to the performance of each individual College), what initiatives health regulatory Colleges are undertaking to improve regulatory excellence and areas where opportunities exist for colleges to learn from each other. The ministry's Summary Report will be posted publicly.

As this will be the first time that Colleges will report on their performance against the proposed CPMF standards, it is recognized that the initial results will require comprehensive responses to obtain the required baseline information. It is envisioned that subsequent reporting iterations will be less intensive and ask Colleges only to report on:

- Improvements a College committed to undertake in the previous CPMF Report;
- Changes in comparison to baseline reporting; and
- Changes resulting from refined standards, measures and evidence.[1]

[1] Informed by the results from the first reporting iteration, the standards, measures and evidence will be evaluated and where appropriate further refined before the next reporting iteration.

Completing the CPMF Reporting Tool

Colleges will be asked to provide information in the right-hand column of each table indicating the degree to which they fulfill the "required Evidence" set out in column two.

Furthermore,

- where a College fulfills the "required evidence" it will have to:
  - provide link(s) to relevant background materials, policies and processes ***OR*** provide a concise overview of this information.
- where a College responds that it "partially" meets required evidence, the following information is required:
  - clarification of which component of the evidence the College meets and the component that the College does not meet;
  - for the component the College meets, provide link(s) to relevant background material, policies and processes ***OR*** provide a concise overview of this information; and
  - for the component the College does not meet, whether it is currently engaged in, or planning to implement the missing component over the next reporting period.
- where a College does not fulfill the required evidence, it will have to:
  - indicate whether it is currently engaged in or planning to implement the standard over the next reporting period.

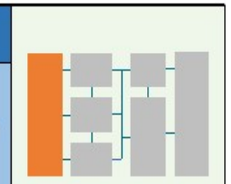
Furthermore, there may be instances where a College responds that it meets required evidence but, in the spirit of continuous improvement, plans to improve its activities or processes related to the respective Measure. A College is encouraged to highlight these planned improvement activities.

While the CPMF Reporting Tool seeks to clarify the information requested, it is not intended to direct College activities and processes or restrict the manner in which a College fulfills its fiduciary duties. Where a term or concept is not explicitly defined in the proposed CPMF Reporting Tool the ministry relies on individual Colleges, as subject matter experts, to determine how a term should be appropriately interpreted given the uniqueness of the profession each College oversees.

The areas outlined in red in the example below are what Colleges will be asked to complete.

Example:

DOMAIN 1: GOVERNANCE



Standard 1

Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.

Measure	Required evidence	College response
1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: Yes ☐ Partially ☐ No ☐ • The competency/suitability criteria are public: Yes ☐ No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* • Duration of orientation training: • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): • Insert a link to website if training topics are public ***OR*** list orientation training topics: *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional):*

PART 1: MEASUREMENT DOMAINS

The following tables outline the information that Colleges are being asked to report on for each of the Standards. Colleges are asked to provide **evidence** of decisions, activities, processes, and verifiable results that demonstrate the achievement of relevant standards and encourages Colleges to not only to identify whether they are working on, or are planning to implement, the missing component if the response is "No", but also to provide information on improvement plans or improvement activities underway if the response is "Yes" or "Partially".

DOMAIN 1: GOVERNANCE		
Standard 1 **Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.**		
Measure	**Required evidence**	**College response**
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: **Yes (pending Council approval of the Council Profile).** **i. meeting pre-defined competency/suitability criteria** **Section to be completed following the March Council meeting to reflect Council's decision regarding the Council Profile.** **ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities** **CPSO is meeting this requirement. In December 2020, CPSO changed its elections process to incorporate a mandatory orientation session - professional members are eligible to stand for election to Council after they have attended an orientation training about CPSO's mandate and expectations for Council members.**

		• The competency/suitability criteria are public: **If approved, link to the Council Profile will be included here.** • Duration of orientation training: **The live orientation training is approximately 1.5 hours in duration. In addition, prospective candidates are expected to review key materials that provide information about CPSO (i.e. Strategic Plan, Annual Report, eDialogue, By-Laws, previous Council meeting package)** • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): **The format is a combination of pre-reading materials and a virtual, real-time session that includes some testing elements.** • Insert a link to website if training topics are public ***OR*** list orientation training topics: **The list of training topics include: The Role of the College, By-Laws, Legislation and Regulation, Fiduciary Duty and Protecting the Public, Confidentiality and Communications, A Day at Council, A Day at Committee, Council Election Process, Remuneration, Anti-Indigenous Racism in Healthcare, Anti-Black Racism in Healthcare, Discrimination Against LGBTQ2S Patients, Implicit Bias in healthcare. Within each of these categories, are various topics which include references to our policies, guidelines and expectations.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Currently the legislation requires that professional members are elected to Council so there is limited control within CPSO to truly ensure that all professional members possess the required skills, knowledge and commitment to be an effective member on Council. CPSO recognizes that a competency-based process for selecting Council members is a leading governance practice and encourages the Ministry to better enable health regulatory colleges to *select* rather than elect. **While this expectation applies to professional members, public members are appointed to Council based on the Minister's prerogative. It is critical that public members also possess the required skills and knowledge to be effective in their role as governors. Moreover, it is extremely challenging for public members to gain the required skills and knowledge within a one-year appointment.** **There is an opportunity to improve the transparency of the public appointment process. The Ministry is encouraged to consider applying a competency-based framework consistent with what is expected of professional members and one that considers diversity of public members.**
	b. Statutory Committee candidates have:	The College fulfills this requirement: **Yes** **i. met pre-defined competency/suitability criteria**

	i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	**The Governance Committee recruits non-Council Committee members using competencies and suitability criteria that are required by the particular Committee. Applicants provide a cover letter and resume outlining the skills and experience they will contribute to the Committee. Interviews are conducted with strong candidates to better assess their fit and identify whether they have any potential conflicts of interest.** **When appointing Council members to Statutory Committees, the Governance Committee considers the skills, experience and commitment of Council members and makes Committee appointments based on the skills and experience required for the Statutory Committee.** **In alignment with the Council Profile, CPSO is in the process of developing skills, competencies and diversity attributes for each Statutory Committee to better inform the recruitment and appointment process.** **ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities** **Currently all new Statutory Committee candidates attend an orientation training about the mandate of the College, the Committee and expectations pertaining to a Committee member's roles and responsibilities.**
		• The competency / suitability criteria are public: **Yes. Click here to view the behavioural competencies that are expected of all Committee members (p. 15). When CPSO posts vacancies for its Committees, the skills and qualifications are posted publicly on our website (currently we are not recruiting). All non-Council members that are being recruited for committees must submit a cover letter and resume outlining what skills they possess as they relate to the Committee to which they are applying. Behavioural interviews are conducted with each non-Council candidate to assess suitability and decisions are made based on the candidate who best matches the skills and qualifications posted with the vacancy.** *If yes, please insert link to where they can be found, if not please list criteria:* • Duration of each Statutory Committee orientation training: **The duration of the training varies depending on the committee, anywhere from 1-2 hours to 1 full day depending on the Committee.** • Format of each orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): **In light of the pandemic, the format of all orientation training is virtual and involves live presenters as well as reference materials to review following the orientation training**

		• Insert link to website if training topics are public ***OR*** list orientation training topics for Statutory Committee: **The orientation training topics for all Statutory Committees include an overview to CPSO Governance. In addition, the Committee specific orientation topics are listed below.** **Discipline Committee and Fitness to Practice Committee:** **Legislative Context, Referrals, Pre-Hearing Processes, Hearing Process, Roles of Participants, Burden of Proof and Evidence. For more details see: https://cpsoonca-my.sharepoint.com/:p:/g/personal/hearings2_cpso_on_ca/EVCQsG1A89FOjZvOIg7-WGwB4h19YF02khfy0-SMAJ2vFg?e=iU8gVQ** **Executive Committee** **Strategic Plan and Key Performance Indicators, CPSO Leadership Team, Legislative and Regulatory Framework, Government Relations Initiatives, Governance Modernization** **Inquiries Complaints and Reports Committee** **Welcome and Introduction to ICRC outlining basic responsibilities of ICRC and introducing the Investigations and Resolutions area, Meeting Logistics, the Pre/Post/During ICRC Panel overview, Administrative Law Part I, Role of the RHPA, Role of ICRC and their focus of analysis in Decision Making, Administrative Law Part II, Deliberative Privilege, Legal Counsel Advice, Basic framework re sexual abuse and ICRC relationship with the Discipline Committee** **Patient Relations Committee:** **Terms of Reference, Funding for Therapy and Counselling, Benchmarks, Privacy/Confidentiality, Webmail, Legal Opinions, Decision Components, Application Package, Legislation, Annual Report** **Quality Assurance Committee:** **QAC Primer and Competency Framework, Policy Minutes, QAC Regulations, QAC Meeting resource material, Remuneration, Sample Peer Report, Orientation to CPSO Technology, Privacy and Confidentiality** **Registration Committee:** **CPSO registration policies https://www.cpso.on.ca/Physicians/Registration/Registration-Policies, CPSO Practice Guide: https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/polices-and-**

		guidance/practice-guide/practice-guide.pdf, CPSO Best Practices – Privacy & Confidentiality http://intra.cpso.on.ca/Employee-Resources-Benefits/Compliance/Confidentiality/Best-Practices-Privacy-Confidentiality, CPD site is an internal site with resources assisting Committee and staff when making education-related decisions: http://cpd.cpso.on.ca/
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		CPSO is currently improving its current Committee recruitment process and is developing Committee Profiles for each of its Statutory and Standing Committees. The Committee Profiles will include not only skills and behavioural competencies but also diversity attributes that are most valuable for the Committee. To ensure that Committee members have some foundational diversity, equity and inclusion training, the following topics have been included as part of the training for Statutory Committees: Anti-Indigenous Racism in Healthcare, Anti-Black Racism in Healthcare, Discrimination Against LGBTQ2S Patients, Implicit Bias in healthcare.
	c. Prior to attending their first meeting, public appointments to Council undertake an orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	The College fulfills this requirement: **Yes.**
		• Duration of orientation training: **Public members are asked to complete 4 hours of orientation training in total.** • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): **The format of the orientation training is online and includes an on demand, interactive course (provided by the Council on Licensure and Enforcement), as well as a live session with the Director of Governance.** • Insert link to website if training topics are public ***OR*** list orientation training topics: **The on demand orientation topics can be found here. The list of training topics covered in the live session include: The Role of the College, By-Laws, Legislation and Regulation, Fiduciary Duty and Protecting the Public, Confidentiality and Communications, A Day at Council, A Day at Committee, Remuneration. Within each of these categories, are various topics which include references to our policies, guidelines and expectations.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ

		Public appointments are made at various times throughout the year, sometimes with little notice to CPSO. At times, it can be very challenging for these orientations to take place in advance of a public member's first meeting, particularly if they have been appointed very close to a Council meeting. There have been instances where the public member doesn't know that they have been appointed by the Minister and are learning of the decision some time after. **Where possible, the Minister's Office is encouraged to provide sufficient notice to CPSO regarding appointment and reappointment decisions to promote stability and effective functioning of Council and its Committees.**
1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	The College fulfills this requirement: **Yes. Council evaluates every meeting to identify strengths, opportunities for improvement and educational topics for Council members. The results are shared with Council members at the next meeting. Council also conducts an annual assessment using a third party to evaluate its effectiveness and benchmark with other not-for-profit health care boards.**
		• Year when Framework was developed ***OR*** last updated: **The framework was last updated in 2020.** • Insert a link to Framework ***OR*** link to Council meeting materials where (updated) Framework is found and was approved: **Information about CPSO Council's annual assessment can be found here. The Council meeting evaluation results are not publicly available.** • Evaluation and assessment results are discussed at public Council meeting: **The evaluation and assessment results are discussed at Council meetings in camera.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement: **Yes.**
		• A third party has been engaged by the College for evaluation of Council effectiveness: **Yes.** • Year of last third-party evaluation: **CPSO last engaged a third-party to provide advice regarding Council effectiveness in 2020.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐

		CPSO's framework for assessing the effectiveness of Council includes a board assessment tool developed by the Ontario Hospital Association. The tool enables Council to compare its performance from year to year and also benchmarks CPSO with other not-for-profit boards. Council also engages external governance experts from time to time to assess Council's effectiveness related to specific areas of its functions.
	c. Ongoing training provided to Council has been informed by: i. the outcome of relevant evaluation(s), and/or ii. the needs identified by Council members.	The College fulfills this requirement: **Yes. Council members receive an online meeting evaluation after each meeting to identify strengths and opportunities for improvement and potential educational topics of interest.** **Ongoing training provided to Council has been informed by:** **i. the outcome of relevant evaluation(s)** **The feedback received through the meeting evaluations informs improvement initiatives and future educational offerings. At the end of each Council meeting, there is also a reflection session which provides a forum for Council members to share observations about the meeting and comment on how effective the Council was in achieving the objectives of the meeting.** **ii. the needs identified by Council members** **Last year, Council members specifically requested more information and education about diversity, equity and inclusion. Based on this feedback, we invited Dr. Javeed Sukhera, to share his expertise and engage Council in a discussion about diversity, equity and inclusion in the health regulatory space. It was very well-received and additional sessions have been planned to build the knowledge and skills gained from the initial session.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* **Ongoing training is also informed by emerging trends as well as government priorities that may be impacting physicians. For example, Council and Committee members will be participating in various education sessions this year related to implicit bias and anti-Indigenous racism.**

Standard 2 **Council decisions are made in the public interest.**		
Measure	**Required evidence**	**College response**
2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.	a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is accessible to the public.	The College fulfills this requirement: **Yes. The Code of Conduct and Conflict of Interest Policies are accessible to the public.**
		• Year when Council Code of Conduct and 'Conflict of Interest' Policy was implemented ***OR*** last evaluated/updated: **The Council Code of Conduct and Conflict of Interest Policy was last updated in 2014.** • Insert a link to Council Code of Conduct and 'Conflict or Interest' Policy ***OR*** Council meeting materials where the policy is found and was discussed and approved: **Click here to access the Code of Conduct policy (p. 59) Click here to access the Conflict of Interest policy (p. 63)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		CPSO is currently reviewing its website to identify ways to make information more accessible to the public.
	b. The College enforces cooling off periods[2].	The College fulfills this requirement: **Yes.**

[2] Cooling off period refers to the time required before an individual can be elected to Council where an individual holds a position that could create an actual or perceived conflict of interest with respect to his or her role and responsibility at the college.

		• Cooling off period is enforced through: **By-Law** • Competency/Suitability criteria **Eligibility Criteria** • The year that the cooling off period policy was developed ***OR*** last evaluated/updated: **The cooling off period was included in the General By-Law in 2020** • How does the college define the cooling off period? **CPSO defines cooling off periods in the manner below. Click here to access the by-laws that describe the cooling off periods.** o **the member does not hold, and has not held within one year before the date of the election, a position which would cause the member, if elected as a councillor, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;** o **the member is not, and has not been within five years before the date of the election, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. The College has a conflict of interest questionnaire that all Council members must complete annually. Additionally:	The College fulfills this requirement: **Yes. On an annual basis, Council members sign a Declaration of Adherence which is a compilation of expectations and policies that they are required to comply with during their term. The Declaration of Adherence includes the conflict of interest policy which has definitions of what would constitute a conflict of interest.**

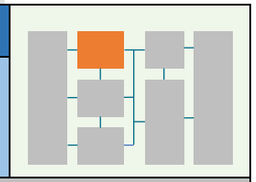
	i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	• The year when conflict of interest the questionnaire was updated: **2014** • Member(s) update his or her questionnaire at each Council meeting based on Council agenda items: **Council has a practice of asking members to verbally declare any conflicts of interest at the beginning of each Council meeting. The recording secretary documents any conflicts declared and the Chair and staff ensure that those Council members who have declared a conflict are not present for the agenda items with which they have a conflict. Those who have declared a conflict leave the meeting at the start of the agenda item and are notified to return once the item is over. Click here to see where conflicts are declared during Council meetings.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	d. Meeting materials for Council enable the public to clearly identify the public interest rationale (See Appendix A) and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g. the minutes include a link to a publicly available briefing note).	The College fulfills this requirement: **Yes**
		• Describe how the College makes public interest rationale for Council decisions accessible for the public: **Over the past year, CPSO has refreshed its briefing note templates for Council to include a field regarding public interest rationale. The briefing note also links the agenda item to CPSO's Strategic Plan. Click here for an example of how CPSO references a public interest rationale and its Strategic Plan. This practice is used for all decision items on a Council meeting agenda.** **Council minutes also include any relevant appendices (i.e. briefing notes or other relevant materials) that are used to support a decision related to the strategic direction or regulatory processes and actions.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Other examples of referencing public interest can be found in our policies. **Click here to see examples from September 2020 (p. 113, 115-116)** **Click here to see examples from March 2020 (p. 96-97, p. 158-160)**

Standard 3 **The College acts to foster public trust through transparency about decisions made and actions taken.**		
Measure	**Required evidence**	**College response**
3.1 Council decisions are transparent.	a. Council minutes (once approved) are clearly posted on the College's website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g. indicate whether decisions have been implemented, and if not, the status of the implementation).	The College fulfills this requirement: **Yes** **Click here to access where Council minutes are posted once they are approved CPSO Council recently introduced a Status Update on Council Decisions, which accompanies the Council meeting minutes (i.e. beginning with the March 4-5, 2021 meeting). This provides an update regarding the implementation of Council's decisions from the previous meeting.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*
	b. The following information about Executive Committee meetings is clearly posted on the College's website (alternatively the College can post the approved minutes if it includes the following information). i. the meeting date; ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive Committee acts as Council or discusses/deliberates on matters or materials that will be brought forward to or affect Council; and iv. if decisions will be ratified by Council.	The College fulfills this requirement: **Yes.** **Click here to see the Terms of Reference for the Executive Committee as well as the meetings that have been scheduled for the year. From time to time there may be ad hoc meetings to address time sensitive matters, for example timely Committee appointments to Statutory Committees so that they can carry out their work effectively. As outlined in our General By-Law, section 29(4), decisions that will be ratified by Council are generally required to be discussed with the Executive Committee first:** • **The council shall, and may only, consider, (a) at a special meeting, the matter for decision at the meeting contained in the requisition deposited with the registrar; (b) at a regular meeting, a motion made and seconded in writing, (i) on behalf of the executive committee; (ii) in a report by a committee which has received prior review by the executive committee; (iii) of which a notice of motion was given by a councillor at the preceding council meeting; or 17 (iv) which the councillors agree to consider by a two-thirds vote of those in attendance; and (c) at any meeting, routine and procedural motions in accordance with the rules of order.** **Thus, when matters such as policy reviews come to Council, they have been reviewed first by the Executive Committee. In situations where the Executive Committee has acted on behalf of Council, those decisions are communicated to Council members by email after the Executive Committee meeting. The Executive**

		Committee's decisions are made available again to Council and to the public in the Executive Report that is included in subsequent Council meeting materials. Click here to see an example of the Executive Committee Report (p. 21)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. Colleges that have a strategic plan and/or strategic objectives post them clearly on the College's website (where a College does not have a strategic plan, the activities or programs it plans to undertake).	The College fulfills this requirement: **Yes**
		Click here to access the Strategic Plan **The Registrar/CEO regularly provides updates on how CPSO is progressing against the strategic plan and the Key Performance Indicators. Beginning in 2021, the Council meeting materials were enhanced to clearly indicate which element of the strategic plan applied to a given agenda item. This enables management to think critically about each item that is brought to Council for discussion or decision; it also serves as a reminder to Council how each agenda item is contributing to CPSO's strategic priorities. Click here to see an example of how agenda items are linked to the Strategic Plan**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
3.2 Information provided by the College is accessible and timely.	a. Notice of Council meeting and relevant materials are posted at least one week in advance.	The College fulfills this requirement: **Yes Click here to see an example of a Notice of Meeting (posted 2.5 weeks in advance). In addition to posting the Notice of Meeting and Council meeting materials on CPSO's website at least one week in advance of the meeting, efforts are made to promote Council meetings to physicians and members of the public, using various social media channels.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

	b. Notice of Discipline Hearings are posted at least one week in advance and materials are posted (e.g. allegations referred)	The College fulfills this requirement: **Yes. Notice of discipline hearings is posted approximately one month in advance at https://www.cpso.on.ca/News/Discipline-Hearings. The allegations referred, contained in the Notice of Hearing, are posted in the subject physician's profile, which can be searched at https://doctors.cpso.on.ca/.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (optional)*

DOMAIN 2: RESOURCES



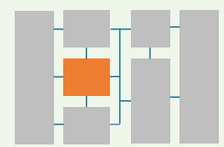
Standard 4

The College is a responsible steward of its (financial and human) resources.

Measure	Required evidence	College response
4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	a. The College's strategic plan (or, where a College does not have a strategic plan, the activities or programs it plans to undertake) has been costed and resources have been allocated accordingly. Further clarification: A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of	The College fulfills this requirement: **Yes** **Click here to access the 2021 annual budget approved by Council (p. 113) Budget allocations are made based on the projected work for the year in every area of the organization which is tied to the strategic plan.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ*

	each activity or program and the budget should be allocated accordingly.	*Additional comments for clarification (optional)*
	b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves; ii. possesses the level of reserve set out in its "financial reserve policy".	The College fulfills this requirement: **Yes. The Finance and Audit Committee regularly reviews the Reserve Fund Policy to ensure it is appropriate and makes recommendations to Council.**
		If applicable: **CPSO Council reviewed its Reserve Fund Policy in September 2020. Click here to view the policy (p. 43).** Has the financial reserve policy been validated by a financial auditor? **CPSO's Reserve Fund Policy was reviewed by a financial auditor.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future (e.g. processes and procedures for succession planning, as well as current staffing levels to support College operations).	The College fulfills this requirement: **Yes.**
		Click here to access the annual budget approved by Council which incorporates the Human Resources Plan (p. 113). **During the budget process all, new FTEs are brought forward for approval with a business plan as part of the budget cycle. Due to ongoing process efficiencies and leveraging strategic enterprise solutions, no new human capital was requested in 2020/2021. Leadership leverages the annual performance review to discuss succession planning with managers, and senior leadership. Discussions are recorded in Ultipro (HR management system).**

		CPSO enhanced the succession planning within its Statutory and Standing Committees in 2020. Each Committee now has a Chair/Vice-Chair model which promotes stability and succession planning to ensure effective functioning of the Committee. In addition, a Mentoring Program was launched in the past year for all Committees to support the onboarding process as well as promote effective knowledge transfer between newer and seasoned Committee members.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

DOMAIN 3: SYSTEM PARTNER	
Standard 5 **The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.**	
Standard 6 **The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.**	
Standard 7 **The College responds in a timely and effective manner to changing public expectations.**	

