CPSO

Board of Directors Meeting

Annual Organizational Meeting

November 28 & 29, 2024

NOTICE

OF

BOARD OF DIRECTORS MEETING

A meeting of the Board of Directors (Board) of the College of Physicians and Surgeons of Ontario (CPSO) will take place in person on November 28 and 29, 2024, in the CPSO Boardroom at 80 College Street, 3rd Floor, Toronto, Ontario. This is the Annual Organizational Meeting of the Board.

The Board meeting will be open to members of the public who wish to attend in person. Members of the public who wish to observe the meeting in person will be required to register online by 4:30 p.m. on November 25. Details on this process are available on the CPSO's website.

The meeting will convene at 10:30 a.m. on Thursday, November 28, 2024, and at 9:00 a.m. on Friday, November 29, 2024.

Nancy Whitmore, MD, FRCSC, MBA, ICD.D
Registrar and Chief Executive Officer

November 6, 2024

Board Meeting Agenda
Annual Organizational Meeting
November 28 and 29, 2024

THURSDAY, NOVEMBER 28, 2024

Item	Time	Topic and Objective(s)	Purpose	Page No.
1	**10:30 am** (10 mins)	**Call to Order and Welcoming Remarks** (I. Preyra) • Note regrets and declare any conflicts of interest	Discussion	N/A
2	**10:40 am** (5 mins)	**Consent Agenda** (I. Preyra) 2.1 Approve Board meeting agenda 2.2 Approve the draft minutes from the Board meeting held on September 6, 2024 2.3 Committee Appointments for 2024/25 2.4 2024 Chair/Vice-Chair Committee Re-appointments Consent Motion	Approval (with motion)	 3-7 8-19 20-25 26 27-28
3	**10:45 am** (5 mins)	**Items for Information:** 3.1 Executive Committee Report - No Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Committee Annual Reports 3.5 Policy Report 3.6 Medical Learners Report 3.7 Update on Board Action Items 3.8 2025 Q3 and Q4 meeting dates	Information	 - 29-32 33 34-63 64-67 68-72 73-78 79
4	**10:50 am** (50 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
5	**11:40 am** (20 mins)	**Key Performance Indicators for 2025** (N. Whitmore) • The Board is asked to consider approving the Key Performance Indicators for 2025	Decision (with motion)	Presentation at time of meeting
*	**12:00 pm** (60 mins)	**LUNCH** (Lunch available in the Dining Room)		
6	**1:00 pm** (10 mins)	**Board Chair's Report** (I. Preyra)	Discussion	N/A
7	**1:10 pm** (20 mins)	**Governance and Nominating Committee Report** (R. Gratton) • The Board receives updates from the October GNC meeting including an overview of the upcoming 2025 province-wide Board elections	Information	N/A

Item	Time	Topic and Objective(s)	Purpose	Page No.
8	**1:30 pm** (60 mins)	**Review Feedback and Discussion: Consent to Treatment Policy** (T. Terzis) • The Board reviews feedback received from the consultation process and discusses draft policy in small groups	Discussion	80-94
*	**2:30 pm** (20 mins)	**NUTRITION BREAK** (Refreshments available in the Members' Lounge)		
9	**2:50 pm** (10 mins)	**Proposed Rescission of the Cannabis for Medical Purposes Policy** (C. Brown) • The Board is asked to consider rescinding the Policy	Decision (with motion)	95-96
*	**3:00 pm**	**Motion to Move In-Camera**	Decision (with motion)	97
10	**3:00 pm** (50 mins)	**In-Camera Session**		Materials provided under separate cover
11	**3:50 pm**	**Adjournment Day 1** (I. Preyra)	N/A	N/A

FRIDAY, NOVEMBER 29, 2024

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING** (Breakfast available in the Dining Room)		
12	**9:00 am** (5 mins)	**Call to Order** (I. Preyra) • Note regrets and declare any conflicts of interest	Discussion	N/A
13	**9:05 am** (20 mins)	**2025 Draft Budget** (S. Califaretti, L. Ferguson) • The Board is asked to consider approving the 2025 Draft Budget	Decision (with Motion)	98-99
14	**9:25 am** (15 mins)	**Draft Policies for Consultation:** • The Board is asked to consider approving the draft policies to be released for external consultation		
		14.1 Accepting New Patients (C. Brown)	Decision (with motion)	100-107
		14.2 Ending the Physician-Patient Relationship (C. Brown)	Decision (with motion)	108-116
		14.3 Treatment of Self, Family Members and Others Close to You (T. Terzis)	Decision (with motion)	117-127
15	**9:40 am** (20 mins)	**Proposed Amendments: Boundary Violations policy** (T. Terzis) • The Board is asked to consider approving the proposed amendments to the policy	Decision (with motion)	128-137
16	**10:00 am** (20 mins)	**Revised Draft Policy for Final Approval: Reporting Requirements** (T. Terzis) • The Board is asked to consider approving the revised draft policy for final approval	Decision (with motion)	138-157
*	**10:20 am** (30 mins)	**NUTRITION BREAK** (Refreshments available in the Members' Lounge)		
17	**10:50 am** (10 mins)	**Minor Amendments: Professional Responsibilities in Medical Education and Social Media Policies** (C. Brown) • The Board is asked to consider approving minor amendments to the policies for final approval	Decision (with motion)	158-181
18	**11:00 am** (45 mins)	**Draft Policies for Circulation:** • The Board is asked to consider approving the draft policies for circulation		
		18.1 Alternative Pathways to Registration for Physicians Trained in the United States (S. Tulipano)	Decision (with motion)	182-186
		18.2 Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada (RCPSC) Practice Eligibility Route and Specialist Recognition Criteria in Ontario Policies (S. Tulipano)	Decision (with motion)	187-193

Item	Time	Topic and Objective(s)	Purpose	Page No.
19	**11:45 am** (15 mins)	**BOARD AWARD PRESENTATION** (I. Preyra) • Celebrate the achievements of Dr. John Rawlinson, Burlington		
*	**12:00 pm** (60 mins)	**LUNCH** (Lunch available in the Dining Room)		
20	**1:00 pm** (10 mins)	**By-law Amendments: Committee Appointments** (T. Terzis, C. Silver, M. Cooper) • The Board is asked to consider approving the proposed By-law amendments relating to changes to Committee Appointments	See note in item 23	194-197
21	**1:10 pm** (10 mins)	**By-law Amendments: Enable Physician Assistants (PAs) to be eligible to Stand for Election to the Board and Incorporating PAs into CPSO's Governance Structure** (T. Terzis, C. Silver, M. Cooper) • The Board is asked to consider approving the proposed By-law amendments to enable PAs to be eligible to stand for election to the Board	See note in item 23	198-204
22	**1:20 pm** (10 mins)	**By-law Amendment: Remuneration and Reimbursement, and Introduction of Operational Reimbursement Rules** (T. Terzis, S. Califaretti, C. Silver, M. Cooper) • The Board is asked to consider approving the proposed By-law amendments relating to remuneration and reimbursement • The Board is asked to rescind the Board policy entitled *Board and Committee Member Expense Reimbursement* • The Board is advised of the new operational *Board Director and Committee Member Remuneration and Expense Reimbursement Rules*	See note in item 23	205-211
23	**1:30 pm** (5 mins)	**By-law Amendments: Minor Housekeeping Changes** (T. Terzis, C. Silver, M. Cooper) • The Board is asked to consider approving the proposed minor housekeeping changes	Decision (with motions) Items 20, 21, 22 and 23 to be approved together in one motion	212-285
24	**1:35 pm** (5 mins)	**General By-law Revocation** (C. Silver, M. Cooper) • The Board is asked to consider revoking the General By-law	Decision (with motion)	286-291
25	**1:40 pm** (10 mins)	**By-law Amendments for Circulation: PA Register and Fees for Emergency Class Certificate of Registration** (C. Silver, M. Cooper, S. Tulipano, T. Terzis) • The Board is asked to approve for circulation the following proposed By-law amendments: 1. to reflect PA terminology in the register and member information By-laws; and 2. to state the fees for an emergency class of certificate of registration for PAs	Decision (with motion)	292-296

Item	Time	Topic and Objective(s)	Purpose	Page No.
26	**1:50 pm** (40 mins)	**Board Chair Items** (I. Preyra) 1. Acknowledge Outgoing Board Directors, Academic Directors and Representatives 2. Board Chair Address 3. Induction of New Board Chair 4. Welcome Incoming Board Directors	Information	N/A
27	**2:30 pm**	**Close Meeting - Day 2** (I. Preyra) • Reminder that the next meeting is scheduled on March 6 and 7, 2025	N/A	N/A
*	**2:30 pm**	**Meeting Reflection Session** (I. Preyra) • Share observations about the effectiveness of the meeting and engagement of Board Directors	Discussion	N/A

Attendees:

Dr. Baraa Achtar
Dr. Madhu Azad
Dr. Glen Bandiera
Dr. Faiq Bilal (Ph.D.)
Ms. Lucy Becker
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Mr. Markus de Domenico
Ms. Joan Fisk
Mr. Murthy Ghandikota
Dr. Robert Gratton
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Dr. Carys Massarella
Dr. Lydia Miljan (Ph.D.)
Dr. Rupa Patel
Mr. Rob Payne
Dr. Judith Plante
Dr. Ian Preyra
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Patrick Safieh
Mr. Fred Sherman
Ms. Anu Srivastava
Dr. Andrea Steen
Dr. Janet van Vlymen
Dr. Mitchell Whyne

Non-Voting Academic Representatives on the Board Present:

Dr. P. Andrea Lum
Dr. Karen Saperson
Dr. Katina Tzanetos

Regrets:
Mr. Stephen Bird
Dr. Deborah Robertson
Dr. Anne Walsh

Guests:
Dr. Susan McNair, Board Award Winner
Mr. Ed MacNeil, Board Award Winner Guest
Ms. Maggie MacNeil, Board Award Winner Guest
Ms. Clara MacNeil, Board Award Winner Guest
Ms. Deanna Williams, Dundee Consulting Group Ltd. *(partial attendance)*
Mr. Rooz Takhavorie - BDO *(partial attendance)*
Ms. Bahiny Sivapathasundaram – BDO *(partial attendance)*

1. Call to Order and Welcoming Remarks

I. Preyra, Board Chair, called the meeting to order at 9:00 am. The Board Chair welcomed Board Directors, invited guests and staff to the Board meeting and acknowledged members of the public in attendance.

L. Robbins, Board Director, provided the land acknowledgment as a demonstration of recognition and respect for the Indigenous peoples of Canada.

The Board Chair noted meeting regrets.

Conflicts of interest were noted for all Academic Directors and Representatives regarding item 13 Appointment of Academic Directors for 2024/25.

2. Consent Agenda

I. Preyra provided an overview of the items listed on the Consent Agenda for approval. He noted that the in-camera session will be shortened by 20 minutes and that time will be allocated to item 15 Demonstration of the new Physician Register.

01-B-09-2024 – For Approval – Consent Agenda

The following motion was moved by L. Miljan, seconded by F. Bilal and carried, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves items 2.1 to 2.4 outlined in the consent agenda, which include in their entirety:

2.1 The Board meeting agenda for September 6, 2024, as amended;
2.2 The draft minutes from the Board meeting held on May 30 and 31, 2024;
2.3 2024 Committee Appointments/Re-Appointments and Exceptional Circumstances

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following individuals to the following Committees effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024 and expiring at the close of the AOM of the Board of Directors in 2025.

Committee	Member Name
Patient Relations	Carol King
Finance and Audit	Sarah Reid
Inquiries, Complaints and Reports	Anu Srivastava

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

The Board of Directors approves the application of the exceptional circumstances[2] clause in Section 7.6.8 of the CPSO By-laws in respect of Dr. Tina Tao when her term limit for the Quality Assurance Committee expires on July 26, 2025.

The Board of Directors of the College of Physicians and Surgeons of Ontario re-appoints the following individuals to the committees listed below effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board of Directors in 2025.

Committee	Member Names
Finance and Audit	Murthy Ghandikota
	Rob Payne
Inquiries, Complaints and Reports	Olufemi Ajani
	Amie Cullimore
	Christopher Hillis
	Asif Kazmi
	Robert Myers
	Wayne Nates
	Jude Obomighie
	Fred Sherman
	Kuppuswami Shivakumar
	Andrew Stratford
	Michael Wan
OPSDT & Fitness to Practise	Madhu Azad
	Lucy Becker
	Marie-Pierre Carpentier
	Jose Cordeiro
	Rupa Patel
	Rob Payne
	Linda Robbins
Premises Inspection	Olubimpe Ayeni
	Richard Bowry
	Hae Mi Lee
	Winnie Leung
	Colin McCartney
	Wusun Paek
	Chris Perkes
	Kashif Pirzada
	Suraj Sharma
	Catherine Smyth
	Michael Wan

[2] Exceptional Circumstances requested. Dr. Tao's QAC term limit expires July 26, 2025. Due to her experience and important contributions, Exceptional Circumstances are requested to allow Dr. Tao to serve an additional one-year term, rather than a brief term ending in July 2025.

Quality Assurance	Mohammad Keshoofy
	Charles Knapp
	Ken Lee
	Ashraf Sefin
	Astrid Sjodin
	Tina Tao[3]
Registration	Bruce Fage
	Murthy Ghandikota
	Edith Linkenheil
	Paul Malette
	Judith Plante

2.4 Chair and Vice-Chair Appointments

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board of Directors in 2025.

Committee	**Role**	**Member Name**
Registration	Chair	Edith Linkenheil
	Vice-Chair	Bruce Fage
Quality Assurance	Chair	Ashraf Sefin
Inquiries, Complaints, and Reports	Chair	Jane Lougheed
	Vice-Chair	Jude Obomighie
Finance and Audit	Chair	Rob Payne

CARRIED

3. For Information

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

3.1 Executive Committee Report
3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
3.3 Government Relations Report
3.4 Policy Report
3.5 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)
3.6 Update on Board Action Items
3.7 2025 Q2 Meeting Dates

[3]Pursuant to application of Exceptional Circumstances to extend beyond Dr. Tao's term limit, as noted above.

4. Chief Executive Officer/Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar, presented her report to the Board. She noted that registration for Physician Assistants opens in January 2025 and regulations will come into force on April 1, 2025.

She provided an update on the 2024 key performance indicators, targets, and metrics. An update was provided on the Practice Ready Ontario program noting that the program is accepting applications for the next cohort. It was noted that the 2024 Annual Renewal had been completed. Statistics from this year's data were shared.

An overview of the following departments and programs was provided:

- Registration and Membership Services;
- Quality Improvement and Quality Assurance Programs;
- Accreditation;
- Investigations;
- Ontario Physicians and Surgeons Discipline Tribunal (OPSDT);
- Policy/Government Relations

An overview was provided on the current policy approval process. A new approach was proposed whereby the Board pilots a simplified approval process when releasing policies for consultation and provides the Board with an opportunity to have a discussion and provide feedback once the draft policy has been released for consultation and prior to final approval of the policy. Following discussion, the Board agreed to trial this new process.

Updates were shared on stakeholder collaboration, the new Dialogue platform, the Public Register Rebuild set to launch on October 16, and the 2024 By-law Implementation Timeline. S. Klejman and her team were recognized for their work on the CIO Award-Winning Data Lake Project. Highlights from the Employee Pulse Survey, noting a 98 percent response rate, were shared. Other recent staff engagement activities were highlighted.

5. Board Chair Report

I. Preyra, Board Chair, presented his report to the Board and reflected on the accomplishments made in governance modernization over the past year. He acknowledged the Senior Leadership Team and the Board for their work in this space. The individual Board Directors' performance evaluation process was introduced, and Directors are requested to participate on a voluntary basis in this important process, which will be led by D. Williams.

6. Draft Policy for Consultation: Consent to Treatment

T. Terzis, Manager, Policy, provided a brief overview regarding the Consent to Treatment policy, noting that the draft policy is being brought forward to the Board for approval to release the draft for consultation. The new pilot approach, as highlighted in the CEO/Registrar Report, will be trialed for this draft policy. The draft will be released for consultation. At the next Board meeting, the Board will be advised of the key consultation feedback and will have an opportunity

to provide feedback on the draft.

02-B-09-2024 – Draft Policy for Consultation: Consent to Treatment

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

The Board of Directors[4] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "Consent to Treatment," (a copy of which forms Appendix "A" to the minutes of this meeting).

CARRIED

7. Revised Draft for Final Approval: Essentials of Medical Professionalism

K. Saperson, Policy Working Group Chair and Academic Representative and T. Terzis, Manager, Policy, provided an overview of the revised draft Essentials of Medical Professionalism, currently titled "Practice Guide". Feedback from the consultation, and key updates made to the document arising from the consultation, were shared with the Board, including the removal of contentious buzzwords and jargon. The Board provided feedback and concerns were raised on certain language used in the document. Following a fulsome discussion, the Board voted on the motion to approve the revised draft policy.

03-B-09-2024 – Revised Policy for Final Approval: Essentials of Medical Professionalism

The following motion was moved by R. Kirkpatrick, seconded by L. Becker and carried, that:

The Board of Directors[5] of the College of Physicians and Surgeons of Ontario approves the revised policy "*Essentials of Medical Professionalism*," formerly titled "*Practice Guide*," as a policy of the College (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

8. Revised Draft for Final Approval: Professional Behaviour

K. Saperson, Policy Working Group Chair and Academic Representative and T. Terzis, Manager, Policy, provided an overview of the revised draft Professional Behaviour policy, currently titled "Physician Behaviour in the Professional Environment". Key changes were highlighted and feedback from the consultation was shared with the Board. Following discussion, the Board expressed support to approve the revised draft policy.

04-B-09-2024 – Revised Policy for Final Approval: Professional Behaviour

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

[4] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.
[5] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

The Board of Directors[6] of the College of Physicians and Surgeons of Ontario approves the revised policy *"Professional Behaviour,"* formerly titled *"Physician Behaviour in the Professional Environment,"* as a policy of the College (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

9. Revised Draft for Final Approval: Infection Prevention and Control for Clinical Office Practice

M. Azad, Policy Working Group Member and Board Director and T. Terzis, Manager, Policy, provided an overview of the new policy, Infection Prevention and Control for Clinical Office Practice. Feedback from the consultation was shared with the Board. The Board provided feedback on the revised draft and requested that additional expectations be added to the policy around the use of multidose vials and the sterilization process. Following discussion, the Board expressed support for having the policy approved as a policy of the College, with the requested amendments to be made.

05-B-09-2024 – New Policy for Final Approval: Infection Prevention and Control for Clinical Office Practice

The following motion was moved by L. Marks de Chabris, seconded by R. Patel and carried, that:

The Board of Directors[7] of the College of Physicians and Surgeons of Ontario approves the new policy *"Infection Prevention and Control for Clinical Office Practice,"* as amended, as a policy of the College (a copy of which forms Appendix "D" to the minutes of this meeting).

CARRIED

Item 11 Board Award Presentation moved up to facilitate flow.

11. Board Award Presentation

L. Miljan, Board Director, presented the Board Award to Dr. Susan McNair of London. Dr. McNair was recognized as a leader in family medicine and for working with vulnerable patients through her work as the Medical Director of the Regional Sexual Assault and Domestic Violence Treatment Centre at St. Joseph's Hospital in London. In addition, Dr. McNair is a co-Medical Advisor to the Ontario Network of Sexual Assault and Domestic Violence Treatment Centres. She continues her work as a clinician, educator and researcher to transform how physicians treat and interact with these patients.

[6] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.
[7] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

10. Code of Conduct and Declaration of Adherence and Board Policies

C. Allan, Director of Governance provided an overview of the changes made to the Code of Conduct and Declaration of Adherence and Board Policies. The Board asked questions about the use of CPSO laptops for CPSO work as well as conflicts of interest. Following discussion, the Board was asked to approve the revised documents as outlined in the briefing materials.

06-B-09-2024 – For Approval: Code of Conduct and Declaration of Adherence

The following motion was moved by L. Miljan, seconded by A. Srivastava and carried, that:

The Board of Directors[8] of the College of Physicians and Surgeons of Ontario approves the revised Declaration of Adherence and Code of Conduct, (a copy of which forms Appendix "E" to the minutes of this meeting).

CARRIED

07-B-09-2024 – For Approval: Board Policies

The following motion was moved by P. Safieh, seconded by M. Ghandikota and carried, that:

The Board of Directors[9] of the College of Physicians and Surgeons of Ontario approves the revised "Conflict of Interest Policy", "Impartiality in Decision-Making Policy" and "Confidentiality Policy", (copies of which form Appendices "F", "G" and "H" to the minutes of this meeting).

CARRIED

12. Governance and Nominating Committee Report

R. Gratton, Chair of the Governance and Nominating Committee (GNC), provided the Governance Report, providing an update on the items from the July 30, 2024 GNC meeting including an overview of the education plan, Chair/Vice-Chair training and approving changes to the CPSO's Governance Orientation to align with the new CPSO By-laws.