	College response
Measure / Required evidence: N/A	***Colleges are requested to provide a narrative that highlights their organization's best practices for each of the following three standards. An exhaustive list of interactions with every system partner the College engages is not required.*** ***Colleges may wish to provide Information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of that***

	dialogue. For the initial reporting cycle, information may be from the recent past, the reporting period, or is related to an ongoing activity (e.g., planned outcomes).
The three standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these three standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry of Health. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. **In preparation for their meetings with the ministry, Colleges have been asked to submit the following information:** • **Colleges should consider the questions pertaining to each standard and identify examples of initiatives and projects undertaken during the reporting period that demonstrate the three standards, and the dates on which these initiatives were undertaken.**	**Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.** Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice within a health system where the profession it regulates has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on: • *How it has engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate and aligned practice expectations? Please provide details of initiatives undertaken, how engagement has shaped the outcome of the policy/program and identify the specific changes implemented at the College (e.g. joint standards of practice, common expectations in workplace settings, communications, policies, guidance, website etc.).* **System Collaboration is one of the five elements of CPSO's Strategic Plan. To achieve system collaboration, CPSO will continue to develop open and collaborative relationships that support a connected health system and promote interprofessional collaboration and share best practices.** **CPSO collaborates frequently with other health regulatory Colleges through the Health Profession Regulators of Ontario (HPRO), which is the collective group of health regulatory colleges across the province. Over the past year, we have been an active contributor through their regular meetings as well as through various working groups that addressed common issues such as Governance, Communications and Anti-BIPOC Racism. Where possible, opportunities to leverage existing efforts underway are explored and CPSO is often sharing resources and practices with and learning from other Colleges in an effort to achieve consistency in our regulatory function.** **All policy reviews including a jurisdictional scan looking at alignment with other health/medical regulatory authorities as appropriate. For example, the Delegation of Controlled Acts policy review included a review of other HPRO Colleges positions on delegation to promote alignment and consistency where possible. Particular efforts were made to work with the College of Nurses of Ontario to align as much as possible given the close working relationship between nurses/physicians. Click here to see an example (p. 114 footnote 1)** **CPSO administers and is the Chair of the Citizen Advisory Group, which is a partnership among 18 colleges and serves as a forum to consult with patients and public about various issues that the colleges are facing. The Citizen Advisory Group is consulted frequently on a variety of issues where the public voice would add tremendous value, an example from last year includes a symposium on virtual care that was hosted in October 2020 and included both physicians and patients. The feedback received directly influenced the initial work to review and update CPSO's policy on Telemedicine.**

<table>
<tr><td></td><td colspan="2">Initiated through the Health Profession Regulators of Ontario, CPSO engaged in some conversations with the Financial Services Regulatory Authority, which is an independent regulatory agency created to improve consumer and pension plan beneficiary protections in Ontario. Based on our early discussions, we identified a better way to communicate with them regarding findings against physicians who may be carrying out work for FSRA so that they are aware and can take appropriate measures to ensure protection of the public. The collaboration with FSRA is an example of how CPSO is identifying opportunities to achieve greater coordination between health care and other sectors where there may be common objectives to serve in the public interest.</td></tr>
<tr><td></td><td>Standard 6: The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public/societal expectations.

The intent of standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is “pushed” information by system partners, or where the College proactively seeks information in a timely manner.

• Please provide some examples of partners the College regularly interacts with including patients/public and how the College leverages those relationships to ensure it can respond to changing public/societal expectations.
• In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in standard 7).

Below are some key examples of how CPSO works with health system stakeholders to respond to changing public expectations. While not an exhaustive list, a few different examples are included to highlight the breadth of organizations with whom CPSO engages.

Black Physicians’ Association of Ontario: Ongoing collaborative relationship to identify opportunities for targeted outreach so that that underrepresented groups can get engaged in CPSO’s work and that we are considering issues that are important to our common members</td><td>Standard 7: The College responds in a timely and effective manner to changing public expectations.

Standard 7 highlights successful achievements of when a College leveraged the system partner relationships outlined in Standard 6 to implement changes to College policies, programs, standards etc., demonstrating how the College responded to changing public expectations in a timely manner.

• How has the College responded to changing public expectations over the reporting period and how has this shaped the outcome of a College policy/program? How did the College engage the public/patients to inform changes to the relevant policy/program? (e.g. Instances where the College has taken the lead in strengthening interprofessional collaboration to improve patient experience, examples of how the College has signaled professional obligations and/or learning opportunities with respect to the treatment of opioid addictions, etc.).
• The College is asked to provide an example(s) of key successes and achievements from the reporting year.

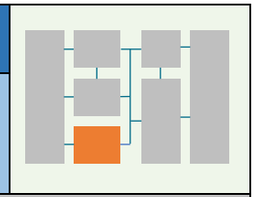
Meaningful Engagement is one of the five elements of CPSO’s Strategic Plan. To achieve meaningful engagement, CPSO will purposefully involve patients, the public and physicians to inform College decisions; and build awareness of our role, mandate and processes through clear and accessible information.

Below are some key examples of how CPSO is responsive to the evolving needs of the public. While not an exhaustive list, a few different examples are included to highlight the various strategies used.</td></tr>
</table>

	Indigenous Physicians Association of Canada: Ongoing collaborative relationship to identify opportunities for targeted outreach so that that underrepresented groups can get engaged in CPSO's work and that we are considering issues that are important to our common members **Ministry of Health: Foster positive relationships with various areas within the Ministry of Health to improve patient safety; recent examples include collaboration on Covid-19 response to ensure sufficient physician resources** **Minister's Office: Foster positive relationships with the Minister's Office; recent examples of collaboration include discussions pertaining to Physician Assistant regulation** **Nishnawbe Aski Nation: Initial discussions with Nishnawbe Aski Nation to identify concrete opportunities to better serve patients living in Indigenous communities** **Ontario Medical Association: Ongoing collaborative relationship to discuss issues of mutual interest given our common members; examples of collaboration last year include Covid-19 response, engagement in CPSO policy consultations, CPSO/OMA Task Force and Diversity, Equity and Inclusion work** **Ontario College of Family Physicians: Ongoing collaborative relationship to discuss issues of mutual interest given our common members; recent examples of collaboration include improved engagement in policy consultations** **Ontario College of Pharmacists: Ongoing collaborative relationship to discuss and ensure alignment throughout the COVID 19 pandemic on issues such as infection control (patients COVID 19 positive coming into pharmacies to pick up prescriptions; vaccine rollout and administration etc.)** **Ontario Hospital Association: Ongoing collaborative relationship to discuss issues of mutual interest given our members provide care within hospitals across the province; examples of collaboration last year include raised awareness of CPSO Quality Improvement Partnership which supports system collaboration and promotes right-touch regulation**	**The Citizen Advisory Group is a valuable resource that assists CPSO in responding to changing public expectations or emerging trends in a nimble and timely manner. As mentioned previously, consultations with the Citizen Advisory Group provide a direct line of sight into patient perspectives; this type of engagement provides rich information that informs policy development and other initiatives for CPSO and other Colleges.** **In February, CPSO conducted a focus group to discuss the draft policy on Complementary/Alternative Medicine.** **In May, CPSO conducted a focus group to discuss COVID-19 which also included 14 partner Colleges.** **Last year, CPSO co-designed a Continuity of Care Guide for Patients and Caregivers with members of the Citizen Advisory Group to reflect their perspectives on how patients can get engaged in their care and improve patient experience. The development of this resource was informed by multiple engagements with the Citizen Advisory Group (i.e. April/May/October) using various formats (i.e. focus groups, online survey).** **In January 2021, CPSO consulted with the Citizen Advisory Group regarding the importance of diversity among Council members; feedback was incorporated as part of the development of a Council Profile. Having a more diverse Council will enable CPSO to better capture the various perspectives of the public that we serve and will ultimately result in more effective regulation of the medical profession.** **From time to time, public polling is also conducted which provides a representative sample of Ontarians and their perspective son a given issue. CPSO engaged in two public polling initiatives in February 2020: Medical Education and Complementary/Alternative Medicine (representative sample of 800 Ontarians), Awareness and Reputational metrics (representative sample of 800 Ontarians). The polling results directly inform the policy development process.**

	Ontario Health: Ongoing collaborative relationship to ensure consistency regarding system wide health care issues (virtual care, etc) **Ontario Medical Students Association: CPSO Council regularly includes a representative from the Ontario Medical Students Association at its Council meetings to engage medical learners in conversations about the regulation of physicians in Ontario** **Patient and Family Advisory Councils: CPSO maintains positive relationships with various Patient and Family Advisory Councils across the province to gather input from patients, families and caregivers to inform key policies and initiatives** **Patient Ombudsman: CPSO and the Office of the Patient Ombudsman share a common mandate in serving the public interest; initiated discussions to explore opportunities to collaborate where appropriate** **Professional Association of Residents of Ontario: CPSO Council regularly includes a representative from the Professional Association of Residents of Ontario at its Council meetings to engage residents in conversations about the regulation of physicians in Ontario** **Rainbow Health Ontario: CPSO initiated discussions to explore how we can better serve LBTQ2S communities; we are developing an ongoing relationship with them as well as physicians involved in the care of LGBTQ2S patients** **Various Community Organizations: CPSO liaises with various community organizations to ensure their perspectives are considered when developing or implementing policies and other key initiatives; examples include Alliance for Healthier Communities** **Various Medical Education Institutions: CPSO maintains effective relationships with the various medical schools in Ontario to engage medical education providers in conversations about the regulation of physicians in Ontario**	**During the Covid-19 response, CPSO worked closely with government to provide and clarify information to assist with the province's response to the pandemic; CPSO was a critical source of information for physicians and many patients who were looking for guidance around what to expect regarding their care; CPSO continuously adapted to public expectations and provided the most current information to patients through the website. CPSO's responses to the FAQs were informed by feedback/needs assessment done with the Citizen Advisory Group.** **CPSO uses information gathered through its Patient Help Centre to understand where there could be gaps or challenges with respect to physician practice; this information is used to inform the review and development processes for policies, standards and strategic initiatives.**

DOMAIN 4: INFORMATION MANAGEMENT

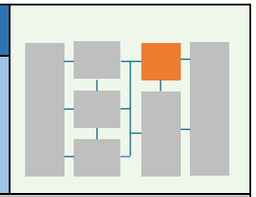


Standard 8

Information collected by the College is protected from unauthorized disclosure.

Measure	Required evidence	College response
8.1 The College demonstrates how it protects against unauthorized disclosure of information.	a. The College has and uses policies and processes to govern the collection, use, disclosure, and protection of information that is of a personal (both health and non-health) or sensitive nature that it holds	The College fulfills this requirement: **Yes** **The approach of the CPSO to protect against unauthorized disclosure of information is multi-faceted, incorporating hardware, software and policy solutions. A summary of this approach including the policies and processes used to govern our information is summarized in the following document and was provided to the CPSO's Finance and Audit Committee in February 2021. Click here to access the summary of CPSO's approach.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (optional)*

DOMAIN 5: REGULATORY POLICIES



Standard 9

Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.