12.1 Approval of the 2025 province-wide election date

An overview was provided on the 2025 province-wide election plan for the upcoming Board elections noting that the timeline in the package aligns with the requirements as set out in the CPSO By-laws and considers operational requirements and the election timelines of other organizations. There was discussion on promoting the Board election given that this is the first year that the College is holding a province-wide election with competency-based selection.

08-B-09-2024 – For Approval: 2025 Election Date

The following motion was moved by C. Massarella, seconded by L. Becker and carried, that:

[8] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.
[9] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

The Board of Directors[10] of the College of Physicians and Surgeons of Ontario approves the 2025 Board election date set out below:

April 25, 2025

CARRIED

12.2 Governance and Nominating Committee Elections

R. Gratton, Chair of the Governance and Nominating Committee (GNC) and Board Director provided an overview of the process for the Governance and Nominating Committee elections, noting that the appointments will become effective as of the conclusion of the November 2024 Annual Organizational Meeting of the Board. Nomination statements for GNC positions have been received from the following individuals; it was noted that Mr. Stephen Bird has since withdrawn his nomination statement:

Dr. Madhu Azad, for Physician Director
Dr. Ian Preyra, Physician Director
Ms. Lucy Becker, for Public Director
Mr. Markus de Domenico, Public Director
Mr. Rob Payne, Public Director

Each of the nominees addressed the Board prior to the election including the incoming Chair of the GNC, Dr. Patrick Safieh. The two GNC positions for Physician Directors were acclaimed. An election for the two GNC positions for Public Directors was held using the electronic voting software (ElectionBuddy). Ms. Lucy Becker and Mr. Rob Payne were elected for the two GNC Public Director positions.

09-B-09-2024 – For Approval: Governance and Nominating Committee (GNC) Elections

The following motion was moved by M. de Domenico, seconded by L. Marks de Chabris and carried, that:

The Board of Directors[11] of the College of Physicians and Surgeons of Ontario appoints

Dr. Patrick Safieh (as GNC Chair),

Dr. Madhu Azad (as Physician Director, GNC member),

Dr. Ian Preyra (as Physician Director, GNC member),

Ms. Lucy Becker (as Public Director, GNC member),

Mr. Rob Payne (as Public Director, GNC member)

[10] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.
[11] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

to the Governance and Nominating Committee for the year that commences with the close of the Annual Organizational Meeting of the Board in 2024.

CARRIED

Due to a conflict of interest, the following Academic Directors and Representatives departed the meeting: M. Carpentier, R. Kirkpatrick, J. van Vlymen, P. Lum, K. Saperson, K. Tzanetos.

13 Appointment of Academic Directors for 2024/25

13.1 Selection Process for the Appointment of Academic Directors

R. Gratton, Chair of the GNC and Board Director, and D. Williams, Governance Consultant, provided an overview of the Selection Process for the appointment of Academic Directors, highlighting that it was a fair and transparent process, using a rating scale to rate each candidate. The Board asked questions regarding the process and the recommendation. It was noted that the GNC is responsible for vetting and recommending candidates to the Board for appointment. The Board was asked to approve the GNC's recommendation to appoint the selected Academic Director nominees for 2024/25.

13.2 Appointment of Academic Directors for 2024/25

10-B-09-2024 – For Approval: Appointment of Academic Directors for 2024/25

The following motion was moved by L. Miljan, seconded by M. Ghandikota and carried, that:

The Board of Directors[12] of the College of Physicians and Surgeons of Ontario selects and appoints Dr. Katina Tzanetos and Dr. Janet van Vlymen for a one-year term as Academic Directors for 2024/25 commencing as of the close of the Annual Organizational Meeting of the Board in 2024 and expiring at the close of the Annual Organizational Meeting of the Board in 2025.

CARRIED

The following Academic Directors and Representatives rejoined the meeting: M. Carpentier, R. Kirkpatrick, J. van Vlymen, P. Lum, K. Saperson, and K. Tzanetos.

Motion to Go In-Camera

The following motion was moved by L. Marks de Chabris, seconded by P. Malette and carried, that:

[12] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

11-B-09-2024 – Motion to Go In-Camera

The Board of Directors[13] of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(d) personnel matters or property acquisitions will be discussed.

CARRIED

14 In-Camera Session

The Board of Directors of the College of Physicians and Surgeons of Ontario entered into an in-camera session at 2:20 pm and returned to the open session at 3:00 pm.

15. Demonstration of the new Physician Register

Mr. Rooz Takhavorie and Ms. Bahiny Sivapathasundaram from BDO provided a demonstration of the new Physician Register. The Board had an opportunity to ask questions.

16. Update on Quality Improvement (QI) Enhanced Data and Age Eligibility Expansion

A. Jacobs, Director, Quality Programs & Accreditation, provided an overview of the proposed expansion of Quality Improvement Enhanced Program from 70-74 years of age to include Physicians Aged 75-79 Years of Age. An overview of the QI data was presented that showcased age-stratified peer assessment and QI Enhanced outcomes from 2020 to 2024. The Quality Assurance Committee is recommending to the Board for approval, the proposed expansion of the QI Enhanced program eligibility to include physicians who are aged 70-79 and who have been selected for Quality Assurance Age-Targeted assessment.

[13] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

12-B-09-2024 – For Approval: Expansion of QI Enhanced Program

The following motion was moved by G. Bandiera, seconded by C. Lemieux and carried, that:

The Board of Directors[14] of the College of Physicians and Surgeons of Ontario approves the proposed expansion of age-eligibility for the Quality Improvement Enhanced Program to include physicians aged 75 to 79 years who are subject to a Quality Assurance Age-Targeted Peer Assessment.

CARRIED

17. Close Meeting

I. Preyra, Board Chair, closed the Board meeting at 3:47 pm. The next Board meeting is scheduled on November 28, 2024.

Board Chair

Recording Secretary

[14] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

Title:	Committee Appointments and Re-appointments (For Decision)
Main Contacts:	Caitlin Ferguson, Governance Coordinator Tanya Terzis, Manager, Policy & Governance
Attachments:	**Appendix A:** Dr. Virginia Roth, Bio **Appendix B:** Dr. Katina Tzanetos, Bio **Appendix C:** Dr. Camille Lemieux, Bio **Appendix D:** Ms. Jay Sengupta, Bio **Appendix E:** Dr. Gina Neto, Bio
Question for Board:	Does the Board of Directors (Board) wish to appoint the individuals as laid out in this Briefing Note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is asked to make several new committee appointments and one re-appointment.
- Ensuring that CPSO committees have qualified and diverse members allows the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.

Current Status and Analysis

- The term of appointment for all candidates listed below will be one year, starting upon the close of the 2024 Annual Organizational Meeting (AOM) until the close of the following AOM.

OPSDT Re-appointment

- Dr. Janet van Vlymen was first appointed to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) and the Fitness to Practise Committee (FTP) in December 2022.
- Following her appointment as an Academic Director for a one-year term at the September 2024 Board meeting, the OPSDT and FTP wish to have Dr. van Vlymen re-appointed.

New OPSDT Appointments

- The OPSDT and FTP recommend the appointment of three Directors. Dr. Katina Tzanetos is an Academic Director, and Dr. Virginia Roth and Dr. Camille Lemieux are Physician Directors. Please see (**Appendices A through C**) for brief bios of each candidate.
- The OPSDT and FTP recommend the appointment of Ms. Jay Sengupta in the role of an adjudicator. As part of a competitive process for experienced adjudicator positions in 2021, Ms. Sengupta was identified to be recommended for appointment by the current Committee Chair, Committee support staff, and a 2021 interview panel. Please see (**Appendix D**) for Ms. Sengupta's bio.

Quality Assurance Committee

- Interviews have been completed to fill one vacancy for a physician member of the Quality Assurance Committee (QAC). Feedback has been received from the current Committee Vice-Chair, Committee support staff, and one reference for the candidate.
- The Executive Committee recommends appointing Dr. Gina Neto (pediatrician) to the QAC. Please see (**Appendix E**) for Dr. Neto's bio.

Appendix A: Dr. Virginia Roth

Dr. Roth, an infectious diseases specialist, will start her first term as a CPSO Board Director at the November meeting. She is Chief of Staff at The Ottawa Hospital and a Professor of Medicine at the University of Ottawa.

After completing her Internal Medicine and Infectious Diseases training at the University of Ottawa, Dr. Roth joined the U.S. Centers for Disease Control and Prevention (CDC) as an Epidemic Intelligence Service Officer with the Hospital Infections Program. She has held various leadership positions at The Ottawa Hospital since being recruited in 2000 as Director of Infection Prevention and Control. She completed an executive MBA at Telfer School of Management in 2012.

Dr. Roth's clinical work focuses on the care of patients with tuberculosis. Her research interests include healthcare leadership, patient experience, and healthcare-acquired infections and she has published over 80 peer-reviewed articles.

Appendix B: Dr. Katina Tzanetos

I am very happy to be here. Thank you for this opportunity to work with all of you and to share a little about myself. I am a general internist, working out of St. Michael's Hospital here in Toronto, since 2021. Before 2021 and for most of my career, I worked at University Health Network, both at the Toronto General and the Toronto Western Hospital sites. While I enjoyed my work at UHN very much, a combination of factors, namely COVID and an upcoming milestone birthday caused me to reflect on my career and nudged me to make a change. I chose SMH for the opportunity it provides to care for a different patient population, a vulnerable population - those affected by a lack of housing, and who are afflicted with substance misuse and comorbid medical and psychiatric illness. I am not a risk taker, at all, and so this was a big move for me. I have to say, it was the right decision. I have really enjoyed my transition. While it still all feels somewhat new, I love the patients at St. Mike's, the caring ethos of the hospital, and I am learning a lot and challenging myself in new ways clinically. As part of my move over to SMH, some of my non-clinical roles also changed. I've been lucky enough over the past 2 years to lead the creation of a fellowship in Hospital Medicine at Unity Health and with that, I have come to know a lot more International Medical Graduates and the challenges they face and this work led to a few discussions with representatives from CPSO as I tried to navigate and understand the licensing landscape. I received much support from the CPSO, and that experience spurred my interest in getting involved with the Board.

On a further personal level, I will share that I have two daughters, Alexandra and Genna, and a partner named Nick. Alexandra is in fourth year at Laurier studying Health Science and Genna is in grade 12 and applying to university, likely to study mathematics. My husband Nick has been a stay-at-home dad for many years, and a huge source of support for me and the girls. We also have a dog named Oliver, a mini-Labradoodle who we adopted to be the girls' dog 8 years ago, but he is really my dog, and the love of my life. He is my first pet ever, and I never could have imagined the joy a dog can bring to your life before I experienced him.

In our spare time as a family, we like to travel, and we often go to Greece, which is where both Nick and my parents are from. If any of you are contemplating visiting there, you definitely should, and I'd be happy to chat with any of you about all the amazing places to visit.

Finally, I just want to say thank you again for having me. As a physician, I really value the privilege of self-governance and I believe in the work of the CPSO and it's an honor to be here. I am excited to learn from all of you, to hopefully contribute an academic lens to our discussions and decisions, and to work closely together and get to know each other more.

Appendix C: Dr. Camille Lemieux

Dr. Camille Lemieux, a family medicine physician, is currently serving her second term as a CPSO Board Director. She has also been a member of the CPSO's Quality Assurance Committee since 2021, and was previously a member of the Policy Working Group from 2021 to 2023.

Dr. Lemieux completed her pharmacy training at the University of Toronto, law school at the University of Ottawa, medical school at Queen's University, and her Master of Public Health in Epidemiology at the Dalla Lana School of Public Health. She currently practises in Toronto, with the Toronto Western Family Health Team, where she holds the role of Department Head and is also a member of the Board of Directors.

Dr. Lemieux has several other leadership and administrative roles, including Chief Family Physician-in-Chief and Associate Director of Infection Prevention and Control at the University Health Network (UHN), co-chair of the Public Health Ontario Antimicrobial Stewardship Advisory Committee, and membership on the UHN's Medical Advisory Committee and Quality of Care Committee. Dr. Lemieux is also an Assistant Professor in the Department of Family and Community Medicine at the University of Toronto.

Appendix D: Ms. Jay Sengupta

Jay Sengupta is a mediator and adjudicator who has been a neutral for over 15 years. In addition to her private dispute resolution practice, she holds appointments with the Law Society Tribunal, the Public Service Grievance Board (PSGB), the Canada Industrial Relations Board (CIRB external adjudicator roster), the Canadian Human Rights Tribunal (CHRT), the NWT Human Rights Adjudication Panel (HRAP) and the inaugural discipline committee of the College of Patent Agents & Trademark Agents (CPATA).

Prior to launching her private mediation and arbitration practice, Jay served as a full-time Vice-chair with the Human Rights Tribunal of Ontario (HRTO) for 10 years, where she was cross appointed to the Child and Family Services Review Board (CFSRB), the Custody Review Board (CRB) and the Special Education Tribunal (OSET).

Jay began her career as a lawyer in Ontario's community legal clinic movement, where she represented people living in poverty, trained and mentored law students and contributed to community development and law reform initiatives to increase access to justice for marginalized and impoverished communities.

Appendix E: Dr. Gina Neto

Dr. Gina Neto is a Pediatric Emergency Medicine Physician at CHEO in Ottawa. She has been the Medical Director and Chief of the Division of Emergency Medicine since 2016. She is an Associate Professor in Pediatrics and Emergency Medicine at the University of Ottawa. Dr. Neto completed her medical degree and pediatrics residency at the University of Manitoba in Winnipeg in 1997 and her pediatric emergency medicine fellowship at the University of Ottawa in 2000, at which time she joined the staff in the Division of Emergency Medicine at CHEO. She was the Pediatric Emergency Medicine Specialty program director at the University of Ottawa from 2001-2010 and the Chair of the Pediatric Emergency Medicine Specialty Committee at the Royal College of Physicians and Surgeons of Canada from 2012-2018. Throughout her career she has been dedicated to medical education, patient safety and improving quality of care.

NOVEMBER 2024

Title:	Committee Chair and Vice-Chair Appointments (For Decision)
Main Contacts:	Caitlin Ferguson, Governance Coordinator Tanya Terzis, Manager, Policy & Governance
Question for Board:	Does the Board of Directors (Board) wish to appoint the individuals as laid out in this Briefing Note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board is asked to appoint several Committee Chairs and Vice-Chairs.
- Ensuring that CPSO committees are led by qualified members will enable the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.

Current Status and Analysis

- The Committees listed in the table below have Chairs and/or Vice-Chairs whose leadership term expires at the close of the 2024 Annual Organizational Meeting (AOM).
- The Governance Office canvassed Committee leadership and Committee support staff regarding leadership succession planning. Leadership candidates have confirmed their willingness to take on the proposed role.
- With the exception of Dr. Tina Tao, Governance staff have verified that the candidates are eligible to serve the suggested term without exceeding their committee, or overall, term limit per By-laws.
    - Dr. Tina Tao's committee term limit for the Quality Assurance Committee (QAC) falls on July 26, 2025, but Exceptional Circumstances have already been approved by the Board, at their September 2024 meeting, to allow her to serve as a member of the QAC until the close of the 2025 AOM.
    - The QAC underwent a major restructuring in 2021, with many new members being appointed. Dr. Tao is currently the longest-serving member of the QAC, and her knowledge and experience are valuable to the committee's functioning.
    - The current QAC Chair, Dr. Sarah Reid, is stepping down to serve as the Board Chair for 2024-2025. The QAC would like to have Dr. Tao appointed as Vice-Chair during this time, to mentor potential leaders before departing the committee.
    - The QAC may request an additional year of Exceptional Circumstances to allow Dr. Tao to serve as Chair for 2025-2026, but further succession planning must be done before this decision is made.
- The following candidates are recommended for one-year appointments, starting at the close of the 2024 AOM until the close of the following AOM:

Committee	Position	Name
Premises Inspection Committee	Chair	Dr. Patrick Davison
	Vice-Chair	Dr. Hae Mi Lee
Quality Assurance Committee	Vice-Chair	Dr. Tina Tao

Board Motion

Motion Title	For Approval: Consent Agenda
Date of Meeting	November 28, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves items 2.1 to 2.4 outlined in the consent agenda, which include in their entirety:

2.1 The Board meeting agenda for November 28 and 29, 2024;

2.2 The draft minutes from the Board meeting held on September 6, 2024;

2.3 Committee Appointments for 2024/25

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints / re-appoints the following individuals to the following Committees effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024, and expiring at the close of the AOM of the Board in 2025.

Committee	Member Name
Ontario Physicians and Surgeons Discipline Tribunal	Janet van Vlymen (re-appointment)
	Camille Lemieux
	Virginia Roth
	Katina Tzanetos
Fitness to Practise	Janet van Vlymen (re-appointment)
	Camille Lemieux
	Virginia Roth
	Katina Tzanetos
Quality Assurance	Gina Neto

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

2.4 2024 Chair/Vice-Chair Committee Re-appointments

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board in 2025.

Committee	Position	Name
Premises Inspection	Chair	Dr. Patrick Davison
	Vice-Chair	Dr. Hae Mi Lee
Quality Assurance	Vice-Chair	Dr. Tina Tao

NOVEMBER 2024

Title:	Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | August 21, 2024 – November 8, 2024 (For Information)
Main Contact:	Dionne Woodward, Tribunal Counsel

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- This report summarizes reasons for decision released between August 21, 2024 – November 8, 2024 by the Ontario Physicians and Surgeons Discipline Tribunal. It includes reasons on discipline hearings (liability and/or penalty), costs hearings, motions and case management issues brought before the Tribunal.

Current Status & Analysis

In the period reported, the Tribunal released 4 reasons for decision:

- 2 reasons on findings (liability) and penalty
- 2 set of reasons on a motion

Findings

Liability findings included:

- 2 findings of disgraceful, dishonorable or unprofessional conduct
- 1 finding of conduct unbecoming a physician

Penalty

Penalty orders included:

- 2 reprimands
- 2 suspensions
- 2 impositions of terms, conditions or limitations on the physician's Certificate of Registration

Costs

The Tribunal imposed a costs order on the physician in all penalty reasons, the highest of which was $6000.

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (August 21, 2024 to November 8, 2024)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Sexual Abuse	Contravened term, condition or limitation on certificate of registration	Disgraceful, Dishonourable or Unprofessional Conduct	Failed to maintain standard of practice	Other
2024 ONPSDT 24	Steinberg	Nov. 5, 2024			X		- Conduct unbecoming a physician
2024 ONPSDT 22	Salib	Oct. 21, 2024			X		

TABLE 2: TRIBUNAL DECISIONS – PENALTIES (August 21, 2024 to November 8, 2024)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Terms, Conditions or Limitations)	Length of suspension in months	Costs
2024 ONPSDT 24	Steinberg	Nov. 5, 2024	Reprimand, suspension, TCL	8 months	$6000
2024 ONPSDT 22	Salib	Oct. 21, 2024	Reprimand, suspension, TCL	2 months	$6000

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (August 21, 2024 to November 8, 2024)

Citation and hyperlink to published reasons	Physician(s)	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2024 ONPSDT 25	Khulbe	Nov. 1, 2024	The registrant's motion included two requests. The first, for an in-person hearing, was denied by the panel. The second request sought to redact health and other information filed in support of the motion. The panel denied this request except for a report filed by the College, which contained detailed information about the registrant's physical and mental health.	In denying the registrant's request for an in-person hearing, the panel found that the benefits of a remote hearing were not outweighed by the circumstances presented. Additionally, regarding the registrant's request to redact certain parts of the record on the remote hearing motion, the panel found that the risks to the public interest in privacy did not outweigh the negative effects of the requested redactions, except for a detailed medical report.
2024 ONPSDT 23	Kilian	August 13, 2024	The panel dismissed the registrants' motion to not have to share patient records requested during the College's investigation.	The panel concluded that the registrants' arguments for withholding records sought by the College — including asserting they had a constitutional right to privacy in their patients' records and alleged deficiencies in the wording of the order appointing investigators— lacked legal merit. Under s. 76 (3.1) of the Code, registrants must "co-operate fully with an investigator." The motion was dismissed.

NOVEMBER 2024

Title:	Government Relations Report (For Information)
Main Contact:	Heather Webb, Communications Manager (Interim) and Senior Government Relations Program Lead

Legislative Update

- The Legislature returned from summer recess on October 21. As it gears up for a likely spring election, government is making a number of campaign-style announcements, including hospital funding and fertility program funding.

Current Status and Analysis

- **Primary care**: Government continues its focus on primary care access with the appointment of Dr. Jane Philpott as Chair of the new Primary Care Action Team.
    - The Team's goal is to connect every person in Ontario to primary health care within five years, including through better service on weekends and after-hours, reducing administrative burden on family doctors and other primary care professionals, and improving connections to specialists and digital tools.
    - An associated announcement at the end of October stated that medical schools will be required to prioritize 95% of undergraduate seats for Ontario residents beginning in the fall of 2026. The "Learn and Stay" grant will also be expanded to include family medicine, so that funding will cover tuition and other direct educational costs in exchange for a term of service as a family physician in any community across Ontario.
- **Registration data**: CPSO continues to provide the Ministry of Health with data regarding the registration of new physicians. While the Ministry indicates that the purpose of the data is not to compare colleges against each other, CPSO is performing very well in its timelines for registration.
- **Involuntary Treatment:** Members of Ontario's Big City Mayors caucus have called on the provincial government to review whether involuntary treatment for individuals with mental health and addictions issues needs to be "strengthened". This follows a statement by the federal Conservative leader that he supports "mandatory, involuntary drug and psychiatric treatment" for incapable minors and prisoners.
- **Alberta Review**: The Premier of Alberta has pledged to review professional regulatory bodies, including the College of Physicians and Surgeons of Alberta, to limit their ability to regulate registrants' expression of personal views.
- **Public member update:** A new public member (Vincent Georgie) was appointed in October. Together with reappointments received for both Rob Payne and Joan Fisk, CPSO is in a good position with 14 public members. With four more public member terms concluding through the spring of 2025, CPSO is working with the Ministry and the Minister's Office to ensure that they are aware of CPSO's needs.

CPSO

Annual Committee Reports 2024

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Executive Committee
Annual Committee Report
2024

Committee Mandate

The Committee Mandate of the Executive Committee is set out in its Terms of Reference and can be found here: Executive Committee Terms of Reference.

Committee Members 2023-2024

Dr. Ian Preyra (Chair)
Dr. Sarah Reid (Vice-Chair)
Ms. Joan Fisk (Executive Committee Representative)
Dr. Robert Gratton (Executive Committee Representative)
Dr. Lydia Miljan Ph.D. (Executive Committee Representative)
Dr. Patrick Safieh (Executive Committee Representative)

The Committee would like to thank Dr. Ian Preyra, whose term is ending in 2024. Dr. Preyra's valuable contributions and commitment to the work of the Executive Committee are appreciated.

Key Accomplishments

The Executive Committee continues to monitor the key performance indicators (KPIs), as well as progress on the 2020-2027 Strategic Plan. KPIs are reported on at each Executive Committee meeting and at each Board of Directors (the "Board") meeting. The Executive Committee supported forwarding to the Board for approval the two-year extension of the CPSO's Strategic Plan to the end of 2027.

This year will be the last year that the CPSO will be holding its Board Awards. This selection process will be removed from the Executive Committee's mandate in 2025.

The Executive Committee supported a new approach to the way that the Board provides feedback on draft policies that are brought to the Board. This new approach will be trialed at the November Board meeting.

The Executive Committee reviewed and discussed several initiatives this year, including a number of Registration policies for circulation/approval as set out below:

- Amendments to O. Reg. 114/95, Part XI: the Out of Hospital Premises Regulation,
- Acceptable Qualifying Examinations and CFPC Without Examination directives;
- Alternative Pathways to Registration for Physicians Trained in the United States and Specialist Recognition Criteria in Ontario policies;
- Acceptable Qualifying Examinations policies;
- Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada Practice Eligibility Route and Specialist Recognition Criteria in Ontario (For Circulation – November Board Meeting);

- Alternative Pathways to Registration for Physicians Trained in the United States (For Circulation – November Board Meeting)

In addition, several By-law amendments were reviewed and forwarded to the Board for approval, including:

- Register By-laws: Post Graduate Training Information;
- Setting the effective date for Register and Member Information By-laws; and
- Setting the effective date for pending CPSO By-law provisions and putting into effect the Academic Directors provisions.

The Executive Committee also reviewed the following By-law amendments which will be going to the November Board meeting for approval/circulation, including those related to:

- Committee Appointments (for Approval);
- Enabling Physician Assistants (PAs) to be eligible to stand for election to the Board and incorporating PAs into CPSO's Governance Structure (for Approval);
- PA Register and Fees for Emergency Class Certificate of Registration (for Approval);
- Remuneration and Reimbursement (for Approval);
- General By-law Revocation (for Approval); and
- PA Register and Fees for Emergency Class Certificate of Registration (for Circulation).

The Executive Committee reviewed and discussed several policies prior to them being brought to the Board for approval, including:

- Infection Prevention and Control for Clinical Office Practice;
- Conflicts of Interest and Industry Relationships;
- Reporting Requirements;
- Essentials of Medical Professionalism; and
- Professional Behaviour.

The Executive Committee also reviewed and discussed the following policies that will be going to the November Board meeting for discussion/approval:

- Consent to Treatment (Draft for Discussion);
- Cannabis for Medical Purposes (Rescission for Approval);
- Boundary Violations (Amendments for Approval);
- Professional Responsibilities in Medical Education (Minor Amendments for Approval); and
- Social Media (Minor Amendments for Approval).

The Executive Committee also reviewed and discussed the following draft policies which will be brought to the Board for approval to release for consultation at its November meeting:

- Accepting New Patients;
- Ending the Physician-Patient Relationship; and
- Treatment of Self, Family Members and Others Close to You.

The Committee also reviewed and recommended to the Board the proposed expansion of the Quality Improvement Enhanced program to include physicians aged 75-79 years of age and changes to the Code of Conduct and Declaration of Adherence package amendments.

Find additional information about the Committee's activities in CPSO's 2023 College Performance Measurement Framework Report.

Looking Ahead to 2025

The Executive Committee will continue to build on this year's successes and bring this momentum into 2025. The following activities will be areas of focus for next year:

- Reviewing and providing feedback on the Plan-Do-Check-Act (PDCA) Cycles for the Province-wide Election Process;
- Monitoring the 2025 Key Performance Indicators; and
- Governance Modernization including working in collaboration with the Governance and Nominating Committee to implement the Board Director evaluation process.

Respectfully submitted,

Dr. Ian Preyra
Chair

Dr. Sarah Reid
Vice-Chair

Finance and Audit Committee
Annual Committee Report
2024

Committee Mandate

The Committee Mandate of the Finance and Audit Committee (FAC) is set out in its Terms of Reference and can be found here: Finance and Audit Committee Terms of Reference.

Committee Members 2023-2024

Dr. Thomas Bertoia (Chair)
Mr. Rob Payne (Vice-Chair)
Dr. Glen Bandiera (FAC Representative)
Mr. Murthy Ghandikota (FAC Representative)
Dr. Ian Preyra (FAC Representative)

The Committee would like to thank Dr. Thomas Bertoia, whose term is ending in 2024. We appreciate Dr. Bertoia's valuable contributions and commitment to the Committee's work.

Key Accomplishments

The FAC continues to review and report to the Board of Directors on the College's financial affairs and position.

The Committee reviewed and recommended to the Board at its May Annual Financial Meeting, the following items: Audited Financial Statements for the fiscal year ended December 31, 2023 and the Appointment of the Auditor for the 2024 fiscal year.

January 30, 2024 (Orientation)

- The Committee received a FAC Orientation and an overview of the Work Plan for 2024
- An update was provided on the new CPSO By-laws and its impact on the FAC. The Committee also reviewed and approved changes to its Terms of Reference
- HIROC representatives provided an overview of the College's insurance coverage
- The Committee reviewed the legacy defined benefit pension plan assets
- The Committee was presented with a forecast of the College's budget variance to year end, based on November, 2023 information

April 16, 2024 (Audit)

- Auditor's Report and Year-end Financial Statements – The Auditors provided a clean audit opinion on the College's financial statements for the 2023 year
- Audit Findings Report – The Auditors, Tinkham LLP presented their audit findings report which includes a number of recommendations to enhance the College's internal control environment
- The Committee recommended to the Board the appointment of Tinkham LLP as the auditor for the 2024 year

- The Committee reviewed the 2025 budget timeline and process and approved objectives to be presented to the Board related to the 2025 budget
- The Committee approved changes to the Membership of the Pension Committee

October 16, 2024

- The Committee was presented with a forecast of the College's 2024 budget variance to 2024 year-end, based on information as at August, 2024
- The College's external auditor presented the 2024 Audit Planning Letter and Engagement Letters for the College's financial statements and summary financial statements to be included in the College's annual report
- FAC approved the cessation of the financial audits of the College's legacy defined benefit and defined contribution pension plans, but will continue to oversee the filing of statutory reporting.
- The Committee was presented with the proposed 2025 Budget and approved a recommendation to the Board forwarding the 2025 Budget for approval

Find additional information about the Committee's activities in CPSO's 2023 College Performance Measurement Framework Report.

2025 Budget

The College is accountable for its operating and capital spending and regularly demonstrates fiscal accountability, optimal resource use, and the delivery of effective and efficient programs through detailed reports to the Finance and Audit Committee and the Board. The transformation that the College embarked on several years ago has allowed the College to provide better service and support to all our stakeholders.

Management is pleased to deliver a budget for 2025 that includes revenues of $87.7M and expenses of $87.6M, resulting in a small projected surplus of $64K, equal to .07% of total budgeted revenues and meeting not for profit balanced budget requirements. Management is also recommending that the independent practice membership fee of $1,725 be maintained for 2025, which has been consistent since 2018.

Looking Ahead to 2025

The FAC will continue to oversee the College's financial position and performance, to ensure the College has the financial resources required to meet its mandate and maintain a balanced budget, keeping any required fee increases to a minimum, minimizing actual surpluses and effectively managing reserves and investments. This will allow the FAC to fulfill its mandate to protect the public. The FAC will continue to build on this year's successes and carry this momentum into 2025.

Respectfully submitted,

Dr. Thomas Bertoia
Chair

Governance and Nominating Committee
Annual Committee Report
2024

Committee Mandate

The Committee Mandate of the Governance and Nominating Committee (GNC) is set out in its Terms of Reference and can be found here: Governance and Nominating Committee Terms of Reference.

Committee Members 2023-2024

Dr. Robert Gratton (Chair)
Dr. Madhu Azad (GNC Representative)
Mr. Rob Payne (GNC Representative)
Dr. Ian Preyra (GNC Representative)
Dr. Sarah Reid (GNC Representative)
Ms. Shannon Weber (GNC Representative)*

*Ms. Shannon Weber's term ended on August 12, 2024

The GNC would like to sincerely thank those members whose terms are ending in 2024. Your dedication, commitment, and contributions to the GNC has been valued and greatly appreciated. The GNC would also like to recognize Dr. Robert Gratton for his dedication and outstanding leadership in making tremendous advancements to many governance modernization initiatives.

Key Accomplishments

In 2024, the GNC continued building on successes from previous years and addressed opportunities for continuous improvement. Areas of focus included internal governance modernization, governance education, and implementation of good governance practices.

The GNC supported the By-law implementation by providing feedback on the Board Profile, including the Board Skills Self-Assessment and Competencies for Board Leadership Roles and Committee Members. The GNC also played a key role in the Academic Appointment and Selection process including recommending Academic Directors to the Board of Directors for the 2024-2025 Board year.

The GNC recommended a number of Public Director re-appointments to the Minister of Health. The Minister appointed three new Public Directors to the Board in 2024. The Governance Office continues to work with the Minister to advocate for new Public Director appointments to bring the slate up to 15.

Right-Touch Regulation

Modernizing and strengthening internal governance structures and processes that are outside the scope of legislation and regulation remains a key priority for CPSO.

Additional information about the GNC's activities can be found in CPSO's 2023 College Performance Measurement Framework Report.

Continuous Improvement

The GNC plays an instrumental role in designing education for Board and committee members. Each year, we make enhancements and recommendations.

The GNC worked with Ms. Deanna Williams, Governance Consultant, who delivered Governance Education Sessions to the Board, Committees and to the Chairs and Vice-Chairs of CPSO Committees. In April, a virtual education session was held for Board and Board Committee Members. This session focused on professional self-regulation, exploration of the public interest, good governance principles, fiduciary duties and why skills and competencies matter.

The GNC worked with the Governance Office to host two workshops for Committee Chairs and Vice-Chairs. We held the first session virtually in May and participants received information on the role and responsibilities of the Chair, with in-depth discussions on managing difficult situations, and the corresponding roles and responsibilities of CPSO Committee Support. Other topics included the challenges facing Chairs and the management of conflicts of interest from the Chair's perspective.

The second Chair/Vice-Chair session is planned for November 19, 2024 and will focus on applying emotional intelligence to leadership roles, emotionally intelligent relationship management for leaders, the dyadic relationship between Chairs and staff leaders, and creating a trusting environment for psychological safety between staff and Chairs or Vice-Chairs.

In addition, the GNC acting as the Governance Orientation Working Group reviewed and approved the Governance Orientation materials.

Other Continuous Improvement opportunities to enhance governance modernization include implementing one-page Briefing Notes, shortening Board packages by linking, instead of attaching, the appendices to the minutes, and moving committee appointments to the Consent Agenda.

Meaningful Engagement

The GNC continued to strengthen the Board elections process and promote the need for physicians with diverse and broad perspectives on the Board.

The GNC continues to develop and refine tools, resources, and processes to support Board and Committees in implementing good governance practices. For example:

- Identifying learnings from the Academic Director selection and appointment process to be applied to the 2025 Academic Director appointment process and province-wide elections; and
- Leading the development of a Board Profile that sets out desired competencies, skills and diversity attributes required for the College's Board to function effectively.

Looking Ahead to 2025

In 2024, the GNC has significantly advanced governance modernization initiatives including planning for the first province-wide elections.

Building on the success of 2024, the GNC will continue reviewing the internal mechanisms for ensuring good governance practices. The GNC will work with the Governance Office, and Governance Consultants to ensure the smooth transition to the CPSO's first province-wide election and will play a key role in reviewing and providing feedback on the Plan-Do-Check-Act (PDCA) Cycles for the Province-wide Election Process. The GNC will also support the implementation of the Individual Board Director performance evaluation process. The

GNC will work on the Board Inventory and Skills-Gap Analysis to inform the 2025 province-wide elections including working with external consultants.

The GNC will continue to enhance governance education and the importance of applying key learnings to our governance processes and structures.

Respectfully submitted,

Dr. Robert Gratton
Chair

Inquiries Complaints & Reports Committee
Annual Committee Report
2024

Committee Mandate

The Inquiries, Complaints and Reports Committee has jurisdiction over all CPSO investigations, of which there are three kinds: complaints investigations, Registrar's investigations and incapacity investigations. The Inquiries, Complaints and Reports Committee carries out its mandate, duties and powers in accordance with the HPPC and other applicable law (including administrative law).

The powers of the Inquiries, Complaints and Reports Committee with respect to investigations of complaints and Registrar's investigations include:

- approving the appointments of investigators [HPPC, s. 75(1)(a)];
- conducting investigations, including through staff to whom it may provide investigative direction.
- making interim orders directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration pursuant to s. 25.4(1) of the HPPC[1].
- reviewing and disposing of investigations, including as follows:
    - referring a specified allegation of a member's misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or the report [HPPC, s. 26(1)];
    - referring a member to a panel of the Inquiries, Complaints and Reports Committee under s. 58 of the HPPC for incapacity proceedings [HPPC, s. 26(1)].
    - requiring a member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned [HPPC, s. 26(1).
    - requiring a member to complete a specified continuing education or remediation program [HPPC, s. 26(3)].
    - taking action it considers appropriate that is not inconsistent with the RHPA, the HPPC, the regulations or by-laws (for example, directing undertakings). [HPPC, s. 26(1)]; and
    - taking no further action; and
- providing reasons when required in support of its decisions [HPPC, s. 27].

With respect to incapacity investigations, the powers of the Inquiries, Complaints and Reports Committee include:

- making inquiries it considers appropriate [HPPC, s. 59(1)];
- requiring the member to submit to physical or mental examinations [HPPC, s. 59(2)];
- referring a matter to the Fitness to Practise Committee [HPPC, s. 61]; and
- making interim orders directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration pursuant to s. 62(1) of the HPPC[2].

Committee Members

2023-2024
Dr. Kashif Ahmed
Dr. Olufemi Ajani
Dr. Trevor Bardell
Dr. George Beiko

Dr. Mary Jane Bell
Dr. Thomas Bertoia – ICRC Chair
Dr. Faiq Bilal, PhD – Board Director
Dr. Mark Broussenko
Dr. Paula Cleiman
Dr. Amie Cullimore
Dr. Thomas Faulds
Ms. Joan Fisk – Board Director
Mr. Murthy Ghandikota- Board Director
Dr. Daniel Greben
Dr. Elaine Herer
Dr. Christopher Hillis
Dr. Asif Kazmi
Dr. Samantha Kelleher
Dr. Lara Kent
Dr. Susan Lieff
Dr. Jane Lougheed - ICRC Vice Chair
Dr. Lydia Miljan, PhD – Board Director
Dr. Diane Meschino
Dr. Paul Miron
Dr. Richa Mittal
Dr. Robert Myers
Dr. Wayne Nates
Dr. Jude Obomighie
Dr. Anna Rozenberg
Dr. Karen Saperson
Dr. P. Gareth Seaward
Dr. Dori Seccareccia
Mr. Fred Sherman – Board Director
Dr. Kuppuswami Shivakumar
Dr. Andrew Stratford
Dr. David Tam
Dr. Shaul Tarek
Dr. Anne Walsh – Board Director
Dr. Michael Wan
Dr. Brian Watada

Three of these ICRC members, representing Family Medicine and Diagnostic Radiology, were new to the committee this year.

We would like to thank those members whose terms are ending in 2024. Their dedication, commitment, contribution to the ICRC and to the regulation of the profession has been greatly appreciated.

Key Accomplishments

Our ICRC Chair, Dr. Thomas Bertoia and our Vice Chair, Dr. Jane Lougheed continued their focus this year supporting the Committee in its decision-making through high-quality training and education.

In 2024, committee members received the following training and education sessions, based on trends and issues identified by ICRC and I&R leadership, panel members and staff:

Committee Training and Education

ICR Committee Training and/or Other Topics at Business Meetings:

- Quality Decision Making 2.0 – Pamela Chapman, Legal Educator & Consultant
    - Fast and Slow Thinking & Cognitive Error
        - Intuitive vs deliberative thinking
        - Common cognitive errors
        - Best Practices to encourage deliberation
    - Implicit Associations & Implicit Bias
        - Implicit associations
        - What is implicit bias & where does it come from?
        - Strategies to interrupt implicit bias
    - Noise in Decision-Making
        - Variability in human judgement
        - Impact in panel decision-making
        - The extended mind
        - Strategies to encourage consistency and fairness
- Policy Presentation – Tanya Terzis and Heather Webb
    - Regulation of Physician Assistants
- Interactive Case Conference Rounds – Facilitated by Dr. Ben Chen, Medical Advisor
- Right Touch principles of decision-making
- Walk Through of Investigations –Mark Bellefontaine, Investigations, Education and Training Lead
- Walk Through of Decision writing– Melina Laverty and Courtney Stewart, Decision Administrators
- Walk Through of Compliance Monitoring and Supervision –Ashley Elie, Compliance Team Lead
- Legal Updates on Reviews and Appeals –Sayran Sulevani, CPSO Legal Counsel

ICRC New Member Orientation and Training:

- ICRC Responsibilities and Introduction to Investigations and Resolutions
- Introduction to the RHPA
- ICRC Meeting Logistics
- Writing Committee Members' Notes and Decision Template
- Self-Regulation and Principles of Administrative Law
- Procedural Fairness and Deliberative Privilege
- Appointing Investigators S.75 Algorithm
- Legal Counsel's Role, Sexual Abuse Cases, and Referring to Discipline Tribunal
- Back to Basics ICRC Refresher
    - The role of ICRC as a Screening Committee
    - Duty to conduct an adequate investigation
    - Duty to conduct a fair investigation
    - The ICRC as an "expert" panel

The Committee's Frequently Asked Questions (FAQ) Reference Tool, addressing commonly asked legal, operational and committee process questions, continues to be updated as new topics and issues arise in our panel meetings or through other means.

Panel changes

In addition to Committee training and education, and in support of CPSO's focus on Right Touch Regulation and Continuous Improvement, some ICRC panel changes were implemented this year:

- A new panel was created for the administration of cautions, with ICRC members trained to address the unique needs of these panels. This panel has resulted in "just in time" caution scheduling, and consistent administration of this important remedial disposition.

- Streamlined panels to support timely listing of investigations using existing panel capacity. Three weekly panels (Teleconferences, Hybrid and Settlement) were reduced to two (Fast Track, Settlement), with updated criteria for listing to each.
- Additional small changes to the approach to panel scheduling have allowed for timelines from investigation completion to consideration by a panel to remain at under 30 days.

Leadership model

Lastly, our ICRC leadership model was evaluated this year to ensure that it continues to meet the needs of the Committee and the College. In doing so, we aligned our model with that of other Committees across the College. The ICRC now has an ICRC Chair and a Vice Chair and will no longer have Specialty Panel Chairs and Vice-Chairs, ensuring instead that we train additional ICRC members to chair individual panels (to be referred to collectively as 'panel chairs'). This new model has proven to be quite successful this year in building leadership capacity amongst the committee as a whole, and will be maintained as we move forward into 2025.