Measure	Required evidence	College response
9.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g. where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).	a. The College has processes in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment.	The College fulfills this requirement: **Yes** • Insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment ***OR*** describe in a few words the College's evaluation process (e.g. what triggers an evaluation, what steps are being taken, which stakeholders are being engaged in the evaluation and how). **CPSO policies are regularly reviewed and updated to ensure they are current. Generally, CPSO aims to initiate the review process for each policy every 5 years, with adjustments given changing priorities or areas of risk. CPSO Council receives a report at each meeting providing an update on the review status of all policies (see the Policy Report in the December 2020 Council materials as an example).** **The review process is multi-staged. Once a policy review is launched, a comprehensive literature review (including jurisdictional scan) is completed along with an analysis of any available data regarding complaints, investigations, or discipline findings. An external consultation is conducted giving all stakeholders, all physicians, and all members of the public an opportunity to provide feedback and inform the process. The consultation process involves broad and targeted announcements or direct invitations to participate via an internal database of interested parties. Regularly patient engagement activities are undertaken at this point as well. The research and feedback inform the development of a draft policy, which is then circulated for external consultation again. Revisions may then be made in response to feedback before receiving final approval from CPSO Council. All of this work is undertaken with the assistance of a Policy Review Working Group comprised of physician and public members of Council and CPSO staff.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐*

		Additional comments for clarification (optional)
	b. Provide information on when policies, standards, and practice guidelines have been newly developed or updated, and demonstrate how the College took into account the following components: i. evidence and data, ii. the risk posed to patients / the public, iii. the current practice environment, iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap) v. expectations of the public, and vi. stakeholder views and feedback.	The College fulfills this requirement: **Yes**
		• For two recent new policies or amendments, either insert a link to document(s) that demonstrate how those components were taken into account in developing or amending the respective policy, standard or practice guideline (including with whom it engaged and how) ***OR*** describe it in a few words. **All CPSO draft policies must be approved by Council prior to external consultation and all revised policies must be approved by Council prior to becoming a policy of CPSO. Each decision point is supported by the development of a comprehensive briefing note highlighting the various factors considered for the key policy changes being proposed.** **Advertising: A new draft *Advertising* policy was developed in 2020 in response to an evolving practice environment, stakeholder feedback, and changing public attitudes. The briefing notes at each stage outline how this information was relied upon to inform the proposed revisions (Draft stage pg. 157; Final Approval, pg. 273)** **Medical Records: Significant updates to our Medical Records policies were made to address changing practice environments, to address issues emerging from the widespread adoption of EMRs, and to support patient access to their records in response to concerns raised externally and internally (Final Approval; pg. 94)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

DOMAIN 6: SUITABILITY TO PRACTICE **Standard 10** **The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.**		
Measure	**Required evidence**	**College response**
10.1Applicants meet all College requirements before they are able to practice.	a. Processes are in place to ensure that only those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[3].	The College fulfills this requirement: **Yes.** **Requirements are set out in the Registration Regulation, in Policy, and in operations as processes/requirements set out as best practices in credentialing and assessment/source verification and complex credentialing. The CPSO are leaders in the complex assessment of qualifications.** **The purpose of assessment of qualifications is to establish authenticity. Complex Credentialing is the process of obtaining, verifying, and assessing qualifications. Credentials are documented evidence of licensure, education, training, experience, or other qualifications. Complex Credentialing cross references all of the documentation presenting as part of the application process to ensure:** • **consistency in information reported;** • **Validity of qualifications; and** • **completeness of record.** **Third party source documents are required from the source. We confirm validity of the source documents accessing our robust reference materials, performing a Quality Assurance check re-confirming the authenticity of the document directly with the third party.** **A variety of tools we utilize in assessing supporting documents sent by third party organizations vary depending on mode of receipt but includes: password protected documents sent from official institutions, documents sent through an email address verifiable through the organization's website, official sealed and stamped envelope from the source organization. Courier delivery is acceptable but documents inside the courier package must be in an official envelope that has been sealed by the source organization, verifying sender's address through organization's website, and our reference database.**

[3] This measure is intended to demonstrate how a College ensures an applicant meets every registration requirement set out in its registration regulation prior to engaging in the full scope of practice allowed under any certificate of registration, including whether an applicant is eligible to be granted an exemption from a particular requirement.

	b. The College periodically reviews its criteria and processes for determining whether an applicant meets its registration requirements, against best practices (e.g. how a College determines language proficiency).	The College fulfills this requirement: **Yes**
		• Insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g. how to assess English proficiency, suitability to practice etc.), link to Council meeting materials where these have been discussed and decided upon ***OR*** describe in a few words the process and checks that are carried out. • Provide the date when the criteria to assess registration requirements was last reviewed and updated. **Council recently reviewed Registration requirements at one of its meetings in 2020 and the relevant materials are accessible here**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		We form part of the Federation of Medical Regulatory Authorities of Canada (FMRAC) of which there is a registration specific special interest working group that meets to discuss, establish and review the registration landscape across Canada. **Additionally, each existing registration policy is regularly reviewed through a formalized multi-staged process.** **Finally, CPSO is subject to annual review by way of a Fair Registration Practices report from the Office of the Fairness Commissioner.**
		The College fulfills this requirement: **Yes**

10.2 Registrants continuously demonstrate they are competent and practice safely and ethically.	a. Checks are carried out to ensure that currency[4] and other ongoing requirements are continually met (e.g., good character, etc.).	• Insert a link to the regulation and/or internal policy document outlining how checks are carried out and what the currency and other requirements include, link to Council meeting materials where documents are found and have been discussed and decided upon ***OR*** provide a brief overview: • List the experts / stakeholders who were consulted on currency: • Identify the date when currency requirements were last reviewed and updated: • Describe how the College monitors that registrants meet currency requirements (e.g. self-declaration, audits, random audit etc.) and how frequently this is done.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		In 2018, the College's Policy "Ensuring Competence: Changing Scope of Practice and /or Re-entering Practice" was revised and approved by Council. This policy sets out the College's expectations regarding scope of practice and defines currency of practice as being engaged in clinical practice or where scope is concerned a particular scope of practice in the proceeding 2 years. **Link: https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ensuring-Competence** **Additionally the Quality Assurance Regulation https://www.ontario.ca/laws/regulation/940114#BK3 sets out the requirement of all members to participate in a program of continuing professional development (CPD) that includes a self-assessment component and that meets the requirements for continuing professional development. This requirement is captured in our annual membership renewal survey.** **Questions in the annual membership renewal survey help to determine whether members continually meet their membership requirements, including good character, etc.**
		The College fulfills this requirement: **Yes**

[4] A 'currency requirement' is a requirement for recent experience that demonstrates that a member's skills or related work experience is up-to-date. In the context of this measure, only those currency requirements assessed as part of registration processes are included (e.g. during renewal of a certificate of registration, or at any other time).

10.3 Registration practices are transparent, objective, impartial, and fair.	a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	• Insert a link to the most recent assessment report by the OFC ***OR*** provide summary of outcome assessment report: **https://www.fairnesscommissioner.ca/en/Professions_and_Trades/Pages/Registration-Practices-Assessment-Report-2016---CPSO.aspx** • Where an action plan was issued, is it: Completed ☐ In Progress ☐ Not Started ☐ **No Action Plan Issued** ☐
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)

Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Measure	Required evidence	College response
11.1 The College supports registrants in applying the (new/revised) standards of practice and practice guidelines applicable to their practice.	a. Provide examples of how the College assists registrants in implementing required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents).	The College fulfills this requirement: **Yes** • Provide a brief description of a recent example of how the College has assisted its registrants in the uptake of a new or amended standard: – Name of Standard – Duration of period that support was provided – Activities undertaken to support registrants – % of registrants reached/participated by each activity – Evaluation conducted on effectiveness of support provided • Does the College always provide this level of support: **Yes** *If not, please provide a brief explanation:* **Quality Care is one of the five components of CPSO's Strategic Plan. To achieve quality care, CPSO will use evidence to evaluate risk and address the greatest concerns for patient care; guide and support doctors throughout their careers; and respond to emerging trends and new technologies.**

		Each time a policy is updated, an announcement is made through CPSO's quarterly magazine *Dialogue* introducing the update and highlighting key changes. Additional announcements are made via email communication to the entire membership aimed at informing them of decisions made at Council meetings. CPSO policies are also regularly supported by companion *Advice to the Profession* resources that provide answers to frequently asked questions and identify some best practices. **Click here to access the Dialogue article regarding the newly approved Advertising Policy** **Click here to access the Advice to the Profession for the Medical Records Documentation Policy** **CPSO has a Physician Advisory Service that provides assistance to physicians regarding a variety of issues, including but not limited to: general practice issues, assistance in managing challenging situations, clarification of CPSO policies or government legislation and annual renewal, including clarification and/or guidance about specific questions, and help with various technical questions or issues. This service is available to physicians year-round and can be connected with trained and knowledgeable staff who can support them with implementing any required changes to standards of practice or practice guidelines.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
11.2 The College effectively administers the assessment component(s) of its QA	a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to	The College fulfills this requirement: **Yes** • List the College's priority areas of focus for QA assessment and briefly describe how they have been identified ***OR*** link to website where this information can be found: **Right Touch Regulation is one of the five components of CPSO's Strategic Plan. To achieve right touch regulation, CPSO will apply a proportionate, consistent, targeted, transparent, accountable and agile approach to all aspects of medical regulation; work with government to align right touch regulation; continually measure, monitor and report on our progress towards more effective regulation.**

Program in a manner that is aligned with right touch regulation[5].	determine which registrants will undergo an assessment activity (and which type if multiple assessment activities); and iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	**In addition to the CPSO's QA Peer Assessment Program, we have recently implemented a Quality Improvement Program option for members. The goal is for every member to go through the QI program once every 5 years. Members who participate in the QI program are exempted from the QA peer assessment. There are 3 streams for the QI program: Individual members; Groups of physicians (e.g. Family Health Teams); and Partnerships with Hospitals.** **Members are asked to complete a number of tools aimed at evaluating their practice and then to identify practice improvement plans for their practice. QI coaches (physicians) evaluate the submission and offer coaching to those registrants who require support.** **Information about the new QI program can be found on the CPSO's webiste.** **All information regarding our Quality Peer Assessment program is available on CPSO's website and includes the peer assessment process as well as the assessment tools that are used so that the subject physician understands the process. In addition, this information is provided again to the subject physician when their notification package is sent out.** **The assessment tools are designed to be:** • **Discipline-specific (define quality from their discipline perspective; decide on evaluation criteria and define quality improvement priorities for their discipline; create appropriate quality improvement resources).** • **Purpose-driven (align the peer assessment program with its purpose to "promote continuous quality improvement by providing physicians with feedback to validate appropriate care and show opportunities for practice improvement")** • **Consistent (ensure consistency in assessor decision-making with well described assessment procedures (e.g., patient record selection) and use of a psychometrically sound measure of assessor agreement).** • **Transparent (make publicly available how the peer assessment defines, evaluates and seeks to improve "quality", i.e. post on CPSO website. Seek feedback from physician groups on the peer assessment content prior to finalization).** • **Relevant (link peer assessment to other quality initiatives (e.g., "Choosing Wisely" campaign; development of a provincial approach to diagnostic imaging peer review)).** • Is the process taken above for identifying priority areas codified in a policy: **No**

[5] "Right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority. Right Touch Regulation. https://www.professionalstandards.org.uk/publications/right-touch-regulation).

		• Insert a link to document(s) outlining details of right touch approach and evidence used (e.g. data, literature, expert panel) to inform assessment approach ***OR*** describe right touch approach and evidence used: **Information to be provided** • Provide the year the right touch approach was implemented ***OR*** when it was evaluated/updated (if applicable): **Right Touch Regulation was included in CPSO's Strategic Plan which was implemented in early 2019 and is being operationalized across the organization. Engagement activities have been conducted on the new QI program extensively with our registrants and other stakeholders like the Ontario Medical Association, Ontario Hospital Association and College of Family Medicine** *If evaluated/updated, did the college engage the following stakeholders in the evaluation:* – *Public* ***No*** – *Employers* ***N/A*** – *Registrants* ***Yes*** – *other stakeholders* ***Yes*** Insert link to document that outlines criteria to inform remediation activities ***OR*** list criteria: **Registrants are provided an opportunity to address the Quality Assurance Committee prior to a final decision being rendered. There are 3 different ways that a member can address the Committee.** **1. Opportunity to Address – Written - This provides the member an opportunity to respond by writing to the Committee to address any of the deficiencies and provide examples of how those changes have been made. The member also has access to a CPSO Medical Advisor, if requested to assist with the written response.** **2. Opportunity to Address with a Medical Advisor – This is something that was initiated in 2019 and provide the member the opportunity to address the issues identified within the assessment report and provide a summary report which is agreed to by the member and forwarded to the QA Committee. This one-on-one approach has worked well since it has been implemented.** **3. Opportunity to Address In-Person – The Quality Assurance Committee can request that a member attend in front of the panel, in-person to address the deficiencies within the report. In 2020, the Quality Assurance Committee has moved away from this option since the introduction of the Medical Advisor role, which serves that function.**