Looking Ahead to 2025

2025 will focus on leadership training as well as further supporting ICRC decision-making, including the application of right-touch principles.

Succession planning and recruitment of additional members to the Committee is also a priority, following the departure of several experienced ICRC members this year due to retirement or term completion. We continuously review and reflect on the needs of the committee for the future to ensure that these needs are met as we move forward.

Lastly, we will continue to identify ICRC members with leadership strengths to chair ICRC panel meetings.

Respectfully submitted,

Dr. Thomas Bertoia
ICRC Chair

Dr. Jane Lougheed
ICRC Vice-Chair

Ontario Physicians and Surgeons Discipline Tribunal

Annual Report

2024

Tribunal Mandate

The Ontario Physicians and Surgeons Discipline Tribunal[1] is a neutral, independent, administrative tribunal that adjudicates allegations of professional misconduct or incompetence of Ontario physicians referred to it by the College of Physicians and Surgeons of Ontario's Inquiries, Complaints and Reports Committee (ICRC). The Tribunal also hears applications brought by former members of the College for reinstatement of their certificate of registration.

The Tribunal is governed by the Health Professions Procedural Code (the Code) and other applicable law, including administrative law. The Tribunal is made up of physicians, non-physician members of the public and experienced adjudicators. The Tribunal manages cases from the point of ICRC referral or a member's reinstatement application forward. This involves conducting pre-hearing conferences, considering motions, holding hearings in a trial-like process on merits and penalty, then releasing orders and reasons for decisions.

The Code sets out that the Tribunal may determine whether a registrant has committed an act of professional misconduct and, if so, may make an order:

- directing the Registrar to revoke the registrant's certificate of registration
- directing the Registrar to suspend the registrant's certificate
- directing the Registrar to impose specified terms, conditions or limitations on the registrant's certificate
- requiring the registrant to appear before the panel to be reprimanded
- requiring the registrant to pay a fine to the Ministry of Finance
- requiring a registrant found to have committed sexual abuse to contribute to funding for therapy and counselling provided to the patient under the program required under section 85.7 of the Code

The Code provides that the Tribunal may determine whether a registrant is incompetent and, if so, make orders directing revocation or suspension of the member's certificate of registration, or imposing terms, conditions and limitations on it.

The Code also gives the Tribunal the power to impose costs orders that compensate for legal and other expenses.

[1] The Ontario Physicians and Surgeons Discipline Tribunal is the College of Physicians and Surgeons of Ontario's Discipline Committee established under the Health Professions Procedural Code.

Tribunal Members

2023 – 2024 Members

Mr. Raj Anand
Dr. Madhu Azad
Dr. Heather-Ann Badalato
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Stephen Bird (appointed April 2024)
Dr. Marie-Pierre Carpentier
Mr. Jose Cordeiro
Mr. Markus de Domenico (appointed February 2024)
Dr. Catherine Grenier
Dr. Stephen Hucker
Dr. Allan Kaplan
Ms. Shayne Kert
Ms. Sherry Liang
Ms. Sophie Martel
Dr. Veronica Mohr
Dr. Joanne Nicholson – Vice Chair
Dr. Rupa Patel
Mr. Rob Payne
Ms. Linda Robbins
Dr. Deborah Robertson
Ms. Jennifer Scott
Dr. Janet van Vlymen
Mr. David Wright – Chair
Dr. Susanna Yanivker

Departing Members and Effective Dates

Dr. Philip Berger (December 2023)
Dr. Michael Franklyn (December 2023)
Dr. Paul Hendry (December 2023)
Dr. Roy Kirkpatrick (November 2024)
Mr. Paul Malette (December 2023)
Mr. Peter Pielsticker (March 2024)
Dr. Ian Preyra (December 2023)
Dr. James Watters (November 2024)
Ms. Shannon Weber (August 2024)

Tribunal Modernization

The OPSDT was established in September 2021 as the identity of the CPSO's Discipline Committee. This name change, facilitated through an amendment to CPSO's General By-law, was part of a broader initiative to modernize and strengthen the discipline process and to more clearly define the Tribunal as independent of the CPSO.

In establishing a distinct identity, the Tribunal introduced new branding, including its own logo, website and mission and values statements. The CPSO Board appointed a full-time independent Tribunal Chair, with

expertise in tribunal leadership and transformation, to lead both Tribunal operations and adjudication. Further, five experienced adjudicators with strong hearing management and mediation skills were appointed to the Tribunal following a competitive, merit-based recruitment process. The experienced adjudicators chair hearing panels, conduct pre-hearing conferences and express the panel's views by preparing the first draft of written reasons for decision. In light of this internal expertise, the Tribunal no longer retains independent legal counsel to advise hearing panels, leading to significant cost savings.

2024: Key Achievements and Initiatives

This report highlights the Tribunal's key initiatives and achievements in 2024, focusing on improvements in decision release times, procedural updates, collaborative efforts through the Health Professions Discipline Tribunals Pilot (HPDTP), and forward-looking plans to support accessible, fair, and efficient hearings.

Continued Commitment to Timely Decision Release

In 2024, the Tribunal's experienced adjudicators drafted written reasons on behalf of the panel in 23 cases, including case management decisions, hearings on the merits and/or penalty and motions to address issues arising before or during a hearing. Written reasons continue to be drafted in a timely manner, with fewer needed edits. In 2024, 90% of written reasons were released within an average of 27 days, well exceeding the 84-day benchmark which was attained in every case.

In three uncontested cases, the panel delivered oral decisions on finding and penalty immediately following the hearing. This approach provided registrants, other hearing participants, and interested parties with the panel's reasons right away, eliminating the wait for a written decision and further enhancing the Tribunal's transparency and efficiency in timely decision release.

Implementing the Tribunal's Rules of Procedure and Associated Resources

In 2022, the Tribunal began a comprehensive overhaul of its Rules of Procedure, including updates to associated forms and practice directions. These revised Rules, which govern the procedures for parties appearing before the Tribunal, took effect on January 1, 2023.

Since then, the Tribunal has gained valuable experience applying these changes, enhancing efficiency and transparency for both the public and participants. For example, Rule 2 simplifies public and media access to Tribunal materials, streamlining processes. Rule 9 establishes a robust case management framework, promoting early case resolution and optimizing hearing time. Additionally, the Interim Practice Direction on Reprimands (effective January to June 2024) allowed the Tribunal to revisit its approach to discretionary reprimands, ensuring alignment with regulatory objectives. Each of these will be elaborated upon below to highlight their impact and application.

i. Rule 2: Adapting to Access Needs

Under the Tribunal's previous rules, members of the public had to file a motion to access documents in the Tribunal's record. This could be a time-consuming process. Following a 2018 Superior Court of Justice decision affirming that the "open court principle" applies to administrative tribunals, it was clear that while public access had always been a priority, more needed to be done to ensure that requests were fulfilled in a more timely way.

The new Rules eliminate the requirement for a member of the public to file a motion for access to documents that are part of the public record. To protect patient privacy, there is an automatic publication ban on patient

names or information that would identify patients. Documents containing personal or health information must be redacted by the submitting party prior to filing with the Tribunal.

Since January 2024, the Tribunal has processed 12 access requests from the public and media under the new Rule, with 90% of these requests fulfilled within one day. This responsiveness reflects our commitment to the Tribunal's core value of "Openness", ensuring transparency in decisions, hearings, and processes while balancing openness and privacy.

ii. Rule 9: Ensuring Fairness and Efficiency through Case Management

Since its transition to the new model, the Tribunal has employed an intensive case management approach. Case management conferences are held several times leading up to a hearing, ensuring a given case moves forward fairly, efficiently and in the public interest. Through the case management process, procedural and legal issues are identified early and adjournments are limited to exceptional circumstances.

Under Rule 9.5.2, the case management chair has authority to issue orders and directions to support fair and effective proceeding management, including scheduling, hearing and deciding pre-hearing motions. The Tribunal's application of this Rule is illustrated in *CPSO v. Kustka*, 2024 ONPSDT 23, where it dismissed requests by several of Dr. Kustka's patients to participate in the proceeding to assert privacy rights. The Tribunal relied on precedents from the Divisional Court and Court of Appeal, affirming that patients do not have a reasonable expectation of privacy over their medical records in College-related proceedings. This decision allowed the case to advance efficiently, avoiding revisiting issues already resolved in higher courts.

In another pre-hearing motion, *CPSO v. Khulbe*, 2024 ONPSDT 17, the Tribunal dismissed Dr. Khulbe's motion to halt proceedings for delay or, alternatively, to exclude evidence gathered from her electronic devices during the College's unannounced visit to her clinic. The Tribunal found that the investigators acted in compliance with the relevant statutory requirements, the Charter, and principles of fairness, and that the delay did not meet the threshold for abuse of process. This decision helped keep the case on track by resolving these issues effectively before the hearing.

In *CPSO v. Clottey*, 2024 ONPSDT 18, the Tribunal rejected a physician's motion to compel the College to call a witness and ruled on the admissibility of defence expert evidence to which the College objected. In dismissing the motion, the panel found that fairness could be ensured if the registrant called the witness, therefore there was no need for an order that the College or the Tribunal do so. The panel further found that probative value of the expert evidence outweighed the prejudicial effect. Again, addressing these matters in advance aimed to facilitate a fair and efficient hearing process.

These cases illustrate how the Tribunal's case management practices promote both fairness and efficiency by addressing procedural issues in advance, allowing hearings to remain focused on substantive matters and moving forward without unnecessary delays.

iii. Reassessing Reprimands: Aligning with Right-Touch Regulation

The Tribunal typically delivers reprimands orally at the end of the process, and the reprimand is posted on the public register along with the decision. Entirely written reprimands are issued in rare cases, such as when the member is not participating. While primarily directed at the registrant, reprimands also communicate the Tribunal's concerns to complainants, affected patients, other professionals, and the public. This is particularly impactful when delivered on the day of the hearing, providing immediate clarity before written reasons are issued.

Under an Interim Practice Direction effective from January to June 2024, the OPSDT signaled its commitment to refining its approach to discretionary reprimands, focusing on when they should be ordered and what they should encompass. The direction invited parties to make submissions on whether a reprimand should be ordered in each case and how it would support regulatory objectives.

During the interim period, OPSDT jurisprudence confirmed that reprimands serve multiple key purposes, with a reprimand ordered in each case. These purposes include deterring similar misconduct, offering direct communication between the panel and the registrant, shaping future behavior, and underscoring the seriousness of the misconduct. Importantly, reprimands are not intended to scold, shame, or humiliate. Rather, they aim to clearly convey the nature of the misconduct, why it was wrong, its gravity, and its impact. Where suitable, reprimands also stress the importance of rehabilitation and preventing future misconduct.

With the interim period concluded, the Tribunal reaffirmed its approach to discretionary reprimands, drawing on data and party submissions collected during the interim period. This approach reflects the principles of right-touch regulation, positioning reprimands as a focused and effective regulatory tool.

New Canvassing Approach Delivers Significant Benefits

In order to address recurring inefficiencies in relation to scheduling hearings, the Tribunal introduced a more streamlined case-specific approach. Previously, scheduling was done on a “worst-case scenario” basis, assuming hearings would be fully contested and setting dates early. This approach led to multiple rounds of canvassing, last-minute settlements or cancellations, unresolved preliminary issues and blocked dates that often went unused, delaying other scheduled hearings and holding Tribunal members’ time.

Case management conferences (CMCs) now play a more proactive role in identifying and addressing preliminary issues early, while also encouraging settlements whenever possible. With the insights gained from this approach, the Tribunal schedules hearings only when a settlement seems unlikely, significantly reducing unnecessary delays.

The Tribunal also reformed its canvassing process, requesting more available dates from the parties than needed, allowing for greater flexibility and reducing scheduling bottlenecks. Virtual hearings remain a key part of the Tribunal’s approach, providing additional flexibility and accessibility to participants, which enhances the efficiency of proceedings.

The results of these adjustments are evident: cancelled hearing dates have decreased and costs for adjudicator fees associated with cancelled hearings dropped by 80% between 2021 and 2023. Additionally, the average time from case opening to closure has improved considerably. These efforts demonstrate the Tribunal’s commitment to reducing delays and optimizing scheduling practices to better serve the public interest.

Leveraging Technology and Automating Processes

The Tribunal has enriched the information available on its website for current cases, now including details such as case type (e.g. conduct, reinstatement, application to vary) and the current stage of a case in the hearing process. This information is automatically populated from the Tribunal’s case management system, ensuring the public has access to the most up-to-date and relevant information.

Update on the Health Professions Discipline Tribunal Pilot

The HPDTP is a collaboration between the OPSDT and the Colleges of Audiologists and Speech-Language Pathologists, Massage Therapists and Registered Psychotherapists. The HPDTP colleges have adopted the OPSDT model, cross appointing the OPSDT chair and experienced adjudicators, while also sharing resources and aligning processes.

The HPDTP has delivered several benefits for the OPSDT including:

- ***Enhanced Independence*:** An identity tied not only to the medical profession highlights the Tribunal's independence from the CPSO.
- ***Reduced Costs*:** Shared educational programming and pooled resources reduce duplication and bring down costs, allowing OPSDT and the other HPDTP colleges to operate more cost-effectively while maintaining consistent, high-quality training. For the second year in a row, this November, OPSDT members will come together with members from other participating colleges for our annual conference: "*Sharing Knowledge, Building Momentum.*"
- ***Streamlined Processes*:** Shared Rules of Procedure, consolidated administrative and adjudicative processes, and a unified approach to training and development promote quality, efficiency, and transparency. For example, the OPSDT recently built on work done by the CMTO in retaining counsel to cross-examine sexual abuse complainants where the registrant is self-represented.

Current pilot colleges will decide in fall 2024 whether to continue, while new colleges are invited to join starting in 2025.

OPSDT Next Steps

Throughout 2024, the Tribunal has consistently evaluated and refined its processes to enhance efficiency, fairness, accessibility, and responsiveness for hearing participants and the public. This commitment to improvement will continue in the coming months, with the Tribunal set to:

- Launch a plain-language guide for self-represented litigants to explain Tribunal procedures and the hearing process in an accessible format, empowering registrants to represent themselves effectively.
- Establish the next phase of the HPDT model, welcoming new colleges to join and promoting shared efficiencies across participating health regulators through collective knowledge and economies of scale.
- Launch a plain-language guide for self-represented litigants to further explain Tribunal procedures and the hearing process in an accessible format, empowering registrants to represent themselves effectively.

The composition and leadership of the Fitness to Practise Committee is the same as that of the OPSDT. There was one case referred to the Fitness to Practise Committee in 2024. A pre-hearing conference was held and the matter was withdrawn.

Patient Relations Committee
Annual Committee Report
2024

Committee Mandate

The Patient Relations Committee is responsible for advising the Board of Directors on the CPSO's patient relations program. The College is required under the HPPC to have a patient relations program which includes measures for preventing and dealing with sexual abuse of patients, including:

- educational requirements for members;
- guidelines for the conduct of members with their patients;
- training for the College's staff; and
- provision of information to the public. [HPPC, s. 84]

The Patient Relations Committee is also responsible for administering the College's program for funding therapy and counselling for persons alleging sexual abuse by a CPSO registrant in accordance with the HPPC. [HPPC, s. 85.7]

Committee Members

Ms. Nadia Bello - Chair
Dr. Rajiv Bhatla
Ms. Sharon Rogers
Dr. Heather Sylvester
Dr. Angela Wang

Key Accomplishments

In 2024, the PRC focused primarily on reviewing funding for therapy/counselling applications and requests for specific types of therapy from eligible applicants. To improve efficiencies at the Committee level, additional decision items were added to the consent agenda this past year. These include applications for funding for therapy and counselling that fall under specific eligibility criteria. In addition, frequently approved specific therapy requests (gym memberships, exercise classes) have been added to the consent agenda.

Looking Ahead to 2025

To support the public interest, the Committee will be finalizing an education resource to help approved applicants identify the types of therapies that might best address the harm caused by sexual abuse. This resource will replace the current resource on the CPSO website that sets out considerations when choosing a therapist/counsellor.

The Committee is looking forward to welcoming a new Committee member, and orientation and mentorship of this member will take place in early 2025.

Premises Inspection Committee
Annual Committee Report
2024

Committee Mandate

The Premises Inspection Committee is responsible for administering and governing the College's premises inspection program, referred to as the Out-of-Hospital Premises Inspection Program, in accordance with Part XI of Ontario Regulation 114/94 (the "Regulation"). The purpose of the Out-of-Hospital Premises Inspection Program (OHPIP) is to ensure that out-of-hospital premises (as defined in the Regulation) comply with its Standards.

The Premises Inspection Committee is required to:

- ensure adequate inspections and re-inspections are conducted as authorized under the Regulation;
- review premises inspection reports and other material referred to in the Regulation and determining whether premises pass, pass with conditions or fail an inspection;
- specify the conditions that shall attach to each "pass with conditions" rating and where applicable, "fail" rating;
- deliver written reports as required under the Regulation; and
- establish or approve costs of inspections and re-inspections and ensure the member or members performing the procedures on the premises are invoiced for those costs. [General By-law, s. 47.1]

The Premises Inspection Committee recommends policy or program updates that impact the OHPIP to the Board.

Committee Members for 2023-2024

Dr. Olubimpe Ayeni
Dr. George Beiko
Dr. Bryan Chung – resigned effective May 10, 2024 due to a conflict of interest
Dr. Patrick Davison – Vice-Chair
Dr. Hae Mi Lee
Dr. Winnie Leung
Dr. Colin McCartney
Dr. Wusun Paek
Dr. Kashif Pirzada
Dr. Suraj Sharma
Dr. Catherine Smyth
Dr. Robert Smyth
Dr Michael Wan
Dr. Ted Xenodemetropoulos –Chair

We thank those members whose terms are ending in 2024. Your dedication, commitment and contribution to the Premises Inspection Committee, over the years of your service, has been valued and greatly appreciated.

Key Accomplishments

The Premises Inspection Committee has made several improvements to the OHPIP with some key changes to note.

In the spirit of Continuous Improvement, all Member-Specific Information (MSI) meetings now have a No Discussion (ND) list to improve meeting efficiency. We additionally focused on right-sizing committee involvement for MSI meetings with a target of no more than 4 panel members per case.

Committee session efficiencies have further enabled more timely review of adverse events, contributing to a full end-to-end review and closure of adverse events in under 4 weeks at the 80th percentile. This further serves to enhance expedient follow up with OHP medical directors to move forward in developing process improvements to mitigate incident reoccurrence and improving upon the quality of care delivered in the OHP setting.

Looking Ahead to 2025

In 2025, all routine inspections previously conducted on a 5-year cycle will shift to conducting routine inspections on a 4-year cycle. This shift allows the work of PIC to align with Accreditation Canada's inspection cycle, streamlining processes and reducing redundancies for premises providing both insured and non-insured services.

The Premises Inspection Committee looks forward to expanding upon the accomplishments of the past year and to continuing to support the College's mandate to protect and serve in the public's interest.

Respectfully submitted,

Ted Xenodemetropoulos
Chair

Patrick Davison
Vice-Chair

Quality Assurance Committee
Annual Committee Report
2024

Committee Mandate

The Quality Assurance Committee is responsible for administering the College's quality assurance program in accordance with the HPPC and the QA Reg[1]. [QA Reg s. 27(1)]

In carrying out the above mandate, the Quality Assurance Committee has the power to:

- appoint assessors for the quality assurance program; [HPPC s. 81]
- require a member to undergo a peer and practice assessment; [QA Reg. s. 28(1)] and
- approve the form and manner in which members are required to maintain a record of their participation in a program of continuing professional development. [QA Reg. s. 29(3)]

The Quality Assurance Committee reviews peer and practice assessment reports and makes decisions regarding members who have been assessed. In so doing, the Quality Assurance Committee may only do one or more of the following:

- confirm the physician had a successful peer assessment and no further action is required;
- require individual members whose knowledge, skill and judgment have been assessed under the quality assurance program and found to be unsatisfactory to participate in specified continuing education or remediation programs;
- direct the Registrar to impose terms, conditions or limitations for a specified period to be determined by the Committee on the certificate of registration of a member,
    - whose knowledge, skill and judgment have been assessed or reassessed under s. 82 of the HPPC and have been found to be unsatisfactory, or
    - who has been directed to participate in specified continuing education or remediation programs as required by the Committee and has not completed those programs successfully;
- direct the Registrar to remove terms, conditions or limitations before the end of the specified period, if the Committee is satisfied that the member's knowledge, skill and judgment are now satisfactory; or
- disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee if the Quality Assurance Committee is of the opinion that the member may have committed an act of professional misconduct, may be incompetent or incapacitated. [HPPC s. 80.2(1)]

CPSO's operational programs and any other aspect of quality assurance that is not expressly stated under the Mandate, Duties and Powers section above, fall within the Board's accountability and are not within the Quality Assurance Committee's scope of authority.

Board Oversight of Quality Improvement Program

The Quality Improvement Program falls within the Board's accountability and is not within the Quality Assurance Committee's scope of authority. From time to time the Quality Assurance Committee may be provided with information and education related to the Quality Improvement Program as it relates to the Committee's authority to require members to undergo peer and practice assessments.

Committee Members

2023-2024:

Dr. Mohammad Keshoofy
Dr. Charles Knapp
Dr. Ken Lee
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Sarah Reid - Chair
Dr. Ashraf Sefin -Vice-Chair
Dr. Astrid Sjodin
Dr. Tina Tao

We would like to thank both Dr. Camille Lemieux and Mr. Paul Malette, whose terms are ending in 2024. Their contributions over their years with the Quality Assurance Committee have been greatly valued.

Moreover, Dr. Sefin and the committee would like to thank Dr. Sarah Reid, whose term is also ending in 2024. Dr. Reid's dedication, commitment, and contributions to the on-going evolution of the work of the Quality Assurance Committee have been significant and tremendously appreciated.

Key Accomplishments

The Quality Assurance Committee continued its collaboration with the Quality Improvement Program during the implementation of the first formal year of Quality Improvement (QI) Enhanced Program in 2024, following its successful pilot in 2023. In line with right-touch regulation principles, the QI Enhanced program option offers an alternative path for select physicians 70 to 74 years of age to fulfill their CPSO quality requirements by taking part in a QI program rather than the traditional peer assessment. 230 physicians participated in this innovative option in 2024. Secondary to the program's ongoing successful engagement and outcomes, the Quality Assurance Committee moved to approve QI Enhanced as a program option for physicians 70- 79 years of age.

Looking Ahead to 2025

With the QI Enhanced program option now available to a larger proportion of physicians in 2025, the Quality Assurance Committee intends to further explore building upon its established continuous improvements opportunities to further augment committee session efficacy and efficiency in case review and decision-making.

Additional continuous improvement initiatives such as augmenting the frequency and quality of feedback provided to Quality Assurance Peer Assessors and developing resources to further standardize disposition decisions are ongoing and slated for further implementation in 2025.

The Quality Assurance Committee looks forward to expanding upon the accomplishments of the past year and to continuing to support the College's mandate to protect and serve in the public's interest.

Respectfully submitted,

Sarah Reid
Chair

Ashraf Sefin
Vice-Chair

Registration Committee
Annual Committee Report
2024

Committee Mandate

The Registration Committee reviews and considers applications for a certificate of registration to practice medicine in Ontario for individuals referred by the Registrar [HHPC, s.15(1)]. An application is referred to the Registration Committee for review when the Registrar:

- Has doubts on reasonable grounds as to whether the applicant fulfils the registration requirements;
- Believes that the College should impose terms, conditions and limitations on a certificate of registration if the applicant does not consent to the imposition or the applicant already holds an out-of-province certificate that is equivalent to the certificate being applied for;
- Proposes to refuse the application [HPPC, s. 15(2)]; or,
- Believes that the College should issue a certificate to an applicant with terms, conditions and limitations imposed and the applicant consents to the imposition [HPPC, s. 15(4)]

The powers of the Registration Committee with respect to the above mandate include:

- making orders directing the Registrar to:
    - issue a certificate of registration to an applicant [HPPC, s. 18(2)];
    - issue a certificate of registration to an applicant subject to the completion of examinations or additional training [HPPC, s. 18(2)];
    - issue, with the applicant's consent, a certificate of registration with the terms, conditions and limitations specified and imposed by a panel of the Registration Committee [HPPC, s. 18(4)];
    - impose specified terms, conditions and limitations on a certificate of registration of an applicant and specifying a limitation on the applicant's right to apply to remove or modify the term, condition or limitation under s. 19 of the HPPC [HPPC, s. 18(2)]; and
    - refuse to issue a certificate of registration. [HPPC, s. 18(2)]

- developing and implementing registration policies passed by the Board, including reviewing and updating the policies based on information provided to the Committee.

Committee Members

Mr. Faiq Bilal
Mr. Markus de Domenico
Dr. Bruce Fage
Mr. Murthy Ghandikota
Dr. Diane Hawthorne
Dr. Anjali Kundi
Dr. Edith Linkenheil – Vice Chair
Mr. Paul Malette
Dr. Judith Plante - Chair
Dr. Sachdeep Rehsia
Dr. Kim Turner

Key Accomplishments

Right Touch Regulation

The Registration Committee remains committed to ensuring that physicians licensed to practice medicine in Ontario meet the required training and experience to ensure patient care is safe and effective.

Following the progress in 2023, the Registration Committee has continued to find new pathways for licensure for Internationally Educated Physicians (IEPs) and continues to remove barriers for qualified IEPs looking to practice medicine in Ontario.

In this regard, the Registration Committee has licensed many physicians in 2024 that are eligible under pathways developed and approved in 2023. The committee has also approved additional policies in 2024 that will continue to remove barriers to licensure for IEPs.

Practice Ready Ontario – Practice Ready Assessment

In 2023, the Registration Committee developed a policy to facilitate the Practice Ready Assessment (PRA) program designed by Practice Ready Ontario (PRO). PRO was developed by the Touchstone Institute in conjunction with the Government of Ontario for the purpose of creating and running an assessment program for internationally trained family physicians looking to practice in Ontario. In 2024, the first cohort of physicians selected by PRO were considered by the Registration Committee for certificates of registration to complete a 12-week clinical field assessment (CFA). In Cohort One, 29 candidates were approved to begin the CFA in spring and summer of 2024. 28 candidates passed the assessment and have subsequently been granted a restricted certificate of registration to practice under supervision for three years, or until they have successfully obtained certification by examination with the College of Family Physicians of Canada.

While Touchstone Institute is responsible for establishing the program eligibility requirements, the Registration Committee consulted with Touchstone in 2024 to ensure that eligibility requirements were updated based on real-world experience with Cohort One. The combined effort has resulted in higher transparency for IEPs looking to apply to the PRA program.

Subsequently, 12 candidates in Cohort Two will be considered by the Registration Committee this fall and clinical field assessments will commence end of 2024.

Alternative Pathways to Registration for Physicians Trained in the United States

- *Addition of certification by the American Osteopathic Association*

At the business meeting in March 2024, the Registration Committee approved several policy amendments that were later approved by the Executive Committee in August 2024. The policy on *Alternative Pathways to Registration for Physicians Trained in the United States* was updated to incorporate the Accreditation Council for Graduate Medical Education's (ACGME) accreditation of postgraduate osteopathic medicine training programs in the U.S. To recognize the newly accredited programs, the Pathways Policy was updated to grant certificates of registration to physicians who have completed ACGME-accredited training and have obtained board certification through either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA). Physicians who are board-certified and have completed training can receive a restricted, scope-defined license (Pathway A), whereas those who are board-eligible can apply for a restricted certificate to practice under supervision for up to three years, or until they achieve certification by exam (Pathway C).

The policy amendment aligns with changes to ACGME-accredited programs and removes barriers for physicians certified by the AOA.

- *Conversion from Restricted to Independent Practice Certificates of Registration*

The *Alternative Pathways Policy* currently grants US-trained physicians a scope-restricted certificate of registration to practice in Ontario. Following a scan of other Canadian jurisdictions and upon review of the FMRAC Model Standards, a proposal was made to revise the current policy to enable licensed physicians to obtain a certificate of registration authorizing independent practice after 5 years of continuous practice in Ontario. The proposed revisions would provide US-trained physicians an alternative route to independent licensure without the need to complete additional training or examinations and would create more clarity for the public with regards to the scope of physicians in Canada.

At the business meeting on October 25, 2024, the Registration Committee approved the proposed revision to the *Pathways Policy,* which will be presented for approval by Executive Committee and the Board, then circulated for notice in accordance with Section 22.21 of the *Health Professions Procedural Code* (the Code) in early 2025.

Amendments to the Acceptable Qualifying Exams Policy

The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 2 has historically had two components: the Level 2 examination and a Level 2 performance evaluation. The performance evaluation was suspended in February 2021 and officially discontinued in June 2022. As such, the Registration Committee approved that reference to the *Level 2 Performance Evaluation* should be rescinded from the policy. This change clarifies examination requirements for IEPs looking to work in Canada.

Royal College of Physicians and Surgeons of Canada – Practice Eligibility Route (RCPSC-PER)

The Registration Committee, at its business meeting on October 25, 2024, approved a new policy to be presented for approval by the Executive Committee and the Board in late-2024. The draft policy would permit the Registration Committee to grant a restricted, time-limited certificate of registration to physicians who are eligible for certification by the RCPSC via the Practice Eligibility Route. Physicians from outside of the RCPSC's approved jurisdictions may apply to the RCPSC to have their training assessed and be granted eligibility to sit RCPSC examinations. Following successful completion of RCPSC examinations, and after obtaining LMCC

designation, the physician would be granted a certificate to practice under supervision for three years, or until they fulfilled the time-in-practice requirement and are certified by the RCPSC.

Following successful certification by the RCPSC, this cohort of physicians would then be eligible to apply for independent practice in Ontario.

The draft policy is another example of the Registration Committee's continued commitment to finding new ways to license IEPs in Ontario and provide registrants a route to independent practice. The policy, if approved, would also align the College with other Canadian jurisdictions that currently recognize the RCPSC Practice Eligibility Route. At the business meeting on October 25, 2024, the Registration Committee made a decision to forward the policy to the Executive Committee for approval.

Specialist Recognition Criteria in Ontario Policy

In early 2024, the Registration Committee also approved an amendment to the *Specialist Recognition Criteria in Ontario Policy* to allow physicians approved under the revised *Alternative Pathways Policy* to be recognized as a specialist. Specialty may be conferred if a physician has completed postgraduate specialty training in an ACGME-accredited program and has obtained certification by examination with the AOA or ABMS.

Additionally, the Registration Committee made a decision to further amend the *Specialist Recognition Criteria in Ontario Policy* at the business meeting on October 25, 2024 and forward the revised policy to the Executive Committee for approval. The proposed amendment would allow for physicians approved under the draft policy, *Restricted certificate of registration for RCPSC – Practice Eligibility Route,* to be recognized as a specialist while practicing under supervision and obtaining certification with the RCPSC.

Fees

The Registration Committee recognized the hard work of residents in Ontario and supported the decision to waive application fees for residents who apply for "moonlighting". In addition, the Committee supported the waiving of application fees for medical trainees from other Canadian provinces who come to Ontario to complete an elective program.

System Collaboration

The Registration Committee and Staff continue to work with various stakeholders to share information regarding registration processes. The Committee met with Touchstone Institute in the spring of 2024 to provide consultation on eligibility criteria for PRO candidates. The group also collaborated throughout 2024 to ensure that physicians who completed the clinical field assessment were brought before the Registration Committee as soon as possible to avoid breaks in practice prior to their return of service.

The staff supporting the Registration Committee met, on their behalf, with stakeholders from the Ontario medical school undergraduate and graduate programs. These sessions were focused on providing feedback for summer registration and devising new strategies to improve registration timelines for 2025.

Education Initiatives

The Registration Committee completed an education session on cognitive biases and quality decision-making in regulation. The Committee have also received relevant white papers and articles from the *World Health Organization* and various *Gray Areas Newsletters* to support their continuing education.

Looking Ahead to 2025

The Registration Committee continue to assess the efficacy of current registration pathways and are working to have new policies presented to the Board and Executive Committee for approval and circulation in 2024/2025.

Administrative and procedural changes will be implemented in 2025 to reduce lead time for applications that require review by the Registration Committee. Additionally, the committee and staff are working to determine the most effective schedule for meetings during summer registration to ensure trainees can start on July 1, 2025.

Additionally, the Registration Committee are preparing to consider applications from Physician Assistants (PA) that have been referred to the Committee. The College is slated to begin regulating PA as of April 1, 2025, and the Registration Committee are preparing to review cases in 2025.

Finally, the Registration Committee continue to plan for the transition of Chair and Vice-Chair positions in 2025. The Committee would like to welcome Dr. Edith Linkenheil as Chair and Dr. Bruce Fage as Vice-Chair, two experienced members who will continue to foster a positive environment for the group. The Committee would like to thank Dr. Judith Plante for her service and guidance as Chair and look forward to her continued work as a committee member.

Respectfully submitted,

Judith Plante, MDCM, CCFP, FCFP
Chair

Edith Linkenheil, MD FRCSC
Vice-Chair

NOVEMBER 2024

Title:	Policy Report (For Information)
Main Contact:	Tanya Terzis, Manager, Policy & Governance
Attachment:	**Appendix A:** Policy Status Report

Purpose, Public Interest Mandate & Relevance to Strategic Plan

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

Current Status & Analysis

- Two policy consultations launched following the September 2024 Board meeting:

Consultation Responses	Feedback Overview[1]

General: *Consent to Treatment*[2]
 	
50 responses received[3]
	• Consultation feedback on the policy and guidance documents was largely positive. Most respondents indicated that it is clear and helpful to have the legal requirements set out in a separate *Guide to the Health Care Consent Act* document.
	• Overall, respondents found the expectations in the draft policy reasonable. In particular:
	  ○ A majority of respondents strongly agreed that the definitions of implied and express consent are clear and distinct from one another.
	  ○ A majority of respondents indicated that the requirement to document consent discussions for procedures that may result in the ablation of a bodily function, which had been removed from the draft, should be retained.
	  ○ A majority of respondents indicated that the new expectation to obtain express consent in certain situations, including for intimate examinations, surgical procedures and/or invasive investigative procedures, was reasonable.
	• Some respondents suggested that patients from certain cultures may wish to delegate consent to others, or have a family member interpret for them, and that the policy should allow for this.

Preliminary: *Closing a Medical Practice* **48** responses received[4]	• A majority of respondents agreed that the current policy is useful, clear, and comprehensive. However, a number of respondents suggested that the policy sets out unreasonable expectations regarding continuity of care given the current physician shortage. • Some respondents were also concerned about fulfilling the policy expectations when there is an unexpected closure due to death or illness. • Some respondents suggested clarifying and expanding on the expectations around medical record retention and storage, specifically with respect to electronic medical record management.

- An *Advice to the Profession: AI Scribes in Clinical Practice* document has been developed and published online. The document highlights some of the benefits of artificial intelligence (AI) scribes and outlines key considerations that physicians should keep in mind when using them.

[1] As of the Board submission deadline.
[2] A preliminary consultation refers to consulting on an existing policy and a general consultation refers to consulting on a draft policy.
[3] Organizational respondents included the Canadian Medical Protective Association, College of Nurses of Ontario (CNO), HIV & AIDS Legal Clinic Ontario, Ontario College of Teachers, Ontario Medical Association (OMA), Ontario Trial Lawyers Association, and Toronto Public Health.
[4] Organizational respondents included CNO, OMA, and the OMA Section on Plastic Surgery.

- CPSO recently partnered with eight other Ontario health regulators[5] to engage with Members of the Citizen Advisory Group (CAG) to understand patient and caregiver experiences, perspectives, and expectations related to healthcare providers' use of AI. These public insights will help inform any future work by CPSO regarding AI use within the profession.

- The polished version of *Essentials of Medical Professionalism*, which sets out CPSO's expectations related to professional ethics and articulates the values and duties at the core of medical practice, has been developed and published online. The resource has been shared with various key stakeholders, including the Ontario Medical Association, the Ontario College of Family Physicians, the Ontario Hospital Association, and the province's medical schools.

- The status of ongoing policy development and reviews, including last reviewed dates and targets for completion, is presented for the Board's information **(Appendix A: Policy Status Report)**.

[5] College of Dental Hygienists of Ontario, College of Kinesiologists of Ontario, College of Midwives of Ontario, College of Nurses of Ontario, College of Occupational Therapists of Ontario, College of Physiotherapists of Ontario, Ontario College of Social Workers and Social Service Workers, and the Royal College of Dental Surgeons of Ontario.

Appendix A

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Analysis/ Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Closing a Medical Practice	Sep-24		✓					**2025**	
Accepting New Patients	Feb-24			✓				**2025**	
Ending the Physician-Patient Relationship	Feb-24			✓				**2025**	
Physician Treatment of Self, Family Members, or Others Close to Them	Dec-23			✓				**2025**	The draft has been retitled *Treatment of Self, Family Members, and Others Close to You*.
Consent to Treatment	Dec-23					✓		**2025**	
Mandatory and Permissive Reporting	Jun-22						✓	**2024**	The draft has been retitled *Reporting Requirements*.

Table 2: Policy Review Schedule

Policy	Reviewed	Policy	Reviewed
Essentials of Medical Professionalism	2024	*Medical Records Management*	2020
Infection Prevention and Control for Clinical Office Practice	2024	*Medical Records Documentation*	2020
Professional Behaviour	2024	*Protecting Personal Health Information*	2020
Conflicts of Interest and Industry Relationships	2024	*Disclosure of Harm*	2019
Medical Assistance in Dying	2023	*Prescribing Drugs*	2019
Human Rights in the Provision of Health Services	2023	*Boundary Violations*	2019
Decision-Making for End-of-Life Care	2023	*Availability and Coverage*	2019
Dispensing Drugs	2022	*Managing Tests*	2019
Virtual Care	2022	*Transitions in Care*	2019
Social Media	2022	*Walk-in Clinics*	2019
Complementary and Alternative Medicine	2021	*Ensuring Competence: Changing Scope of Practice and Re-entering Practice*	2018
Professional Responsibilities in Medical Education	2021	*Public Health Emergencies*	2018
Third Party Medical Reports	2021	*Uninsured Services: Billing and Block Fees*	2017
Delegation of Controlled Acts	2021	*Providing Physician Services During Job Actions*	2014
Advertising	2020		

Ontario Medical Students' Association
CPSO Council Update
November 28 and 29, 2024

Maxim Matyashin, President
Zoe Tsai, President-Elect

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

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting. This council meeting we ask that you welcome both Vidhi Bhatt, OMSA's VP Operations, and Aditi Venkatraman, OMSA's VP Public Relations, to your meeting as our representatives.

Updates on Previous Advocacy Efforts:

1. **Western's Location Tracking** - Western University has removed location tracking as part of their mandatory attendance policy, a win for Ontario Medical Students and our privacy rights.
2. **Difficulties with Distributed Education -** At the most recent OMA Queen's Park day we received strong interest from the Ministry of Colleges and Universities and the Ministry of Health in expanding funding for electives in northern and rural Ontario. Talks are ongoing with regard to this and we would appreciate support from our colleagues at the CPSO on this matter as much as possible.

New Updates:

1. **AFMC's Match Tender** - The Association of Faculties of Medicine of Canada (AFMC) has recently started the process to seek a potential new service provider for the residency match process other than CaRMS. OMSA has met with AFMC CEO and President Dr. LeBlanc for productive conversations, while also being in contact with our national partners including the Canadian Federation of Medical Students (CFMS) and the Resident Doctors of Canada (RDoC). In our conversations on the ground, students are not strongly opposed to this process if certain guarantees are made; though significant concerns remain about the AFMC's reasoning behind this decision. The OMSA has asked the AFMC, CFMS, and RDoC to come together for additional talks to find a common path forward. We are encouraged to see the AFMC pausing the Match tender process in favour of further consultation from partners.
2. **A Provincial Medical Education Standards Document** - The OMSA has taken on a project to create a document with recommendations for Ontario medical schools on their policies. Recommendations will include Clerkship duty policies (e.g., maximum hours worked), absence policies, rural and regional activities, remediation, elective scheduling, and more. The recommendations will be based on analyses of current policies at each school.

Thank you once again for inviting us to the CPSO meetings. If you have any questions, or wish to help with our advocacy priorities, please do not hesitate to reach out.

Sincerely,

Maxim Matyashin
President, OMSA
president@omsa.ca

Zoe Tsai
President-Elect, OMSA
president_elect@omsa.ca

PARO

Inspired by our love of medicine

CPSO Board November 2024

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

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

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

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

We are pleased to submit this update on some strategic initiatives at PARO.

PARO-OTH Collective Agreement – September 2024 Arbitration Award
Through arbitration we were awarded a three-year contract to June 30, 2026.

SALARY INCREASES
Salaries will increase by the following amounts:

- Retroactive to July 1, 2023: 3.5% increase
- Retroactive to July 1, 2024: additional 3.0% increase
- Effective July 1, 2025: additional 2.65% increase

These increases are also applicable to Chief & Senior Administrative Bonuses.

CALL STIPENDS
Call stipend increases have been awarded, retroactive to July 2023, with additional increases coming this July and next July for all categories of call.

EXTENDED HEALTHCARE BENEFIT IMPROVEMENTS

- Increase in mental health coverage (including psychotherapy) to a maximum of $3000.00 yearly from a previous maximum of $2000.00.
- Effective July 1, 2025, introduction of a $250 yearly health spending account, with one year carry over.