		Additional comments for clarification (optional)
11.3The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgment.	a. The College tracks the results of remediation activities a registrant is directed to undertake as part of its QA Program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practising.	The College fulfills this requirement: **Yes** **The Quality Assurance Committee can request the member undergo a peer and practice reassessment that focuses on the areas of concern to ensure that the member has fulfilled the requirements. This is based on their response to the Opportunity to Address (OTA) avenues described above. These peer and practice reassessments happen within 12 months following the QAC decision.** **If there are clinical concerns identified following the OTA process and/or the physician has no insight to the deficiencies the QAC has the power under section 80.2 to resolve the matter via SCERP (Specified Continuous Educational Remediation Program). The SCERP is monitored by the College's Compliance Monitoring and Supervision area. Compliance will notify the QAC when the SCERP elements have been successfully completed and returns the matter to the QAC for a reassessment to ensure that the remediation plan has been successful.** **If the member wishes to resolve the matter by way of an Educational Undertaking, this undertaking is also monitored by the College's Compliance Monitoring and Supervision department. The Individual Education Plan is developed in consultation with the QAC which is attached as part of the Undertaking. In these situations, the reassessment is completed by the Compliance Monitoring and Supervision department. Outcomes of the reassessment are not conveyed to the QAC as these matters remain outside of the QAC "black box" of information.** • Insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation ***OR*** describe the process: **https://www.cpso.on.ca/Physicians/Your-Practice/Quality-Management/Assessments/Peer-Assessment SCERP and Educational Undertakings are public information and placed on the CPSO website, under the physician's name. These are updated once a member has successfully completed their SCERP and the Educational Undertaking.** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (if needed)*

Standard 12 **The complaints process is accessible and supportive.**		
Measure	**Required evidence**	**College response**
12.1The College enables and supports anyone who raises a concern about a registrant.	a. The different stages of the complaints process and all relevant supports available to complainants are clearly communicated and set out on the College's website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy).	The College fulfills this requirement: **Yes**
		• Does the College have policies and procedures in place to ensure that all relevant information is received during intake and at each stage of the complaints process: **Yes** • Does the College evaluate whether the information provided is clear and useful: **Yes** **A link to the complaints process can be accessed here.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		While CPSO is meeting the requirements as described by the Ministry of Health, we are aware that there are equity seeking groups who feel that the complaints process is not accessible to them and does not provide a safe mechanism by which to raise their concerns. For example, there are many reports indicating that complaints processes need to be made accessible and safe for Indigenous people. **The FMRAC Working Group on anti-racism has specifically called on Medical Regulatory Authorities to examine complaints processes via an anti-racist lens. Similar experiences are often had by patients from Black communities, people of colour, and those identifying as LGBTQ2S. CPSO has begun to examine how it can better apply a diversity, equity and inclusion lens as well as anti-racism praxis to its various functions, policies and processes, including the complaints process. A Diversity, Equity and Inclusion Lead has been appointed to oversee this work across the organisation and we are also engaging with external experts. E.g. San'yas Indigenous Cultural Safety training for all staff.**
	b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement: **Yes.**
		The CPSO responds to inquiries from the public within 5 business days 97.7% of the time.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
	c. Examples of the activities the College has undertaken in supporting the public during the complaints process.	• List all the support available for public during complaints process: **Support available to the public during the complaints process includes:** • **Access to an assigned mediator or investigator throughout the entire process; able to communicate via email, telephone or Canada Post** • **Details of the complaints process on the CPSO website, including how to make a complaint, what to expect, consent and common Q&A** • **Concerns of the complainant are discussed and confirmed by the mediator/investigator at the initiation of the mediation/investigation** • **Language translation services are available; either in the moment through a translation service or by sending documents out for translation** • Most frequently provided supports in CY 2020: **Direct connection with a mediator/investigator for information or support throughout the process**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)
12.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.	a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process.	The College fulfills this requirement: **Yes**
		• Insert a link to document(s) outlining how all parties will be kept up to date and support available at the various stages of the process ***OR*** provide a brief description: **An intake investigator contacts the complainant within 2 business days of receiving a public complaint; the intake investigator assesses the complaint for risk, reviews the complaints process with the complainant, explores the intention of their complaint and confirms their concerns. The intake investigator will identify cases appropriate for ADR; these cases are streamed to a mediator** **Within a week, the case is assigned to either a mediator or investigator who will contact the complainant to review the details of the complaint and to ensure all appropriate consents are on file**

		During an investigation, the complainant is kept up to date by the investigator every 3-4 weeks on the status of their complaint **The complainant is contacted when the investigation has been listed for ICRC review** **The complainant is sent a copy of the ICRC decision immediately upon release, which is usually within 6 weeks** **Once a matter is referred to discipline, the Witness Support Coordinator establishes and maintains regular contact with witnesses to assists in the coordination of scheduling witnesses for hearings and to provide direct support to those testifying at a hearing** **The Witness Support coordinator will follow up with witnesses regarding the outcome and decisions of the Discipline Committee; provide updates and involve witnesses in penalty hearings; provide some guidance and structure for witness impact statements if required**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (optional)

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Measure	Required evidence	College response
13.1The College addresses complaints in a right touch manner.	a. The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g.	The College fulfills this requirement: **Yes** • Insert a link to guidance document ***OR*** describe briefly the framework and how it is being applied: **Intake investigators assess each public complaint for risk by considering the following (the guide document is in the form a decision tree and a step by step process):** • **Patient safety/public interest**

	risk matrix, decision matrix/tree, triage protocol).	• **Physician's history with the CPSO, including registration status; previous investigations & outcomes** • **Isolated report vs. multiple sources with similar information** • **Another trusted organization is already investigating** • **Requirements of a public complaint met (e.g. concerns are regarding a physician)** • **Direction provided to investigations regarding decision making supports** • **Checks & balances in place when closing a file without an investigation (investigator -> manager -> registrar/delegate)** **Triage team assesses all incoming *reports* for risk and appropriate action, using the principles of right touch regulation** • Provide the year when it was implemented ***OR*** evaluated/updated (if applicable): **The decision tree guide document for assessing a public complaint was updated in February 2020** **The guide for risk assessment of reports used by the triage team was updated in March 2020**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Right Touch Regulation is one of the five components of CPSO's Strategic Plan. To achieve right touch regulation, CPSO will apply a proportionate, consistent, targeted, transparent, accountable and agile approach to all aspects of medical regulation; work with government to align right touch regulation; continually measure, monitor and report on our progress towards more effective regulation.
Standard 14 **The College complaints process is coordinated and integrated.**		
Measure	**Required evidence**	**College response**
		The College fulfills this requirement: **Yes**

14.1 The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).	a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	• Insert a link to policy ***OR*** describe briefly the policy: **Information to be provided** • Provide an overview of whom the College has shared information over the past year and purpose of sharing that information (i.e. general sectors of system partner, such as 'hospital', or 'long-term care home'). **Information to be provided** *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ* *Additional comments for clarification (if needed)*

Domain 7: Measurement, Reporting, and Improvement

Standard 15

The College monitors, reports on, and improves its performance.

Measure	Required evidence	College response
15.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.	a. Outline the College's KPI's, including a clear rationale for why each is important.	The College fulfills this requirement: **Yes** • Insert a link to document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), link to Council meeting materials where this information is included ***OR*** list KPIs and rationale for selection: **CPSO's initial set of Key Performance Indicators were discussed and approved by Council in December 2019 to accompany its Strategic Plan for 2020-2025. The Key Performance Indicators were selected based on how meaningful and relevant they were to the strategic plan and leveraging information that can be collected and monitored in a feasible and timely manner. CPSO successfully met its targets in 2020 and Council discussed and approved a new set of Key Performance Indicators for 2021. Click here to view the relevant Council materials (p. 157-171)**

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Continuous Improvement is one of the five elements of CPSO's Strategic Plan. To achieve continuous improvement, CPSO will foster a culture of continuous improvement and openness to change; and modernize all aspects of our work to fulfill our mission. Over the past year, staff have been completing training in the LEAN methodology so that it can be applied across all areas of the organization.
	b. Council uses performance and risk information to regularly assess the College's progress against stated strategic objectives and regulatory outcomes.	The College fulfills this requirement: **Yes**
		• Insert a link to last year's Council meetings materials where Council discussed the College's progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes: **CPSO publishes an annual report that highlights its accomplishments and its performance against its Strategic Plan. Click here to see the 2019 Annual Report. CPSO's Key Performance Indicators are presented quarterly to Council by the Registrar. Click here to access the presentation from December 2020 Council meeting where Key Performance Indicators were discussed.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (if needed)
15.2 Council directs action in response to College performance on its KPIs and risk reviews.	a. Where relevant, demonstrate how performance and risk review findings have translated into improvement activities.	The College fulfills this requirement: **Yes**
		CPSO applies the LEAN methodology to its work in an effort to continuously improve and gain efficiencies. Below are two examples where the CPSO's assessment of its performance against the Key Performance Indicators resulted in improvement activities that were approved by Council: • **Approval of QI program in relation to strategic plan (p. 30)** • **Changes to Discipline Committee (p. 46)**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ

		CPSO participated in the Federation of Medical Regulatory Authorities of Canada Integrated Risk Management System (FIRMS) for the first time in 2020. This is a risk management tool used by all medical regulatory authorities across the country which enables benchmarking and identifying common risks among regulators so that common mitigation strategies may be developed where appropriate. This process will further assist CPSO with enhancing its performance.
15.3The College regularly reports publicly on its performance.	a. Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website.	The College fulfills this requirement: **Yes**
		In 2020, CPSO reported on its performance in the following reports: **CPSO 2019 Annual Report - *Note that the 2020 Annual Report will be published in Spring 2020*** **COVID FAQs – This document was developed to provide guidance and information to the profession and the public on the CPSO's pandemic response** **E-dialogue – Provides information related to CPSO activities and performance in a publicly consumable format.**
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ϒ No ϒ
		Additional comments for clarification (if needed)

PART 2: CONTEXT MEASURES

The following tables require Colleges to provide **statistical data** that will provide helpful context about a College's performance related to the standards. The context measures are non-directional, which means no conclusions can be drawn from the results in terms of whether they are 'good' or 'bad' without having a more in-depth understanding of what specifically drives those results.

In order to facilitate consistency in reporting, a recommended methodology to calculate the information is provided in the companion document "Technical Specifications for Quantitative College Performance Measurement Framework Measures." However, recognizing that at this point in time, the data may not be readily available for each College to calculate the context measure in the recommended manner (e.g. due to differences in definitions), a College can report the information in a manner that is conducive to its data infrastructure and availability.

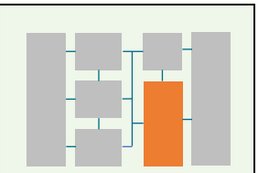
In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: 'Nil' and indicate any plans to collect the data in the future.

Where deemed appropriate, Colleges are encouraged to provide additional information to ensure the context measure is properly contextualized to its unique situation. Finally, where a College chooses to report a context measure using methodology other than outlined in the following Technical Document, the College is asked to provide the methodology in order to understand how the College calculated the information provided.