Additional items that we reached agreement on through negotiations and mediation, that will form part of the new Collective Agreement, include the following:

- We are very pleased that the hospitals have agreed that, no later than October 1, 2025, the exception clause regarding home after handover will **cease to exist** in the Agreement. For historical reasons, this exception provision

permitting dismissal from duties on call at noon applied solely to the University of Toronto Department of Surgery. It has been a priority in many past rounds of negotiations to remove this clause and we have now finally succeeded in achieving this change towards equity for all residents. **No later than October 1, 2025**, all services in the province must comply with the home after handover language relevant to their service (Article 16.4).

- Changes to improve the existing handover language making it clear that a resident handing over will not be required to complete tasks that can reasonably be performed by the incoming resident.

- New standard in the contract providing that, "a resident shall normally not be required to be on call in-hospital for two consecutive weekends within the same block or within consecutive blocks within the same service, except where required to meet patient care responsibilities". The requirement that residents shall not be scheduled for consecutive weekends on home call remains in place.

Other negotiated changes:

- Requirement that on-call facilities will now include access to internet (through WIFI or hard-wired) and computer equipment connected to the Hospital's electronic medical record and information systems. Non-OTH Sites must endeavour to provide this same level of access if residents take call at their hospitals.

- Final day of residency on call: "a final year resident working call on any part of a recognized holiday that fell on their last day of their training is entitled to take an earlier lieu day prior to the end of their training".

- An attachment outlingin a process for PARO and the hospitals to meet to explore Alternative Scheduling Models for Trauma Services. This is in alignment with our existing process to consider alternative models of call scheduling with services.

Residency Match Governance

In March of this year, the AFMC unilaterally embarked on a process to take control of the residency match. This was despite the decades-long history and understanding that the governance of the match is shared by all relevant partners, including medical students and residents.

The match was originally created and run by medical students and residents. Forty years ago, an agreement was reached for joint ownership and shared governance of the match by medical students, residents, and key national organizations, including the AFMC and the provincial regulatory bodies. Nothing has changed legally to alter this principle.

Nonetheless, the AFMC announced unilaterally through a press release that they were terminating the contract with CaRMS (Canadian Resident Matching Service), the organization that was created by all partners for the sole purpose of administering the match.

In response, national and provincial learner organizations launched diplomatic efforts to halt this process, and we are pleased that these collective efforts were ultimately successful. On Monday, October 28, 2024, the AFMC Board of Directors met and decided to pause the tender process. Subsequently they have written to acknowledge

that the governance of the match is shared, and they have also indicated that they will reach out to CaRMS to engage in contract discussions.

Medical students and residents worked hard over many years to ensure that we have a seat at the table that oversees the match. As we pointed out to the AFMC, having a seat at their table and having a seat at a shared table are two very different things. There is still work to be done, but we are confident that with a solutions-oriented mindset and a willingness to work together, that all stakeholders will find the necessary solutions to preserve the shared ownership and bring much needed stability to the entire matching process.

PARO Teaching to Teach Program

We continue to deliver Teaching to Teach workshops, via Zoom and in person, to training programs as part of their academic half day sessions. Since its launch in 2016, the workshop has been successfully delivered to over 1000 residents at all of the university sites.

An important requirement to ensure the success of the teaching to teach program is a comprehensive training component for resident facilitators. To-date, 93 residents have been trained as facilitators and we are planning to host one more training session this academic year.

NOVEMBER 2024

Title:	Update on Board Action Items (For Information)
Main Contacts:	Carolyn Silver, Chief Legal Officer Tanya Terzis, Manager, Policy & Governance Adrianna Bogris, Board Administrator

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- To promote accountability and ensure that the Board is informed about the status of its decisions, an update on the implementation of the Board's decisions is provided below.

Current Status and Analysis

- The Board held a meeting on September 6, 2024. The motions carried, and the implementation status of the decisions are outlined in Table 1.

Table 1: Board Decisions from the September 6, 2024 meeting

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td><u>01-B-09-2024</u></td><td><u>Consent Agenda</u>

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves items 2.1 to 2.4 outlined in the consent agenda, which include in their entirety:

2.1 The Board meeting agenda for September 6, 2024;
2.2 The draft minutes from the Board meeting held on May 30 and 31, 2024;
2.3 2024 Committee Appointments/Re-Appointments and Exceptional Circumstances

The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following individuals to the following Committees effective as of the close of the Annual Organizational Meeting (AOM) of the Board in 2024, and expiring at the close of the AOM of the Board of Directors in 2025.

<table><tr><th>Committee</th><th>Member Name</th></tr><tr><td>Patient Relations</td><td>Carol King</td></tr><tr><td>Finance and Audit</td><td>Sarah Reid</td></tr><tr><td>Inquiries, Complaints and Reports</td><td>Anu Srivastava</td></tr></table></td><td>Completed.</td></tr>
</table>

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td></td><td>
The Board of Directors approves the application of the exceptional circumstances[2] clause in Section 7.6.8 of the CPSO By-laws in respect of Dr. Tina Tao when her term limit for the Quality Assurance Committee expires on July 26, 2025.

The Board of Directors of the College of Physicians and Surgeons of Ontario re-appoints the following individuals to the committees listed below effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board of Directors in 2025.
<table>
<tr><th>Committee</th><th>Member Names</th></tr>
<tr><td rowspan="2">Finance and Audit</td><td>Murthy Ghandikota</td></tr>
<tr><td>Rob Payne</td></tr>
<tr><td rowspan="11">Inquiries, Complaints and Reports</td><td>Olufemi Ajani</td></tr>
<tr><td>Amie Cullimore</td></tr>
<tr><td>Christopher Hillis</td></tr>
<tr><td>Asif Kazmi</td></tr>
<tr><td>Robert Myers</td></tr>
<tr><td>Wayne Nates</td></tr>
<tr><td>Jude Obomighie</td></tr>
<tr><td>Fred Sherman</td></tr>
<tr><td>Kuppuswami Shivakumar</td></tr>
<tr><td>Andrew Stratford</td></tr>
<tr><td>Michael Wan</td></tr>
<tr><td rowspan="7">OPSDT & Fitness to Practise</td><td>Madhu Azad</td></tr>
<tr><td>Lucy Becker</td></tr>
<tr><td>Marie-Pierre Carpentier</td></tr>
<tr><td>Jose Cordeiro</td></tr>
<tr><td>Rupa Patel</td></tr>
<tr><td>Rob Payne</td></tr>
<tr><td>Linda Robbins</td></tr>
<tr><td rowspan="10">Premises Inspection</td><td>Olubimpe Ayeni</td></tr>
<tr><td>Richard Bowry</td></tr>
<tr><td>Hae Mi Lee</td></tr>
<tr><td>Winnie Leung</td></tr>
<tr><td>Colin McCartney</td></tr>
<tr><td>Wusun Paek</td></tr>
<tr><td>Chris Perkes</td></tr>
<tr><td>Kashif Pirzada</td></tr>
<tr><td>Suraj Sharma</td></tr>
<tr><td>Catherine Smyth</td></tr>
</table>
</td><td></td></tr>
</table>

[2] Exceptional Circumstances requested. Dr. Tao's QAC term limit expires July 26, 2025. Due to her experience and important contributions, Exceptional Circumstances are requested to allow Dr. Tao to serve an additional one-year term, rather than a brief term ending in July 2025.

<table>
<tr><th>Reference</th><th>Motions Carried</th><th>Status</th></tr>
<tr><td></td><td>
<table>
<tr><td></td><td>Michael Wan</td></tr>
<tr><td rowspan="6">Quality Assurance</td><td>Mohammad Keshoofy</td></tr>
<tr><td>Charles Knapp</td></tr>
<tr><td>Ken Lee</td></tr>
<tr><td>Ashraf Sefin</td></tr>
<tr><td>Astrid Sjodin</td></tr>
<tr><td>Tina Tao[3]</td></tr>
<tr><td rowspan="5">Registration</td><td>Bruce Fage</td></tr>
<tr><td>Murthy Ghandikota</td></tr>
<tr><td>Edith Linkenheil</td></tr>
<tr><td>Paul Malette</td></tr>
<tr><td>Judith Plante</td></tr>
</table>
2.4 Chair and Vice-Chair Appointments
The Board of Directors of the College of Physicians and Surgeons of Ontario appoints the following Committee Members as Chairs and Vice-Chairs, as noted below, to the following Committees, effective as of the close of the AOM of the Board in 2024 and expiring at the close of the AOM of the Board of Directors in 2025.
<table>
<tr><th>Committee</th><th>Role</th><th>Member Name</th></tr>
<tr><td rowspan="2">Registration</td><td>Chair</td><td>Edith Linkenheil</td></tr>
<tr><td>Vice-Chair</td><td>Bruce Fage</td></tr>
<tr><td>Quality Assurance</td><td>Chair</td><td>Ashraf Sefin</td></tr>
<tr><td rowspan="2">Inquiries, Complaints, and Reports</td><td>Chair</td><td>Jane Lougheed</td></tr>
<tr><td>Vice-Chair</td><td>Jude Obomighie</td></tr>
<tr><td>Finance and Audit</td><td>Chair</td><td>Rob Payne</td></tr>
</table>
<u>CARRIED</u>
</td><td></td></tr>
<tr><td><u>02-B-09-2024</u></td><td><u>Draft Policy for Consultation: Consent to Treatment</u>

The Board of Directors of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, “Consent to Treatment,” (a copy of which forms Appendix “A” to the minutes of this meeting).

<u>CARRIED</u></td><td>This item will be discussed at the November Board meeting.</td></tr>
</table>

[3]Pursuant to application of Exceptional Circumstances to extend beyond Dr. Tao’s term limit, as noted above.

Reference	Motions Carried	Status
03-B-09-2024	**Revised Policy for Final Approval: Essentials of Medical Professionalism** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the revised policy "*Essentials of Medical Professionalism*," formerly titled "*Practice Guide*," as a policy of the College (a copy of which forms Appendix "B" to the minutes of this meeting). **CARRIED**	Completed.
04-B-09-2024	**Revised Policy for Final Approval: Professional Behaviour** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the revised policy *"Professional Behaviour,"* formerly titled *"Physician Behaviour in the Professional Environment,"* as a policy of the College (a copy of which forms Appendix "C" to the minutes of this meeting). **CARRIED**	Completed.
05-B-09-2024	**New Policy for Final Approval: Infection Prevention and Control for Clinical Office Practice** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the new policy *"Infection Prevention and Control for Clinical Office Practice,"* as amended, as a policy of the College (a copy of which forms Appendix "D" to the minutes of this meeting). **CARRIED**	Completed.
06-B-09-2024	**For Approval: Code of Conduct and Declaration of Adherence** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the revised Declaration of Adherence and Code of Conduct, (a copy of which forms Appendix "E" to the minutes of this meeting). **CARRIED**	Completed.
07-B-09-2024	**For Approval: Board Policies** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the revised "Conflict of Interest Policy", "Impartiality in Decision-Making Policy" and "Confidentiality Policy", (copies of which form Appendices "F", "G" and "H" to the minutes of this meeting). **CARRIED**	Completed.

Reference	Motions Carried	Status
08-B-09-2024	**For Approval: 2025 Election Date** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the 2025 Board election date set out below: April 25, 2025 **CARRIED**	Completed.
09-B-09-2024	**For Approval: Governance and Nominating Committee (GNC) Elections** The Board of Directors of the College of Physicians and Surgeons of Ontario appoints Dr. Patrick Safieh (as GNC Chair), Dr. Madhu Azad (as Physician Director, GNC member), Dr. Ian Preyra (as Physician Director, GNC member), Ms. Lucy Becker (as Public Director, GNC member), Mr. Rob Payne (as Public Director, GNC member) to the Governance and Nominating Committee for the year that commences with the close of the Annual Organizational Meeting of the Board in 2024. **CARRIED**	Completed.
10-B-09-2024	**For Approval: Appointment of Academic Directors for 2024/25** The Board of Directors of the College of Physicians and Surgeons of Ontario selects and appoints Dr. Katina Tzanetos and Dr. Janet van Vlymen for a one-year term as Academic Directors for 2024/25 commencing as of the close of the Annual Organizational Meeting of the Board in 2024 and expiring at the close of the Annual Organizational Meeting of the Board in 2025. **CARRIED**	Completed.
11-B-09-2024	**Motion to Go In-Camera** The Board of Directors of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below). **Exclusion of public** 7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that, (b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public; (d) personnel matters or property acquisitions will be discussed. **CARRIED**	Completed.

Reference	Motions Carried	Status
12-B-09-2024	**For Approval: Expansion of QI Enhanced Program** The Board of Directors of the College of Physicians and Surgeons of Ontario approves the proposed expansion of age-eligibility for the Quality Improvement Enhanced Program to include physicians aged 75 to 79 years who are subject to a Quality Assurance Age-Targeted Peer Assessment. **CARRIED**	Completed.

NOVEMBER 2024

Title:	2025 Q3 and Q4 meeting dates (For Information)
Main Contact:	Christina Huang, Team Lead, Governance

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The Board of Directors (Board) is provided with CPSO meeting dates for Q3 and Q4 of 2025.

Current Status & Analysis

- In 2024 a new quarterly meeting scheduling model was implemented. Below are Q3 and Q4 meeting dates. Two quarters are being brought forward as it is best practice to have meetings booked one year in advance. Moving forward, one quarter will be brought to the Board at a time.

Q3

Jul-25

M	T	W	T	F
	1 Canada Day	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

Aug-25

M	T	W	T	F
				1
4 Civic Holiday	5 GNC-V	6	7	8
11	12 EC	13	14	15
18	19	20 CMPA Toronto	21	22
25	26	27	28	29

Sep-25

M	T	W	T	F
1 Labour Day	2	3 IAMRA (Dublin) Sep 3-7	4	5
8	9	10	11	12
TIFF (Sep 4-15)				
15	16	17	18	19
CLEAR (Chicago) Sep 15-18				
22	23	24 Rosh Hashanah Sep 22-24	25 BOD	26 BOD
MCC (Ottawa) Sep 22-23				
29	30 T&R Day			

Q4

Oct-25

M	T	W	T	F
		1 Yom Kippur	2	3
6	7 EC-V	8	9	10
13 Thanksgiving	14 FAC-V	15	16	17
Diwali 20	21	22	23	24
CNAR (Oct 22-22) Calgary				
27	28 GNC-V	29	30	31

Nov-25

M	T	W	T	F
3	4 EC	5	6	7
10	11 Rem Day	12	13	14
17	18	19	20	21
24	25	26	U.S. Thgsg 27 BOD	28 BOD

Dec-25

M	T	W	T	F
1	2	3	4	5
		CLEAR (Dec 3-5) Wellington, NZ		
8	9 GNC-V	10	11	12
15	16	17	18	19
22	23	24	25 Christmas	26 Boxing Day
29 CPSO Closure	30	31 Hanukkah Dec 14-Dec 22		

BOD	Board of Directors
EC EC-V	Executive Executive-Virtual
GNC-V	Governance & Nominating-Virtual
FAC FAC-V	Finance & Audit Finance & Audit-Virtual
	Stat/religious holidays/Mar break
	Conference/AGM

NOVEMBER 2024

Title:	Review Feedback and Discussion: *Consent to Treatment* Draft Policy (For Discussion)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Laura Rinke-Vanderwoude, Policy Analyst
Attachments:	**Appendix A:** Draft *Consent to Treatment* Policy **Appendix B:** Draft *Guide to the Health Care Consent Act* **Appendix C:** Draft *Advice to the Profession: Consent to Treatment*
Question for Board:	Does the Board of Directors (Board) have any feedback on the draft policy?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A new draft of CPSO's *Consent to Treatment* policy (**Appendix A**) and two companion documents, *Guide to the Health Care Consent Act* ("*Guide*") (**Appendix B**) and *Advice to the Profession: Consent to Treatment* ("*Advice*") (**Appendix C**), were released for external consultation following the September Board meeting.

- The Board will be provided with an overview of the feedback received and discuss the draft policy at the Board meeting.

Current Status and Analysis

- The current *Consent to Treatment* policy[1] and *Advice* were revised in response to preliminary consultation feedback and input from the Policy Working Group. Key revisions included:

    - A *Guide to the Health Care Consent Act* document was created, and the substantial legal content in the current policy was moved to this document to allow for a clearer, significantly shorter policy;
    - The definitions of "express" and "implied" consent were clarified;
    - Requirements to address language and communication issues were strengthened; and
    - A requirement to obtain express consent for intimate examinations was added.

- The *Advice* document was updated to include content on key areas, including distinguishing between types of consent, using translators when obtaining consent, delegation of consent, managing conflicts between substitute decision-makers, and the Consent and Capacity Board.

- Consultation feedback on the policy and its associated documents was largely positive. An overview of the feedback is provided in the Policy Report and will be shared during the Board meeting.

- Small group discussions will take place at the Board meeting so that Board Directors have an opportunity to provide feedback on the drafts that were released for consultation. The Board's feedback will be considered by the Policy Working Group and will inform future revisions to the drafts.

[1] The *Consent to Treatment* policy was last substantively reviewed in 2015.

CONSENT TO TREATMENT POLICY

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

Treatment: Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan. It does not include, among other things, a capacity assessment, health history-taking, assessment or examination of a patient to determine the general nature of their condition, communication of an assessment or diagnosis, admission to a hospital or other facility, personal assistance service, or treatment that poses little or no risk of harm to the person.[1]

Capacity: A person is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. Capacity to consent to a treatment can change over time.

Substitute decision-maker (SDM): A person who may give or refuse consent to a treatment on behalf of a patient who is incapable with respect to consent.

Express consent: Agreement that is direct, explicit, and unequivocal. Express consent can be given orally or in writing.

Implied consent: Agreement that is inferred from the words or behaviour of the patient or the circumstances under which the treatment is given.

Policy

This policy sets out expectations of physicians in obtaining and documenting consent to treatment, in addition to the requirements of the *Health Care Consent Act, 1996* (*HCCA*). Further

[1] See section 2(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. and sections 1(1) and 33.7 of the *Mental Health Act*, R.S.O. 1990, c. M.7 for further information.

information about the *HCCA*'s requirements is set out in the *Guide to the Health Care Consent Act* companion document.

Obtaining Consent

1. Physicians **must** comply with all of the requirements in the *HCCA*, including obtaining valid consent[2] before treatment is provided.

    a. While consent can be either express or implied, physicians **must** obtain express consent in situations where the examination or treatment is an intimate examination[3], carries appreciable risk, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness.

    b. A physician proposing treatment may request another health-care provider to obtain consent from the patient, but they **must** be assured that the health-care provider has the knowledge, skill, and judgment required to obtain consent. The physicians involved in the treatment are ultimately responsible for the consent being obtained.

2. One element is that consent be informed. For consent to be informed, physicians **must** engage in a dialogue with the patient or the SDM prior to obtaining consent about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action and the likely consequences of not having the treatment.

3. Another element is that consent be given voluntarily and not under duress. If physicians believe that consent is not being freely given, they **must** take reasonable steps to ensure that there has been no coercion.

4. Physicians **must** consider and address language and communication issues that may impede a patient's ability to give valid consent.

    a. Physicians **must** use their professional judgment to determine whether it is appropriate to use family members as interpreters and only do so where it is in the patient's best interests.

Incapable Patients and Substitute Decision-Making

[2] The HCCA sets out the elements that are required for obtaining valid consent. For further information, see the *Guide to the Health Care Consent Act* companion document.
[3] An intimate examination includes breast, pelvic, genital, perineal, perianal and rectal examinations of patients. Additional guidance around consent for examinations is set out in CPSO's *Advice to the Profession: Maintaining Appropriate Boundaries* document.

Treatment can only be provided where the patient is capable with respect to the treatment and has given consent, or the patient is incapable and the SDM has given consent on the patient's behalf.

5. Where a patient is incapable with respect to a treatment, physicians **must**, where possible, inform the incapable patient that an SDM will assist them in understanding the proposed treatment and will be responsible for the final decision.

    a. Where a patient disagrees with the finding of incapacity, physicians **must** advise them that they can apply to the Consent and Capacity Board (CCB) for a review of the finding.

    b. Where a patient disagrees with the involvement of the designated SDM, physicians **must** advise them that they can apply to the CCB to appoint an SDM of their choice.

    c. When appropriate, physicians **must** involve the incapable patient, to the extent possible, in discussions with the SDM.

Documenting Consent

6. Physicians **must** comply with all relevant legislation related to medical record-keeping[4] and the expectations set out in CPSO's *Medical Records Documentation* policy.

7. Physicians **must** document information in the patient's medical record about consent to treatment where the examination or treatment carries appreciable risk, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness.

[4] Including the *Medicine Act,* General Regulation, Part V.

ADVICE TO THE PROFESSION: CONSENT TO TREATMENT

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

The College's *Consent to Treatment* policy and *Guide to the Health Care Consent Act* companion document set out physicians' professional and legal obligations with respect to obtaining consent to treatment. This *Advice to the Profession: Consent to Treatment* document is intended to help physicians interpret these obligations and provide guidance around how they may be effectively discharged.