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 1. Type and distribution of QA/QI activities and assessments used in CY 2020*

Type of QA/QI activity or assessment	#
i. QI: Practice Improvement Plan submitted	1535
ii. QI: Coaching	235
iii. QA: Peer assessment	344
iv. QA: Out of Hospital Premises Inspection	79
v. QA: Completion of a self-assessment questionnaire	337
vi. *<Insert QA activity or assessment>*	
vii. *<Insert QA activity or assessment>*	
viii. *<Insert QA activity or assessment>*	
ix. *<Insert QA activity or assessment>*	

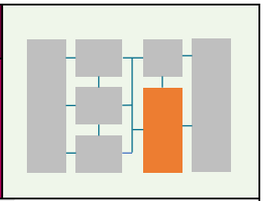
* *Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College's QA Program, the requested statistical information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period.*

***NR** = Non-reportable: results are not shown due to < 5 cases*

What does this information tell us? *Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g. changing roles and responsibilities, changing public expectations, legislative changes).*

The information provided here illustrates the diversity of QA activities the College undertook in assessing the competency of its registrants and the QA and QI activities its registrants undertook to maintain competency in CY 2020. The diversity of QA/QI activities and assessments is reflective of a College's risk-based approach in executing its QA program, whereby the frequency of assessment and activities to maintain competency are informed by the risk of a registrant not acting competently. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 13(a) of Standard 11.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

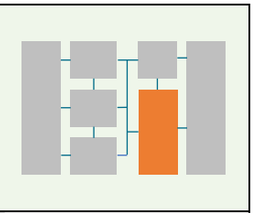
If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
	#	%	***What does this information tell us?*** *If a registrant's knowledge, skills and judgement to practice safely, effectively and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer him or her to the College's QA Committee.* *The information provided here shows how many registrants who underwent an activity or assessment in CY 2020 as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program.*
CM 2. Total number of registrants who participated in the QA Program CY 2020	681		
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation. *	53	7.8	

Additional comments for clarification (optional)

** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Statistical data collected in accordance with recommended methodology or College own methodology: **Recommended Methodology**

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 4. Outcome of remedial activities in CY 2020*:	#	%	***What does this information tell us?*** *This information provides insight into the outcome of the College's remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its "QA remediation activities". Without additional context no conclusions can be drawn on how successful the QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.*
I. Registrants who demonstrated required knowledge, skills, and judgment following remediation**	28	52.8	
II. Registrants still undertaking remediation (i.e. remediation in progress)	25	47.2	

Additional comments for clarification (if needed)

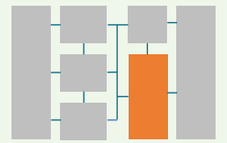
** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*

*** This measure may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY2020.*

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: N/A

If College methodology, please specify rationale for reporting according to College methodology: The CPSO codes investigations upon closure of the file. The issues identified in an investigation is not available for ongoing cases.

Context Measure (CM)

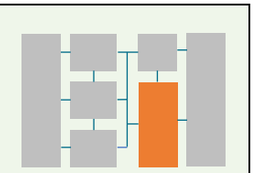
CM 5. Distribution of formal complaints* and Registrar's Investigations by theme in CY 2020	Formal Complaints received‡		Registrar Investigations initiated‡		
Themes:	#	%	#	%	
I. Advertising					***What does this information tell us?*** *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent themes identified in formal complaints received and Registrar's Investigations undertaken by a College.*
II. Billing and Fees					
III. Communication					
IV. Competence / Patient Care					
V. Fraud					
VI. Professional Conduct & Behaviour					
VII. Record keeping					
VIII. Sexual Abuse / Harassment / Boundary Violations					
IX. Unauthorized Practice					
X. Other <*please specify*>					
Total number of formal complaints and Registrar's Investigations**		**100%**		**100%**	

* ***Formal Complaint**: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.* ***Registrar's Investigation**: Where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.* ǂ ***NR** = Non-reportable: results are not shown due to < 5 cases (for both # and %)* ** *The requested statistical information (number and distribution by theme) recognizes that formal complaints and registrar's investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations.*	

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2020	1890		
CM 7. Total number of ICRC matters brought forward as a result of a Registrars Investigation in CY 2020	200		
CM 8. Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2020	92		
CM 9. Of the formal complaints* received in CY 2020**:	#	%	
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)ǂ	152	8.1	
II. Formal complaints that were resolved through ADR	126	6.7	
III. Formal complaints that were disposed** of by ICRC	1709		
IV. Formal complaints that proceeded to ICRC and are still pending	195	10.3	
V. Formal complaints withdrawn by Registrar at the request of a complainant Δ	359	16.0	
VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious	81	3.4	
VII. Formal complaints and Registrars Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	41	2.2	

** ***Disposal:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

* ***Formal Complaints:*** *A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.*

ǂ ***ADR****: Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.*

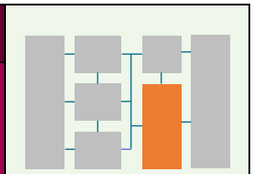
What does this information tell us? *The information helps the public better understand how formal complaints filed with the College and Registrar's Investigations are disposed of or resolved. Furthermore, it provides transparency on key sources of concern that are being brought forward to the College's committee that investigates concerns about its registrants.*

D The Registrar may withdraw a formal complaint prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. *# May relate to Registrars Investigations that were brought to ICRC in the previous year.* *** The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted in total number of complaints disposed of by ICRC.* *ϕ* ***Registrar's Investigation:*** *Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.* ***NR** = Non-reportable: results are not shown due to < 5 cases (for both # and %)*	
Additional comments for clarification (if needed)	

Domain 6: Suitability to Practice

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: **Recommended Methodology**

If College methodology, please specify rationale for reporting according to College methodology:

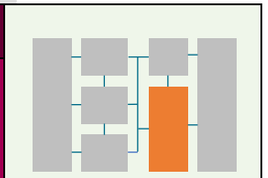
Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2020							
Distribution of ICRC decisions by theme in 2020*	# of ICRC Decisions‡						
Nature of issue	Take no action	Proves advice or recommendations	Issues an oral caution	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws.
I. Advertising	NR	NR	0	0	NR	NR	0
II. Billing and Fees	25	NR	6	NR	5	11	0
III. Communication	266	32	11	17	7	NR	0
IV. Competence / Patient Care	888	238	32	133	72	22	0
V. Fraud	11	0	0	0	NR	5	0
VI. Professional Conduct & Behaviour	128	21	21	6	9	17	0
VII. Record keeping	106	103	22	70	34	18	0
VIII. Sexual Abuse / Harassment / Boundary Violations	47	5	12	6	27	8	0
IX. Unauthorized Practice	9	NR	5	NR	6	5	0
X. Other: Accepting new patients and Termination	9	15	0	NR	0	0	0

** Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar's investigations brought forward prior to 2020.*

*‡ **NR** = Non-reportable: results are not shown due to < 5 cases.*

++ The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations, or findings.
What does this information tell us? *This information will help increase transparency on the type of decisions rendered by ICRC for different themes of formal complaints and Registrar's Investigation and the actions taken to protect the public. In addition, the information may assist in further informing the public regarding what the consequences for a registrant can be associated with a particular theme of complaint or Registrar investigation and could facilitate a dialogue with the public about the appropriateness of an outcome related to a particular formal complaint.*
Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology ϒ

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)		
CM 11. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College.* *The information enhances transparency about the timeliness with which a College disposes of formal complaints or Registrar's investigations. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the disposal of a formal complaint filed with, or Registrar's investigation undertaken by, the College.*
I. A formal complaint in working days in CY 2020	241	
II. A Registrar's investigation in working days in CY 2020	908	

* ***Disposal Complaint:*** *The day where a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

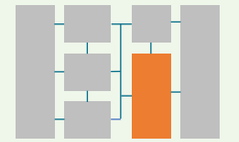
* ***Disposal Registrar's Investigation:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)		
CM 12. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed. ** *The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.*
I. An uncontested^ discipline hearing in working days in CY 2020	541	
II. A contested# discipline hearing in working days in CY 2020	684	

* ***Disposal:*** *Day where all relevant decisions were provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).*

^ ***Uncontested Discipline Hearing:*** *In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent.*

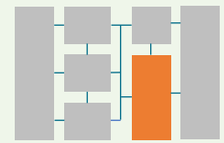
\# ***Contested Discipline Hearing:*** *In a contested hearing, the College and registrant disagree on some or all of the allegations, penalty and/or costs.*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology: Note that we added the finding 'Suitability to Practice' in item (IV) below, due to numerous findings in 2020

Context Measure (CM)

CM 13. Distribution of Discipline finding by type*

Type		#
I.	Sexual abuse	NR
II.	Incompetence	5
III.	Fail to maintain Standard	9
IV.	Suitability to Practice	8
V.	Conduct unbecoming	NR
VI.	Dishonourable, disgraceful, unprofessional	30
VII.	Offence conviction	
VIII.	Contravene certificate restrictions	NR
IX.	Findings in another jurisdiction	
X.	Breach of orders and/or undertaking	
XI.	Falsifying records	
XII.	False or misleading document	NR
XIII.	Contravene relevant Acts	NR

What does this information tell us? *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent discipline findings where a formal complaint or Registrar's Investigation is referred to the Discipline Committee by the ICRC.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.*

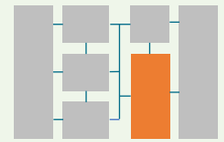
***NR** = Non-reportable: results are not shown due to < 5 cases.*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: Recommended Methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 14. Distribution of Discipline orders by type*

Type		#
I.	Revocation+	8
II.	Suspension$	21
III.	Terms, Conditions and Limitations on a Certificate of Registration**	21
IV.	Reprimand^ and an Undertaking	NR
V.	Reprimand^	36

What does this information tell us? *This information will help strengthen transparency on the type of actions taken to protect the public through decisions rendered by the Discipline Committee. It is important to note that no conclusions can be drawn on the appropriateness of the discipline decisions without knowing intimate details of each case including the rationale behind the decision.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the numbers set out for findings and orders may not be equal and may not equal the total number of discipline cases.*

\+ *Revocation of a registrant's certificate of registration occurs where the discipline or fitness to practice committee of a health regulatory college makes an order to "revoke" the certificate which terminates the registrant's registration with the college and therefore his/her ability to practice the profession.*

$ *A suspension of a registrant's certificate of registration occurs for a set period of time during which the registrant is not permitted to:*

- *Hold himself/herself out as a person qualified to practice the profession in Ontario, including using restricted titles (e.g. doctor, nurse),*
- *Practice the profession in Ontario, or*
- *Perform controlled acts restricted to the profession under the Regulated Health Professions Act, 1991.*

** *Terms, Conditions and Limitations on a Certificate of Registration are restrictions placed on a registrant's practice and are part of the Public Register posted on a health regulatory college's website.*

^ *A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with his or her practice*

\# *An undertaking is a written promise from a registrant that he/she will carry out certain activities or meet specified conditions requested by the College committee.*

***NR** = Non-reportable: results are not shown due to < 5 cases*

Additional comments for clarification (if needed)

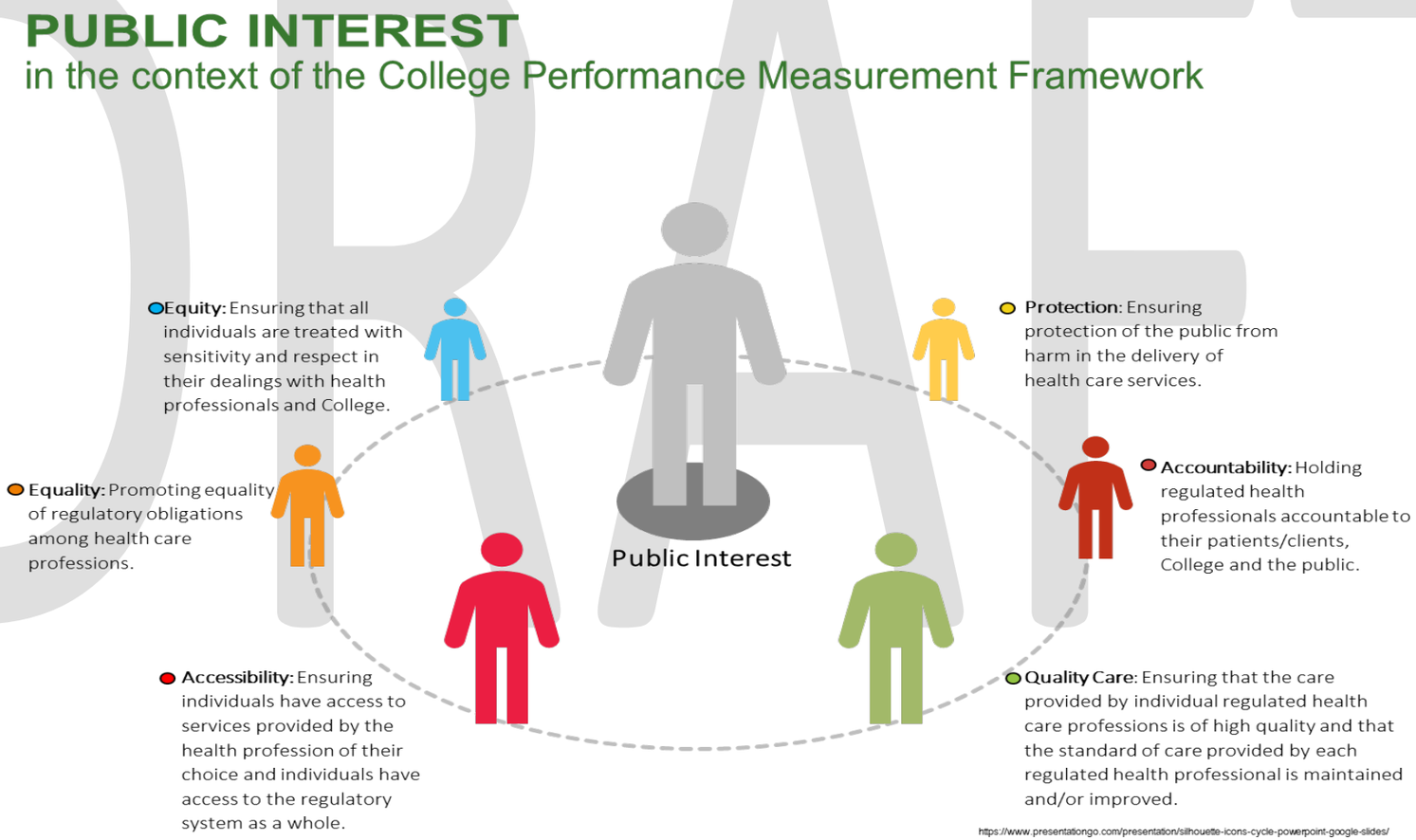
For questions and/or comments, or to request permission to use, adapt or reproduce the information in the CPMF please contact:

Regulatory Oversight and Performance Unit
Health Workforce Regulatory Oversight Branch
Strategic Policy, Planning & French Language Services Division
Ministry of Health
438 University Avenue, 10th floor
Toronto, ON M5G 2K8

E-mail: RegulatoryProjects@Ontario.ca

Appendix A: Public Interest

When contemplating public interest for the purposes of the CPMF, Colleges may wish to consider the following (please note that the ministry does not intend for this to define public interest with respect to College operations):



Council Motion

Motion Title	Methadone Maintenance Treatment – Proposal to Rescind the Methadone Policy and Program Standards and Guidelines
Date of Meeting	March 5, 2021

It is moved by_____, and seconded by_____, that:

The Council rescind the College's:

a) *Methadone Maintenance Treatment for Opioid Dependence* policy (a copy of which forms Appendix "…" to the minutes of this meeting); and
b) *Methadone Maintenance Treatment Program Standards and Guidelines* (a copy of which forms Appendix "…" to the minutes of this meeting).

Council Briefing Note

March 2021

Topic:	Methadone Maintenance Treatment – Proposal to Rescind the Methadone Policy and Program Standards and Guidelines
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	Modernizing policy and program approaches to improve access to care for patients, by setting principled expectations that support and guide physicians in exercising their professional judgment.
Main Contact(s):	Craig Roxborough, Director, Policy Tracey Marshall, Supervisor, Quality Management Angela Carol, Medical Advisor Jessica Amey, Counsel Alexandra Wong, Policy Analyst
Attachment(s):	N/A

Issue

- CPSO's *Methadone Maintenance Treatment for Opioid Dependence* policy and the corresponding *Methadone Maintenance Treatment Program Standards and Guidelines* were last updated and approved in 2010 and 2011 respectively. Since then, the treatment of opioid use disorder and the regulatory environment regarding methadone have evolved significantly.

- Council is provided with an overview of CPSO's current approach to regulating methadone and a proposal to modernize this regulatory approach. Council is asked whether the policy and program standards and guidelines can be rescinded.

Background

- Methadone was originally introduced as a means for treating opioid use disorder. Given the risks associated with this drug (specifically, its long half-life relative to other drugs)

and the stigma associated with this patient population, methadone prescribing has historically been highly regulated by each level of government and, as such, CPSO.

  - In the 1990s, CPSO began to administer a methadone program on behalf of the Ministry of Health, leading to the development of the *Methadone Maintenance Treatment Program Standards and Clinical Guidelines* (hereinafter, 'program standards'). This program has consistently received annual funding from the provincial government.

  - The federal government then amended the *Narcotic Control Regulations* under the *Controlled Drugs and Substances Act,* requiring practitioners to obtain an exemption from the federal government prior to prescribing methadone.

  - As a result, CPSO was charged with recommending to the federal government which physicians should be granted this exemption, leading to the creation of the non-statutory Methadone Committee. The Committee was tasked with making and monitoring the appropriateness of these recommendations in close collaboration with the methadone program area.

  - In the early 2000s CPSO then developed a methadone administration policy and companion framework that enabled physicians with prescribing privileges to have trained individuals administer methadone on their behalf. These were later collapsed into the *Methadone Maintenance Treatment for Opioid Dependence* policy in 2010 (hereinafter, 'methadone policy').

- By the late 2010s, the opioid crisis was worsening and new drugs (e.g., Suboxone) were introduced as alternative first-line treatments without the same risks or regulatory burden. In 2018, the federal government removed the requirement to obtain an exemption to prescribe methadone, impacting the regulatory approach at the provincial level as well.

  - As part of a broader 'opioid strategy', the Ontario College of Pharmacists moved away from a position of exceptionalism with respect to methadone, instead, folding their methadone policy into a broader opioid policy with some methadone specific guidance set out in a companion resource.

  - The CPSO added a disclaimer to the current methadone policy, indicating that it was out of date and that some requirements no longer applied. A commitment to review the policy was made, but not executed.

  - Without the requirement for an exemption from the federal government, CPSO lost the 'hook' needed to require physicians to undergo the assessment and approval process. This contributed to some changes at the programmatic level as well as the disbanding of the Methadone Committee, with members becoming part of a

'Methadone Specialty Panel' under the Quality Assurance Committee to address problematic prescribers.

- Given the diminished need for a methadone program, changes to the program have gradually been introduced, including easing some of the preceptorship and assessment requirements, and CPSO has notified the Ministry of Health that it can cease funding the methadone program in 2021. Additionally, responsibility for the annual prescribers' conference, historically hosted by CPSO, and Ministry of Health funding for outreach initiatives have both been moved to the Centre for Addiction and Mental Health (CAMH).

Current Status and Analysis

- The current methadone policy and program standards are out of date and are either due to be reviewed and updated or rescinded.

- In keeping with CPSO's commitment to the continued modernization of our approach to regulation and in response to the evolution of medicine as it pertains to methadone and the treatment of opioid use disorder more broadly, a proposal to rescind both the policy and program standards is being brought forward for consideration.

- An overview of the analysis that has led to the development of this proposal is outlined below, followed by a proposed transition plan.

History of Exceptionalism Regarding Methadone

- CPSO's current approach to regulating methadone is one of exceptionalism, where a single drug is addressed through both a policy and program standards. While historically this was consistent with the regulatory approach of various levels of government, this is no longer the case given the changes at the federal level.

    - Notwithstanding the removal of the federal exemption, other Canadian medical regulatory authorities continue to regulate methadone closely, although in many cases within a broader opioid agonist therapy policy and program. The College of Physicians and Surgeons of Nova Scotia is an exception to this, having recently retired its *Methadone Maintenance Treatment Handbook*.

- Within CPSO, the methadone policy is an outlier among other policies, in that it focuses on a single drug where there are not additional or unique regulatory considerations regarding its use.[1]

- Similarly, it is unusual[2] for CPSO to have developed clinical practice guidelines such as the methadone program standards.

    - Typically, clinical practice guidelines are systematically developed evidence-based or consensus-based statements advanced by those with clinical expertise in the relevant domains. While a similar process was undertaken when the methadone program standards were developed, ultimate approval and ownership resided with CPSO Council.

    - In fact, CPSO does not typically endorse any specific clinical practice guidelines and instead recognizes their broad value in a position statement. This statement also explicitly notes that these resources are just **guidelines** and that clinical judgement and patient specific consideration is needed.

Implications of Current Approach to Regulating Methadone

- CPSO's current approach to regulating methadone has created real or perceived barriers that compromise access to and the delivery of high-quality care to patients.

    - CPSO's significant oversight of this space has acted as a disincentive to physicians wanting to include this treatment within their scope of practice. This limits access to care and restricts the availability of treatment modalities to patients otherwise within treatment programs.

    - Physicians are also interpreting the program standards as mandatory practice requirements of CPSO. Despite a caveat that these are not intended to replace sound clinical judgment, the detailed nature of the program standards and CPSO's ownership of them has inhibited physicians from exercising professional and clinical judgment even where departing from the standards is in the patient's best interest.

[1] The *Cannabis for Medical Purposes* and *Medical Assistance in Dying* policies, while narrow in scope, have unique regulatory frameworks and there are unique features of the practice of medicine in these contexts such that additional and focused guidance is needed for physicians.
[2] The Out of Hospital Premises and Independent Heath Facilities programs are exceptions to this general rule. However, given the regulatory framework and the requirement to proactively inspect these practices, standards needed to be developed. Notably, a comprehensive review of these standards is currently being planned to ensure the approach adopted here is consistent with other modernization efforts.

Principle Based Prescribing Expectations

- CPSO's *Prescribing Drugs* policy was last reviewed and updated in December 2019. This policy explicitly adopts a principle-based approach to regulating the prescribing of all drugs, including narcotics and controlled substances.
    - The policy includes expectations that apply in all instances of prescribing and specific expectations that apply for *all* narcotics and controlled substances given the risk profile associated with these drugs. Exceptional expectations are only set out where required by law (e.g., fentanyl patches).
- As part of the review process for the *Prescribing Drugs* policy, specific attention was paid to ensure that the prescribing of methadone was captured by the policy expectations. As a result, specific references to methadone were added to the policy.

Approaches to Methadone and "Safer Supply" Prescribing

- Members of the Methadone Specialty Panel have expressed some concerns regarding CPSO's approach to "safer supply" opioid prescribing (a harm reduction strategy involving the provision of pharmaceutical grade opioids to opioid-dependent patients as an alternative to the toxic street supply). Recently, it has become clear that a key area of contention is the divergent approaches taken with respect to safer supply (i.e., principle based) and methadone (i.e., prescriptive).
- The *Prescribing Drugs* policy review process included consideration of the emerging practice of "safer supply", which was being utilized as a means for addressing the ongoing and worsening opioid crisis.
    - In keeping with the principle-based approach of the policy and avoiding exceptionalism regarding this prescribing practice, Council **did not** set out unique expectations or restrictions for the practice.
    - Instead, Council adopted general expectations that applied in all instances of prescribing narcotics and controlled substances and developed substantive guidance in the companion *Advice to the Profession* to help articulate how the policy expectations apply in this emerging area of practice.
- The Federal Minster of Health, Patty Hajdu, also recently requested all provincial governments and regulators to remove any regulatory barriers to therapeutic modalities that could assist with the current opioid crisis. In response, CPSO's approach to safer supply was re-affirmed at the October Executive Committee meeting and the language of the *Advice to the Profession* was updated to help eliminate perceived barriers to physician participation in these practices.

Feedback from the Methadone Specialty Panel

- Given the expertise of those on the Methadone Specialty Panel, CPSO staff from policy, legal, and the methadone program area met with panel members in order to understand their concerns and explore potential changes with respect to the regulation of methadone.