Obtaining Consent

What is the difference between implied consent, express consent, and written consent?

As stated in the policy, implied consent is inferred from the words or behaviour of the patient or the circumstances, whereas express consent is direct, explicit, and unequivocal. Written consent is a form of express consent (express consent can also be given orally).

You are expected to capture any written consent (e.g. a signed consent form) in the patient's medical record[1] although, as noted below, you are advised to document consent discussions in all circumstances, where possible.

What should I consider in determining whether it is appropriate to use family members as interpreters?

In many cases, using a family member as an interpreter will be the most accessible, convenient, practical, and comfortable option for patients. At the same time, using family members as interpreters can present challenges, such as language limitations, difficulty understanding medical terms, inter-family dynamics and conflict, and important information being deliberately or accidentally omitted. As a result, and where the patient is in agreement, physicians are advised to use a formal or third-party interpretation service where available.

What do I do if a patient wants to provide consent without hearing about the risks of the treatment or if they want to delegate consent to a family member?

[1] See CPSO's *Medical Records Documentation* policy.

A patient may feel anxious about the proposed treatment and want to provide consent without hearing about the risks. In other cases, the patient may ask that you obtain consent from a family member, even where they are capable.

However, the act of providing consent cannot be delegated. The law requires that consent be obtained by a capable patient directly or, where they are incapable, the SDM. It also requires that consent be informed. As such, you are required to provide information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action, and the likely consequences of not having the treatment. If a patient refuses to hear this information, their decision will not be informed and their consent will not be valid.

You may want to sensitively explain this requirement to the patient and emphasize the importance of understanding the risks. You may also want to give patients time to process the information, gather family or friends if they need additional support, and try to arrange for an opportunity to continue the dialogue at a later date if time permits.

Can family members or friends be involved in the consent discussion?

Yes, it is appropriate and often helpful to involve others in the consent discussion, provided you have the patient's permission and the patient makes the final decision regarding treatment. It may be helpful to ask at the beginning of the patient encounter how the patient prefers to hear information about their condition (e.g., prognosis), and who they want to be present with them while they receive the information.

Does a signed consent form constitute informed consent?

Not necessarily. The requirement for informed consent will not be met where the patient simply signs a consent form or receives written education materials or pamphlets without a discussion of the expected benefits and material risks of the proposed treatment, or having an opportunity to ask any questions they may have. It is important to consider the patient's particular circumstances when determining whether a risk is material. The information to be discussed must be determined on a case-by-case basis so that it relates to the specific patient and is neither over- or under-inclusive.

What steps can I take to help my patients understand the information being provided when obtaining consent?

You may want to be mindful of the factors that can limit patient comprehension, as well as the tools that can help support comprehension. Some of these include:

- Using language appropriate for the patient's comprehension of concepts like probability and medical terminology.
- Considering the impact of pain, mental illness, and biases when communicating information.

Other tools can be found in the CMPA document "Helping patients make informed decisions."

Remember that patients or substitute decision-makers (SDMs) will need time to review and understand any information you provide prior to giving or refusing consent to a treatment. Consider "pacing" the information you provide so that the patient or SDM has an opportunity to reflect on it and any questions they wish to ask.

In order to obtain informed consent, I need to provide certain information, including the "material risks" associated with the treatment. What are "material" risks, and which risks do I have to disclose?

Courts have defined a "material" risk as a risk about which a reasonable person in the same circumstances as the patient would want to know in order to make a decision about the treatment. This includes but is not limited to risks that the physician believes may lead the patient to refuse or withhold consent to treatment.

The material risks that must be disclosed are risks that are common and significant, even though not necessarily grave, and those that are rare, but particularly significant. Generally speaking, the more frequent the risk, the greater the obligation to inform the patient about it. In addition, risks of great potential seriousness, such as paralysis or death, must likely be disclosed even if uncommon.

Determining Capacity

Can I assume that once a patient is considered capable with respect to a treatment, they will always be capable regarding that treatment or will be capable for all other treatment decisions?

No. Capacity is fluid: it can change over time and is treatment-specific; that is, it will depend on the nature and complexity of the specific treatment decision.

For this reason, consent may need to be revisited after it has been obtained in case there are any significant changes in the patient (e.g., their health status, health-care needs, specific circumstances, capacity, etc.) or treatment (e.g., the nature, expected benefits, material risks and material side effects, etc.). The passage of time may also increase the risk that these changes will arise and that consent may need to be obtained again.

It may be appropriate to involve the future SDM(s) in ongoing consent discussions, with the patient's permission, if the patient does lose capacity and the SDM is required to start making treatment decisions in accordance with the patient's stated wishes and/or best interests.

My patient is refusing to consent to a treatment that I think they should have. Does this mean they are incapable?

Not necessarily. Patients and SDMs have the legal right to refuse or withhold consent. Patients may sometimes make decisions that are contrary to the physician's treatment advice, and you cannot automatically assume in these cases that they are incapable of making that decision.

In some cases, however, a patient's decision may cause you to question whether the patient has the capacity to make the decision (e.g., truly understands the consequences of not proceeding with the treatment). Where this is the case, you may want to consider doing a more thorough investigation of the patient's capacity to ensure the patient's decision is informed and valid. This could start with questions about their reasons for refusing treatment and/or the information they are relying on in making their decision.

It is important to remember that it is inappropriate for a physician to end the physician-patient relationship in situations where the patient chooses not to follow the physician's treatment advice (for more information, see the College's *Ending the Physician-Patient Relationship* policy).

Incapable Patients and Substitute Decision-Makers

Where a patient expresses a desire to apply to the CCB for review of a decision involving capacity or the identity of the SDM, you might consider providing the contact information for the Law Society of Ontario's Referral Service.

What do I do if the SDMs disagree on whether to give or refuse consent?

Because the HCCA permits two or more people within the same rank to jointly act as SDM, you may encounter a situation where the SDMs disagree about whether to give or refuse consent.

If two or more SDMs within the same rank disagree about whether to give or refuse consent, one of the SDMs or another person may apply to the CCB for the right to make the decision. Alternatively, the Public Guardian and Trustee (PGT) will make the decision as a last resort. More information about how to involve the PGT may be obtained from the Treatment Decisions Unit.

The SDM is required to give or refuse consent in accordance with the wishes of the patient, provided the patient was, at the time the wishes were expressed, capable and 16 years or older. How can a patient communicate their wishes to the SDM?

Wishes can be expressed in writing, orally, or in any other manner. Written wishes may involve advance care planning documents, commonly known as an 'advance directive' in a power of attorney, or some other form. For more information about advance care planning, see the CPSO's Decision-Making for End-of-Life Care policy.

Later wishes expressed while capable, whether written, oral, or any other manner, prevail over earlier wishes.

I have a legal obligation to ensure that SDMs understand the requirements for giving or refusing consent as set out in the HCCA. What steps can I take to fulfill this obligation?

First, you need to determine how familiar the SDM is with the HCCA requirements. Some SDMs may not know what the HCCA requirements are, so you may need to tell them. You may want to consider referring SDMs to existing substitute decision-making resources that outline the

requirements, such as the Hamilton Health Sciences' Making Decisions for Others: Your Role as a Substitute Decision Maker education document.

Other SDMs may be very familiar with the requirements, as they may have had to give or refuse consent on behalf of an incapable patient before. In these circumstances, you may not need to tell SDMs what the requirements are. Instead, you must be satisfied that the SDM understands what the HCCA requirements are when you are obtaining consent to a treatment from an SDM.

What if I am concerned that the SDM is not acting in accordance with the patient's wishes or best interests?

If you are of the view that the SDM is not acting in accordance with the patient's wishes or best interests, you can apply to the CCB to determine how to proceed. Among other things, the CCB is responsible for reviewing findings of incapacity, considering the appointment and termination of SDMs, giving directions on issues of treatment, and reviewing an SDM's compliance with the rules for substitute decision-making. For more information about this process, the CCB website or the Ontario Hospital Association's A Practical Guide to Mental Health and the Law in Ontario.

Documentation

What should I consider when documenting consent discussions?

Proper documentation is the best evidence that physicians have to demonstrate that valid consent was obtained. As such, while the policy requires physicians to document consent discussions in specific circumstances, it is best practice to document consent in all circumstances.

You need to use your professional judgment when recording the encounter and include enough information to provide an accurate summary of your discussion with your patient.

GUIDE TO THE HEALTH CARE CONSENT ACT

This document sets out the requirements for obtaining consent to treatment that are set out in the *Health Care Consent Act* and related case law (judge-made law). Although some of the language is taken directly from the legislation, the requirements have been restated and presented in a way that speaks directly to physicians.

Physicians may want to seek independent legal advice if they have questions about meeting the legal requirements. The obligation to ensure that valid consent is obtained always rests with the physician proposing the treatment. In the case of any inconsistency between this document and any applicable legislation, the legislation will prevail.

General Principles for Obtaining Valid, Informed Consent

The *Health Care Consent Act* (*HCCA*) requires physicians to obtain valid, informed consent before providing treatment.

Before treatment is administered, physicians must believe the patient is capable with respect to treatment and has given consent.

If the physician believes that the patient is not capable of making decisions about their treatment, then the consent must be obtained from the Substitute Decision Maker (SDM).

Patients and SDMs have the legal right to refuse, withhold, or withdraw consent to a treatment, and physicians must respect this decision even if they do not agree with it.

Elements of Valid Consent

Consent is valid when:

- It relates to the proposed treatment;
- It is informed;
- It is given voluntarily and not under duress; **and,**
- It was not obtained through misrepresentation or fraud.

Identifying Informed Consent

Consent is informed when a physician has:

- Provided information about the nature of the treatment, its expected benefits, material risks and side effects, alternative courses of action, and the likely consequences of not having the treatment;
- Responded to requests for additional information about the treatment; and,
- Is satisfied that the patient or their SDM understood the information provided, which includes taking reasonable steps to facilitate that understanding.

The information provided to the patient or their SDM must include information that a reasonable person in the same circumstances would require in order to make a treatment decision. This must include information about material risks that are relevant for both a broad range of patients and the specific patient.

Scope of Valid, Informed Consent

Unless the circumstances make it unreasonable to do so, physicians are entitled to presume that consent to treatment includes:

- consent to variations or adjustments in the treatment when the nature, expected benefits, and material risks and side effects are not significantly different than the original treatment; and
- consent to the same treatment's continuation in a different setting, if the change in setting will not significantly change the expected benefits or material risks or side effects of the treatment.

Capacity, Incapacity, and Minors

A person is capable with respect to a treatment if they are able to understand the information that is relevant to making a decision, and appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Capacity to consent to a treatment can change over time, and a patient can be capable with respect to some treatment decisions and incapable for others. Therefore, physicians must consider the patient's capacity at various points in time and in relation to the specific treatment being proposed.

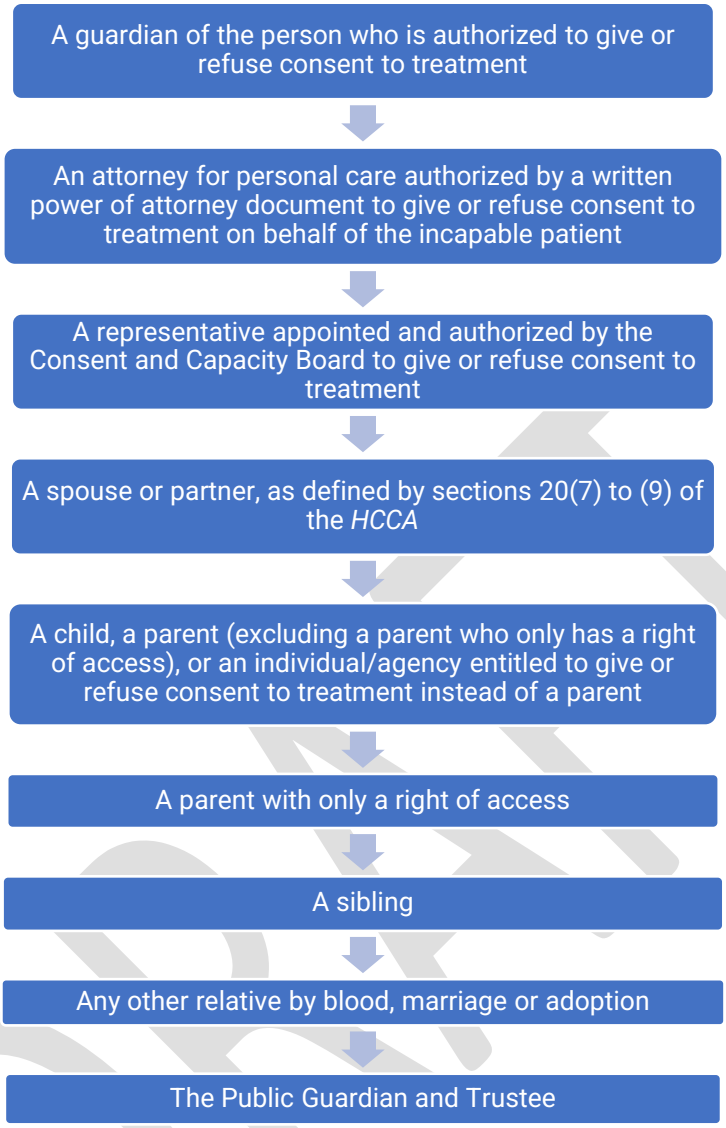
A person is presumed to be capable with respect to treatment unless there are reasonable grounds to believe otherwise (e.g., something in a patient's history or behaviour raises questions about their capacity to consent to the treatment).

Minors and Capacity

In Ontario, the presumption of capacity applies to everyone, including minors. If a minor is capable with respect to a treatment, the physician must obtain consent from the minor directly, even if the minor is accompanied by their parent or guardian.

Identifying the Substitute Decision-Maker

The *HCCA* sets out a hierarchy of the individuals and agencies who may give or refuse consent on behalf of an incapable patient as follows:



Using the Hierarchy

Where a patient is incapable with respect to treatment, physicians must obtain consent from the SDM identified by the hierarchy. The SDM is the highest-ranking person in the hierarchy set out in the *HCCA* who is also:

- capable with respect to the treatment (the test for capacity applies equally to both patients and SDMs);
- at least 16 years old, unless they are the incapable person's parent;
- not prohibited by a court order or separation agreement from having access to the incapable patient or from giving or refusing consent on their behalf;
- available to communicate consent or refuse consent within a reasonable time in the circumstances; and
- willing to assume the responsibility of giving or refusing consent.

If a higher-ranking person in the hierarchy does not satisfy the requirements

If a higher-ranking person in the hierarchy does not satisfy all of the requirements for substitute decision-making under the *HCCA*, physicians must move to the next-highest person in the hierarchy who meets the requirements.

Once an SDM is Identified

Once an SDM is identified, the HCCA requires that they give or refuse consent in accordance with the most recent and known wish expressed by the patient while they were both capable and at least 16 years old.

If no valid wish is known or the wish is impossible to comply with, the SDM must act in the patient's best interests.

Physicians are responsible for taking reasonable steps to ensure that SDMs understand these requirements.

Determining an Incapable Patient's Best Interests

To determine the incapable patient's best interests, the SDM must consider:

- any values and beliefs the patient held while capable which the SDM believes they would still act on if capable;
- any wishes the patient expressed that the SDM is not legally required to follow (e.g., because the wish was expressed when the patient was not capable or was under the age of 16);
- how providing or not providing the treatment will impact the patient's condition or well-being;
- whether the expected benefit of the treatment outweighs the risk of harm; and
- whether a less restrictive or less intrusive treatment would be as beneficial.

Assessing the Impact of Providing or Not Providing the Treatment

To assess the impact of providing or not providing the treatment on the patient's condition or well-being, SDMs must consider whether:

- the treatment is likely to:
    - improve the incapable patient's condition or well-being;
    - prevent their condition or well-being from deteriorating; or,
    - reduce the extent or rate of their condition or well-being's deterioration; and,
- the incapable patient's condition or well-being is likely to improve, remain the same, or deteriorate without the treatment.

Emergency Treatment

Under the *HCCA*, an emergency is a situation where the patient is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if the treatment is not administered promptly.

In emergencies, physicians must obtain consent from a patient who is apparently capable with respect to the treatment unless, in the opinion of the physician, all the following are true:

- the communication required to establish consent cannot take place because of a language barrier or a patient's disability;
- reasonable steps have been taken to find a practical means of enabling communication but were not successful;
- the delay required to find a practical means of communication will prolong the patient's apparent suffering or put them at risk of sustaining serious bodily harm; and,
- there is no reason to believe that the patient does not want the treatment.

If a Patient Previously Wished to Refuse Consent to the Treatment

Physicians must not provide treatment in emergencies if they have reasonable grounds to believe that the patient, while capable and at least 16 years of age, expressed a wish to refuse consent to the treatment that would be applicable in the circumstances.

Contacting SDMs in Emergencies

In an emergency where the patient is incapable with respect to the treatment, physicians must obtain consent from the incapable patient's SDM unless, in the opinion of the physician, the delay required to establish consent or refusal:

- will prolong the suffering that the patient is apparently experiencing; or,
- will put the patient at risk of sustaining serious bodily harm.

If an SDM Refuses to Consent to a Treatment in an Emergency

Where an SDM refuses to consent to a treatment in an emergency, the physician must respect this decision unless, in the physician's opinion, the SDM has not complied with the substitute decision-making requirements outlined in section 21 of the *HCCA*.

If the SDM has not complied with the *HCCA* requirements, the treatment may be administered despite the refusal.

If a Patient Becomes Capable During an Emergency

If, in the opinion of the physician, the patient becomes capable with respect to the treatment during emergency treatment, the physician must seek the patient's consent. The patient's decision to give or refuse consent to the continuation of the treatment supersedes the SDM or physician's decision.

After Administering Emergency Treatment Without Consent

After administering treatment in an emergency without consent, the physician must promptly note in the patient's record the physician's opinions at the time of treatment that they relied on in administering the emergency treatment under the HCCA.

Duration of Emergency Treatment

Treatment in an emergency may continue only for as long as is reasonably necessary to:

- find a practical means of enabling communication with the capable patient; or,
- find the incapable patient's SDM.

Physicians must ensure that reasonable efforts are made to enable communication or find the SDM.

NOVEMBER 2024

Title:	Proposed Rescission of the *Cannabis for Medical Purposes* Policy (For Decision)
Main Contacts:	Laura Rinke-Vanderwoude, Policy Analyst Courtney Brown, Team Lead, Policy Tanya Terzis, Manager, Policy & Governance
Question for Board:	Does the Board of Directors (Board) approve rescinding the *Cannabis for Medical Purposes* policy?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Prior to initiating a routine review of the *Cannabis for Medical Purposes* policy, staff assessed the policy to determine whether it was still needed, after significant changes to the legal landscape. The assessment identified that the policy is no longer needed.

- Ensuring that policies are continually assessed for appropriateness and relevancy aligns with right-touch regulation principles.

Current Status & Analysis

- The *Cannabis for Medical Purposes* policy was first approved in 2002, following the government's creation of the *Marihuana Medical Access Program*. The policy has not been substantively updated since the *Cannabis Act* (the Act) and the *Cannabis Regulations* were created in 2018. At the time of the policy's first approval, cannabis authorization was novel and was governed by the *Controlled Drugs and Substances Act*, personal use of cannabis was criminalized, and legal access to cannabis for medical purposes could only be provided through an authorization. This is no longer the case; cannabis can now be obtained legally without an authorization.

- Research indicates that the main issues covered by the policy are already either covered by other CPSO policies or legislation, that the policy is used infrequently by CPSO decision-making bodies, and that some other Canadian medical regulators have rescinded their own cannabis policies. Cannabis is also currently the only substance with a designated CPSO policy[1] – former drug-specific policies, such as the *Methadone Maintenance Treatment for Opioid Dependence* policy, have already been rescinded.

    - Only three elements of the policy are not already addressed by other CPSO policies or by the Act.[2] Minor amendments to the *Advice to the Profession: Prescribing Drugs* document can be made to address these elements, if needed. Other organizations also already have extensive best practice guidance for prescribing or authorizing medical cannabis.[3]

- Given the above analysis, it is recommended that the policy be rescinded and that doing so would not create substantial risk to the public or CPSO.

[1] Narcotics and controlled substances are incorporated in the *Prescribing Drugs* policy.
[2] The three areas are: clarifying that authorization is considered prescribing for CPSO policy purposes, guidance on prescribing to people under age 25, and written treatment agreements. An additional area, fees charged for authorizations, is covered by legislation but not another CPSO resource.
[3] The College of Family Physicians of Canada has Cannabis resources for family physicians, Health Canada maintains a Cannabis webpage and Stats Hub, and the Ontario Medical Association has a Physician Responsibilities guide.

Board Motion

Motion Title	Proposed Rescission of the *Cannabis for Medical Purposes Policy*
Date of Meeting	November 28, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario rescind the College's *Cannabis for Medical Purposes* policy (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

Board Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	November 28, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (d) of the Health Professions Procedural Code (set out below).