- While there was some disagreement among the panel members, a few key themes emerged from the discussion. Namely, that:

    - The current approach to regulating methadone is creating barriers to access and compromising patient care;

    - The program standards are out of date and need to be rescinded;

    - New clinical practice guidelines, set out by experts in addiction medicine, are needed to help guide best practice;

    - The degree of risk associated with methadone is high, even relative to many other narcotics and controlled substances, but the **kinds** of risks are the same (e.g., misuse, abuse, diversion, overdose, etc.); and

    - A transitional approach is warranted in order to provide guidance on key issues related to methadone including educational requirements, risk mitigation strategies, and continuous quality improvement and oversight to ensure the public is protected.

Opioid Use Disorder Guidelines

- Given the importance of treating opioid use disorder, other guidelines and quality standards exist outside CPSO to support appropriate practice in this space, including with respect to the prescribing of methadone.

    - For example, the *Canadian Research Initiative in Substance Misuse National Guidelines for the Clinical Management of Opioid Use Disorder* and Health Quality Ontario's *Opioid Use Disorder* Quality Standard. While less specific, clinically speaking, than CPSO's methadone program standards, there is helpful guidance in these resources.

    - Additionally, CAMH developed *Opioid Agonist Treatment Delivery* guidelines with specific clinical recommendations to support appropriate prescribing and access to treatment during the pandemic.

- Most notably, CAMH has been leading (with funding from CPSO) the development of national opioid use disorder clinical practice guidelines, setting out best practices for a range of treatment modalities. The genesis of this project included an intention to have these guidelines replace CPSO's own methadone program standards and support as much standardization across the country as possible.

    - It is anticipated that CAMH will have the guidelines finalized and ready for publication in the coming months.

    - While higher level than the current program standards, it is felt that this resource will provide appropriate guidance while also allowing prescribers to exercise their professional and clinical judgment.

Proposal to Rescind

- Taken together, the above analysis indicates the need for a significant overhaul of CPSO's approach to regulating methadone.

- Given the external and internal moves away from treating methadone as an exceptional drug and the implications associated with access and patient care that flow from CPSO's current regulatory approach and ownership of the program standards, it is proposed that the policy and program standards be rescinded.

- To support the profession and protect the public, transitional guidance specific to methadone will be developed and outlined in the *Prescribing Drugs Advice to the Profession*. Key topics addressed and guidance that will be provided include:

    - *Expertise:* Articulating the core CPSO expectation that physicians only practice within the limits of their clinical competence and/or scope of practice and direct physicians to key resources to assist in education and training in this space.

    - *Risk mitigation:* Reminding physicians of the importance of managing methadone's long half-life and the lead time required to reach an optimal dose.

    - *Interprofessional collaboration:* Highlighting the importance of working collaboratively with pharmacists and other health-care providers to provide comprehensive and safe methadone treatment.

    - *Methadone administration:* Reminding physicians of the knowledge, skill, judgment needed to support methadone administration, particularly when other health care providers are assisting in this capacity.

    - *Clinical judgment:* Reminding physicians of the need to exercise sound clinical judgment taking into consideration the needs of each patient while being informed

by any relevant practice standards, quality standards, and clinical practice guidelines where they exist, and directing physicians to key resources.

Next Steps

- If Council approves the rescinding of the policy and program standards, the necessary transitional guidance will be developed and the changes in CPSO's regulatory approach to methadone will be announced to the profession via *Dialogue* and other communication channels.

Questions for Council

1. Does Council approve the rescinding of the *Methadone Maintenance Treatment for Opioid Dependence* policy and the corresponding *Methadone Maintenance Treatment Program Standards and Guidelines*?

Council Motion

Motion Title	Governance Committee Appointment Process
Date of Meeting	March 5, 2021

It is moved by_____, and seconded by_____, that:

In accordance with s. 34(1) of the general bylaw, the members of the Governance Committee referred to in ss. 44(1)(b) and (c) of the bylaw shall be appointed by Council without election.

Council Briefing Note

March 2021

Topic:	Governance Committee Appointment Process and Vacancy
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	Ensure appointment of Governance Committee members reflects good governance practices and ensures the Committee is populated with competent, qualified committee members.
Main Contact(s):	Laura Rinke-Vanderwoude, Jr. Governance Analyst Debbie McLaren, Senior Governance Coordinator Laurie Cabanas, Director of Governance and Committees
Attachment(s):	Appendix A: Draft Governance Committee Competency Framework

Issue

- Discuss moving to an appointment process for the Governance Committee to align with current governance best practices.
- Discuss the current vacancy for a public member on the Governance Committee.

Background

Appointment Process

- Previously, an election process has been used to fill annual vacancies for Governance Committee positions that are not held by defined Officers.
- Based on our current by-laws and reflecting governance best practices, CPSO staff are suggesting an appointment process to fill vacancies on the Governance Committee moving forward.

Current Vacancy

- Mehdi Kanji's public member appointment expired on February 7, 2021, creating a vacancy for one public member position on the 2020/2021 Governance Committee.

Current Status and Analysis

Appointment Process

- The General By-Law allows an appointment process to fill annual vacancies not held by defined Officers on the Governance Committee. Council does not need to consider changing any by-laws or other rules. The switch to an appointment process is only a change in approach.

- An appointment process would allow the Governance Committee to select the best candidate(s) based on certain criteria which would position the Governance Committee well to carry out its governance modernization initiatives at the CPSO. Additionally, it would reduce administrative activities at the December Council meeting, freeing up Council to engage in other discussions.

- The Governance Centre of Excellence, an initiative of the Ontario Hospital Association, is committed to leading excellence in health care governance. In its third edition of "The Guide to Good Governance" under "Committee rules and regulations"; it is noted that:

    - Members will be *appointed* by the board on recommendation of either the board chair or a committee established by the board for that purpose (such as the Governance Committee); and

    - Board will ensure a process is in place to select committee members.

- Staff conducted research with various Advisory Group on Regulatory Excellence[1] colleges and members of the Federation of Medical Regulatory Authorities of Canada regarding current appointment practices as they relate to Governance Committees:

    - For those that responded and where the College has a Governance Committee, membership is generally an appointed process with a blend of physicians and public members.

[1] These colleges include: College of Medical Radiation and Imaging Technologists of Ontario, College of Nurses of Ontario, College of Optometrists of Ontario, College of Physicians and Surgeons of Ontario, College of Physiotherapists of Ontario, Ontario College of Pharmacists and Royal College of Dental Surgeons of Ontario

- In addition, most other Committees at CPSO already use an appointment process for their membership. Moving to an appointment process would not affect the election process for the Executive Committee, or Council's ability to appoint their executives for Council as a whole.

Proposed Process to Appoint Governance Committee Members

- CPSO staff suggest utilizing an appointment process based on a competency framework (similar to the Policy Review Working Group's process and framework; see Appendix A) to replace the existing election process for filling vacant positions on the Governance Committee as follows:

    - Announce vacant committee position(s) to Council members. Provide Council members with the Governance Committee Terms of Reference and competencies that are relevant for the Governance Committee's work;

    - Invite Council members to submit a brief letter of interest outlining their skills, knowledge and governance experience, along with their CV to the Governance Office;

    - A working group comprised of the President, Chair of the Governance Committee and Director of Governance will review all applications and select qualified candidate(s) based on how well they meet the desired skills and competencies; and

    - Selected candidate(s) will be put before the Executive Committee for recommendations to Council to appoint to the Governance Committee.

- Candidates for vacancies for the 2021-2022 year will be appointed at the June meeting of Council and will begin their term in December.

- This process would not apply to the Past President, President, and Vice President, who are pre-determined members of the Governance Committee.

Current Vacancy

- Mehdi Kanji's public member appointment expired on February 7, 2021, creating a vacancy for one public member position on the 2020/2021 Governance Committee.

- It is in the best interests of the Governance Committee to fill this vacancy on an expedited basis. It is proposed that this vacancy be filled in accordance with the process set out

above, except that the Executive Committee would exercise its authority under the By-laws[2] to make the appointment, rather than waiting until June Council.

Next Steps

- Council is asked to discuss the proposed process to fill vacancies on the Governance Committee, and to consider the appointment process for the current Governance Committee public member vacancy.

- If approved, the new appointment process will be used to fill vacancies for 2021/2022 at the June meeting of Council.

Question for Council

1. Does Council approve the move to an appointment process for vacancies on the Governance Committee, generally, and with respect to the current vacancy?

[2] The General By-Law Section 37(4) states: the executive committee may and, if necessary, for a committee to achieve its quorum, shall make appointments to fill any vacancies which occur in the membership of a committee

Council Motion

Motion Title	Quality Assurance Committee Renewal
Date of Meeting	March 5, 2021

It is moved by_____, and seconded by_____, that:

The Council appoints the following committee members to the Quality Assurance Committee from April 1, 2021 to December 10, 2021:

Dr. Steven Bodley
Dr. Jacques Dostaler
Dr. Ken Lee
Dr. Camille Lemieux
Dr. Michael Franklyn
Mr. Paul Malette
Mr. Peter Pielsticker
Dr. Patrick Safieh
Dr. Ashraf Sefin
Dr. Robert Smith
Dr. Tina Tao

Council Briefing Note

March 2021

Topic:	Quality Assurance Committee Membership Renewal
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	Ensure the Quality Assurance Committee members have the skills and knowledge to carry out the work of the Committee in alignment with the Strategic Plan
Main Contact(s):	Brenda Copps, Chair of Governance Committee Janet van Vlymen, Chair of Quality Assurance Committee Sarah Reid, Vice Chair of Quality Assurance Committee
Attachment(s):	N/A

Issue

- The Quality Assurance Committee Chair/Vice-Chair and the Governance Committee Chair have reviewed the Quality Assurance Committee membership composition and are recommending appointments to support the renewal and ongoing work of the Quality Assurance Committee Membership.

Background

- As a result of governance challenges within the Quality Assurance Committee last year, the Chair and Vice Chair of the Quality Assurance Committee, along with Governance and Executive Committee approval, agreed that a review of the committee membership would take place in early 2021.

- In December, Council appointed all Quality Assurance Committee members (other than the Chair and Vice Chair) until March 31, 2021, which allowed the Chair and Vice Chair of the Quality Assurance Committee, the Chair of the Governance Committee and relevant senior staff to conduct the review.

- The review included the following key inputs:

Interviews with current Committee members	Staff feedback regarding Committee member performance	General observations from QAC Chair/Vice-Chair and Chair of Governance Committee	Consideration of the skills and diversity needed on the Committee

- Although public member participation on the Quality Assurance Committee is not required for quorum, the Committee members confirmed a desire to maintain some public member presence on the Committee.

Current Status and Analysis

- Based on the four sources of input and considering the projected workload for the Committee in 2021, the following committee members are recommended for appointment to the Quality Assurance Committee for the term, April 1, 2021 to December 10, 2021:

Council Members:

Dr. Camille Lemieux
Dr. Michael Franklyn
Dr. Patrick Safieh
Mr. Paul Malette
Mr. Peter Pielsticker

Non-Council Committee Members:

Dr. Steven Bodley
Dr. Jacques Dostaler
Dr. Ken Lee
Dr. Ashraf Sefin
Dr. Robert Smith
Dr. Tina Tao

Next Steps

- Governance Office staff will work with the Committee Chair/Vice Chair and senior committee support staff to plan for the upcoming Quality Assurance Committee meeting on March 12, 2021 and consider a succession plan for this year.

- A set of skills and competencies for the Quality Assurance Committee will be developed to inform upcoming recruitment efforts and ensure a sufficient number of Quality Assurance Committee members are appointed to the Committee to carry out the work.

Question for Council

1. Does Council wish to appoint the committee members, listed above, to the Quality Assurance Committee for the term April 1, 2021 to December 10, 2021?