Exclusion of public

7(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,

(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;

(d) personnel matters or property acquisitions will be discussed.

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

Title:	**Budget 2025 (For Decision)**
Main Contacts:	**Thomas Bertoia, Chair, Finance and Audit Committee** **Nathalie Novak, Chief Operating Officer** **Sandra Califaretti, Corporate Controller** **Lori Ferguson, Corporate Accountant**
Questions for Board:	**1. Does the Board of Directors approve the 2025 operating budget, as presented?** **2. Does the Board of Directors approve the 2025 capital budget, as presented?**

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- **At its meeting of October 16, 2024, the Finance and Audit Committee (FAC) was presented with the proposed 2025 Operating and Capital budgets for the College of Physicians and Surgeons of Ontario (CPSO).**
- **FAC is recommending that the Board of Directors (Board) approve the CPSO proposed 2025 Operating and Capital budgets, as presented.**

Current Status & Analysis

- **Operating Budget 2025 is summarized as follows:**
  - **Revenues planned at $87.7M**
  - **Expenses planned at $87.6M**
  - **Surplus planned at $64K, a small residual value that meets not for profit balanced budget standards**
- **Operating Budget 2025 incorporates the following, based on objectives approved by FAC and the Board prior to the start of the budget process, internal objectives set by the Chief Operating Officer and ongoing operational requirements:**
  - **No increase to membership fees, which have remained at $1,725 since 2018**
  - **First year assumptions related to Physician Assistant registration**
  - **A 3% cost of living increase to staff salaries and the per diem amount, which is in line with mean inflation over the past five years**
  - **A 5% increase to direct staffing costs (8% was the objective)**
  - **A 9% reduction of staff positions vacated through attrition, which was made possible through process improvements and infrastructure transformation**
  - **Cost increases aligned with inflation, contractual obligations and salary administration plans including estimated results of the five-year job evaluation program, an important practice to secure and retain professional and high-quality talent**
- **Capital Budget 2025 consists of $5.6M in planned expenditures focused on technology and building improvements, which will continue the College's technology transformation through the F&O 2.0 financial system enhancements and facility improvements for building sustainability and staff workplace enrichment.**
- **The Board will receive a presentation with full details and is asked to approve these budgets, as presented.**

Board Motion

Motion Title	For Approval: 2025 Operating Budget and 2025 Capital Budget
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the following budgets authorizing expenditures for the benefit of the College during the year 2025:

1. the 2025 Operating budget in the amounts of $87.068 million in revenues, $87.004 million in expenses, and a surplus of $64,000, and
2. the 2025 Capital budget in the amount of $5.617 million in capital asset expenses.

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Draft Policy for Consultation: *Accepting New Patients* (For Decision)
Main Contacts:	Mike Fontaine, Policy Analyst Kaitlin McWhinney, Junior Policy Analyst Courtney Brown, Team Lead, Policy
Attachments:	**Appendix A:** Draft *Accepting New Patients* policy **Appendix B:** Draft *Advice to the Profession: Accepting New Patients*
Question for Board:	Does the Board of Directors (Board) approve releasing the draft *Accepting New Patients* policy for external consultation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A draft *Accepting New Patients* policy (**Appendix A**) and associated *Advice to the Profession ("Advice")* (**Appendix B**) have been developed. The Board is asked whether the draft policy and *Advice* can be released for external consultation.
- Clarifying expectations for accepting new patients helps physicians manage their practice while supporting equitable access to care for patients and aligns with CPSO's public interest mandate.

Current Status & Analysis

- The current *Accepting New Patients* policy[1] and *Advice* have been revised in response to preliminary consultation feedback[2] and input from the Policy Working Group.
- While many elements of the current policy have been retained in the draft, a few key revisions have been made, including the following:
    - The draft has been restructured to emphasize the principles that must inform how physicians accept new patients (e.g., fairness and transparency), as well as to set out what physicians are permitted and not permitted to do when accepting or refusing to accept patients into their practice.
    - The draft includes a few new or updated expectations that explicitly set out when physicians cannot refuse to accept new patients into their practice (e.g., due to a patient's beliefs which may impact their therapeutic choices) and when it is permissible for them to refuse (e.g., the physician serves a defined target population). The expectation that physicians use a "first-come, first-served" approach to accepting patients has been removed, and instead, the draft allows physicians to establish scope-based criteria for accepting new patients.
    - The draft expands the patient populations for whom physicians can prioritize access to care and now includes groups such as older people, people experiencing homelessness or poverty, and those living in rural or remote areas.
    - The draft sets out how and when introductory meetings can be used. The draft prohibits physicians from using introductory meetings to unfairly screen patients, but it does allow physicians to refuse to accept patients after these meetings. Physicians who use introductory meetings must inform patients about whether or not they have been accepted into the practice, and, if the patient has been refused, they must communicate the reasons for that refusal.
- Given the draft policy's articulation of general principles related to accepting new patients, specialist-specific issues have been moved into the draft *Advice*. The *Advice* has also been expanded to address physician and patient concerns relating to catchment areas, patients seeking second opinions, and physician responsibilities when using self-managed waitlists.

[1] The *Accepting New Patients* policy was last reviewed in 2017.
[2] A preliminary consultation on the draft policy received 108 total responses. All of the written comments can be viewed on the consultation webpage, and an overview of the feedback was provided to the Board in the May 2024 Policy Report.

ACCEPTING NEW PATIENTS

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

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

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

Definitions

Discrimination: An act, communication, or decision that results in the unfair treatment of an individual or group, for example, by excluding them, imposing a burden on them, or denying them a right, privilege, benefit, or opportunity enjoyed by others. Discrimination may be direct and intentional; it may also be indirect and unintentional, where rules, practices, or procedures appear neutral but have the impact of disadvantaging certain groups of people.

Good Faith: A legal term that means an intention to act in a manner that is honest and decent. The term may be characterized as a sincere intention to deal fairly with others.

High or Complex Care Needs: High or complex care needs include, but are not limited to, conditions or needs requiring urgent care; chronic conditions or comorbidities, particularly those that are unmanaged; activity-limiting disabilities; and/or mental illnesses. Social determinants of health may also contribute to patients' high or complex care needs.

Introductory Meetings: Meetings used by physicians to share information about the practice, disclose information about their scope of practice and/or focused practice area, inform the patient of any criteria they have for accepting new patients, and/or determine in collaboration with the patient whether there is a good foundation for an effective therapeutic relationship. Introductory meetings are not typically used to provide medical care.

Policy

1. Physicians are permitted to decide:

    a. Whether their practice is accepting new patients;[1] and
    b. Which patients to accept into their practice.

    These decisions **must** be made in good faith and in accordance with this policy.

2. Physicians must not discriminate against patients based on any protected grounds under the *Ontario Human Rights Code* when determining whether to accept them into their practice.[2]

[1] The expectations set out in this policy apply broadly to all physicians, including family physicians and specialists, and to those acting on their behalf. For instance, physicians may rely upon clinical managers and/or office staff to accept new patients on their behalf. Organizations may also act as a physician's representative in this context.
[2] The *Ontario Human Rights Code ("Code")* prohibits actions that discriminate against people based on protected grounds in protected social areas (including goods, services, and facilities, such as hospitals and health services). The protected

3. Physicians **must not** refuse to accept a patient solely on the basis that the patient has:

    a. Complex or chronic health-care needs, unless those needs are beyond the physician's clinical competence, scope of practice, and/or focused practice area;
    b. A history of prescribed opioids and/or psychotropic medication; [3]
    c. Needs that require additional time to manage;
    d. A physical or mental health condition or disability[4] that may require the physician to prepare and provide additional documentation or reports; or
    e. Beliefs or ideologies which do not align with the physician's own and which may impact the patient's therapeutic choices.

4. Physicians are permitted to establish criteria for accepting new patients. These criteria **must**:

    a. Be directly relevant to the physician's clinical competence, scope of practice, and/or focused practice area;[5]
    b. Comply with the terms and conditions of the physician's practice certificate and associated practice restrictions, if applicable;
    c. Be fair and promote equitable access to health-care services;
    d. Be clearly communicated to any prospective patient seeking care; and
    e. Be shared with CPSO, on request.

5. Where a physician refuses to accept a patient, the physician **must**:

    a. Do so in good faith;
    b. Clearly communicate the reasons for the refusal to the patient (or referring provider, as needed); and
    c. Document the reasons for the refusal.

6. Given the broad scope of practice of primary care physicians, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient. Once accepted into a primary care practice, should elements of the patient's health-care needs be outside of the physician's clinical competence and/or scope of practice, the physician **must not** abandon the patient.

    a. Physicians **must** make a referral to another appropriate health-care provider for those elements of care that they are unable to manage directly.

7. Physicians are permitted to prioritize access to care for patients with high or complex care needs and those belonging to priority populations. Physicians **must** use their professional judgment to determine whether prioritizing or triaging patients is appropriate, taking into account the patient's health-care needs and any known social factors that may influence the patient's health outcomes.

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grounds include age; ancestry, colour, race; citizenship; ethnic origin; place of origin; creed; disability; family status; marital status; gender identity; gender expression; receipt of public assistance; record of offences; sex; and sexual orientation. For more information see CPSO's *Human Rights in the Provision of Health Services* policy.

[3] Physicians are advised to consult CPSO's *Prescribing Drugs* policy for further information on blanket 'no narcotics' prescribing policies.

[4] Physicians should be aware that under the *Code*, the term 'disability' is interpreted broadly and covers a range of conditions. 'Disability' encompasses physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions. The *Code* protects individuals from discrimination because of past, present and perceived disabilities.

[5] Physicians with a 'focused practice area' may include those with a commitment to one or more specific clinical practice areas, such as geriatrics, psychotherapy or adolescent health, or who serve a defined target population.

8. Physicians are permitted to prioritize the family members of current patients but **must** use their professional judgment to determine whether accepting family members is appropriate (e.g., it would reasonably assist in the provision of quality care).[6]

9. Physicians are permitted to use introductory meetings to meet with prospective patients and to determine the patients' needs but **must not** use introductory meetings or questionnaires to unfairly screen prospective patients.[7]

10. Physicians who use introductory meetings **must** inform patients of the purpose of the meeting, for example, that:

    a. An introductory meeting is not typically used to provide medical care;[8] and
    b. Offering a patient an introductory meeting does not mean that the patient has been accepted as a patient.

11. Physicians who use introductory meetings **must** inform patients in a timely manner whether they have or have not been accepted into the practice.

[6] While the policy permits physicians to prioritize family members of current patients, physicians are not required to do so. It may be inappropriate for physicians practising in certain specialties (e.g., psychiatry) to accept family members of current patients into their practice.
[7] Medical questionnaires include those administered in person or virtually by physicians or those acting on their behalf.
[8] Once a physician provides any medical service or care to a patient, a physician-patient relationship will have been established. In these cases, patients may reasonably assume that they have been accepted into the physician's practice.

ADVICE TO THE PROFESSION: ACCEPTING NEW PATIENTS

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

The establishment of trust between a physician and a patient can begin as early as when patients start seeking care. A patient's perception about whether a physician is accepting new patients in a fair and transparent manner can support the establishment of a trusting physician-patient relationship and foster trust in the profession.

The *Accepting New Patients* policy sets out physicians' professional and legal obligations when accepting new patients and helps to ensure that decisions to accept new patients are equitable, transparent and non-discriminatory. This companion *Advice to the Profession* document is intended to help physicians interpret their obligations as set out in the *Accepting New Patients* policy and provide guidance around how these obligations can be met.

Acting in "good faith"

The term "good faith" is a legal term that means an intention to act in a manner that is honest and decent. In other words, the term may be characterized as a sincere intention to deal fairly with others.

In the context of accepting new patients, physicians can act in good faith by:

- Closing their practice when it has reached capacity, not as a way to refuse patients who may be perceived as less desirable;
- Assessing, in a fair and honest manner, whether their medical knowledge and clinical skills will meet a patient's health-care needs, and not using a lack of medical knowledge or clinical skills to unfairly refuse patients with complex or chronic health needs; and
- Prioritizing access to care because a patient truly has high and/or complex health-care needs, and not because a patient is perceived as "easy" and/or requires less time or resources.

Priority populations

"Priority populations" refers to any population group that experiences (or is at risk of experiencing) health inequities and/or that would benefit most from public health services. While priority populations may differ slightly depending on a physician's practice type and location, some common examples of priority populations include:

- Pregnant people and newborns;
- Older people;
- People living in rural, remote or other communities with poorer access to care;
- People experiencing homelessness;
- People experiencing severe and persistent mental illness;
- Marginalized people;[1]
- Refugees, asylum seekers, and migrants;
- People who use or misuse substances; and
- People experiencing poverty.

[1] Marginalization refers to a social process by which individuals or groups are (intentionally or unintentionally) distanced from access to power and resources, and constructed as insignificant, peripheral, or less valuable/privileged to a community or "mainstream" society.

Communicating physician criteria for accepting new patients

Some physicians may choose to establish criteria for accepting new patients. Physicians need to use their professional judgment to determine when and how to communicate any criteria they use when accepting patients into their practice. To promote patients' understanding and ensure that decisions to accept new patients are equitable, transparent, and non-discriminatory, physicians are encouraged to inform patients of any criteria they have at the earliest opportunity, for example, during an introductory meeting or when the patient first inquires whether the practice is accepting patients.

Physicians' criteria for accepting new patients must be directly relevant to their clinical competence, scope of practice, and/or focused practice area. Appropriate criteria for physicians who serve a defined target population could include, but are not limited to, the following examples:

- Family physicians focused on Indigenous health may decide to mostly accept First Nations, Inuit, and Métis patients.
- Family physicians with a focused practice on addiction medicine may decide to primarily accept patients with substance use disorders.
- (Sub)specialists who provide limited or highly specialized services may primarily accept patients with a specified condition, or those with a higher likelihood of having that specific condition.

Ensuring criteria for accepting new patients is "fair and equitable"

By ensuring that any criteria for accepting patients is fair and equitable, physicians fulfill their legal obligations under the *Ontario Human Rights Code (the 'Code')* which entitles every Ontario resident to equal treatment with respect to services, goods and facilities, without regard to race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status, or disability.

There are different ways in which physicians can ensure that their criteria are fair and equitable and that all prospective patients receive equal treatment with respect to accessing health services. For example, using "first-come, first-served" approaches, "lottery" systems, or other non-discriminatory, equal-opportunity approaches to accepting patients can help ensure that patients who fall under the physician's criteria for accepting new patients are accepted into the practice in a fair and transparent manner.

Physicians will need to use their professional judgment in determining what approach best fits with their practice and how they can meet this requirement.

Informing patients that they will not be accepted into a practice

Physicians are reminded of the importance of clear, respectful, and honest communication when informing patients of their decisions not to accept them into their practice. Some individuals may interpret refusal as discrimination even when the physician's reasons for refusing to accept the patient are legitimate, and effective communication can help dispel perceived discrimination. The Canadian Medical Protective Association's (CMPA) *Patient-centred communication* offers guidance to physicians on how to communicate effectively with patients to optimize their care.

Accepting patients with a history of opioid use

Physicians who feel that treating patients with a history of prescription opioid use is legitimately outside of their clinical competence and/or scope of practice are reminded that:

- Responsibly prescribing narcotics and controlled substances is part of good clinical care, and refusing to prescribe these drugs altogether (e.g., through "no narcotics" policies) may lead to inadequate management of some clinical problems and leave some patients without appropriate treatment.
- There are relevant resources and clinical practice guidelines that can assist in managing the care of patients with a history of prescription opioid use. For example, the Centre for Addiction and Mental

Health (CAMH) has developed the *Canadian Opioid Use Disorder Guideline*, a national clinical guideline that standardizes guidelines for Canadian prescribers of opioid agonist therapy.[2]

- Where elements of a patient's care needs are legitimately outside a physician's clinical competence and/or scope of practice, the patient will need to be referred to a provider for those elements of care that they are unable to manage directly.
- Given the broad scope of practice of primary care physicians, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient, and determinations about whether a patient's health-care needs fall within their clinical competence and/or scope of practice must be made in good faith.

Patients who live a significant distance away from a practice

CPSO does not restrict physicians from accepting or refusing to accept new patients solely based on designated catchment areas or geographical boundaries. However, physicians will need to use their professional judgment to determine whether they can provide quality care to the patient despite the significant geographical distance between them.

For example, a physician may be able to accept a patient who lives far away from the practice if the patient is willing to travel to the clinic or if the physician feels appropriate care can be provided virtually.[3] On the other hand, it may not be appropriate for (or in the best interest of) patients whose care requires regular in-person visits to be accepted into a practice that is located a significant distance from where they live if they are unable to attend in-person appointments.

When determining whether to accept a patient who lives far away from their practice, physicians can discuss with the patient how the geographical distance between them could impact the patient's ability to receive the care they need.

Patients seeking a second opinion

Specialist physicians will need to use their professional judgment to determine whether it is appropriate to refuse a request for a second opinion. Specialist physicians will need to weigh any potential benefit to the patient of receiving a second opinion against the demand for health services from patients who have not yet received care. It would be inappropriate, however, for physicians to practise medicine in a manner that hinders patient autonomy or limits patient decisions about the care they receive.

Regardless of the reason for refusal, specialist physicians who refuse to accept a referral need to comply with the relevant expectations set out in CPSO policies, including *Accepting New Patients* and *Transitions in Care*.

Using waitlists

While physicians are not prohibited from using self-managed waitlists, those who use waitlists in their practice need to use them cautiously and carefully manage patient expectations by clearly communicating the expected waiting period.[4]

Resources such as CMPA's *Wait times when resources are limited* contain additional guidance for physicians who use waitlists. Physicians will need to use their professional judgment to balance the patient's best interest with the availability of resources and clearly communicate with the patient and their care team.

Where available, physicians who are accepting new patients are encouraged to use provincial wait lists (e.g., Health Care Connect for unattached patients seeking a primary care provider) and/or centralized referral systems (e.g., physician networks within Ontario Health Teams).

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[2] See CPSO's *Prescribing Drugs* policy and *Advice to the Profession: Prescribing Drugs* for more information, including the use of prescription treatment agreements ("narcotics prescribing contracts") and education and training resources.
[3] See CPSO's *Virtual Care* policy and *Advice to the Profession: Virtual Care* for more information, including on establishing physician-patient relationships in virtual settings and the limitations of virtual care.
[4] See CPSO's *Transitions in Care* policy for more information on consultant physicians' obligations to communicate wait times and appointment dates with referring physicians and patients.

Board Motion

Motion Title	Draft Policy for Consultation: *Accepting New Patients*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Accepting New Patients*," (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Draft Policy for Consultation: *Ending the Physician-Patient Relationship* (For Decision)
Main Contacts:	Courtney Brown, Team Lead, Policy Nikki Karagach-Manta, Policy Analyst
Attachments:	**Appendix A:** Draft *Ending the Physician-Patient Relationship* policy **Appendix B:** Draft *Advice to the Profession: Ending the Physician-Patient Relationship*
Question for Board:	Does the Board of Directors (Board) approve releasing the draft *Ending the Physician-Patient Relationship* policy for external consultation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A draft *Ending the Physician-Patient Relationship* policy (**Appendix A**) and associated *Advice to the Profession* ("*Advice*") (**Appendix B**) have been developed. The Board is asked whether the draft policy and *Advice* can be released for external consultation.

- Setting expectations that support fair and transparent decision-making when ending the physician-patient relationship aligns with CPSO's public interest mandate.

Current Status & Analysis

- The current *Ending the Physician-Patient Relationship* policy[1] and *Advice* have been revised in response to preliminary consultation feedback[2] and input from the Policy Working Group.

- While many elements of the current policy have been retained in the draft, key revisions include:

    - re-arranging and streamlining the draft policy to make it clearer and more succinct;

    - removing or amalgamating a number of prescriptive, detailed provisions to make the draft more high-level and principle-based;

    - setting out specific provisions that physicians are not required to meet if they do not feel safe doing so, because a patient poses a risk of harm to them, or others; and

    - specifying that physicians must provide necessary medical services[3] to patients for a period of at least three months once the physician-patient relationship has ended.

- Given that the draft policy has been streamlined, considerations for specific reasons for ending the physician-patient relationship have been moved to the draft *Advice*.

- The *Advice* has also been updated to better reflect the concerns of physicians and patients, including providing guidance on outside use and de-rostering patients, navigating when the patient ends the physician-patient relationship, and managing difficult patient encounters.

[1] The *Ending the Physician-Patient Relationship* policy was last reviewed in 2017.
[2] A preliminary consultation on the draft policy received 112 total responses. All of the written comments can be viewed on the consultation webpage, and an overview of feedback was provided to the Board in the May 2024 Policy Report.
[3] For example, renewing prescriptions, where medically appropriate, and ensuring appropriate follow-up on all laboratory and test results ordered.

ENDING THE PHYSICIAN-PATIENT RELATIONSHIP

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

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

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

Policy

1. Physicians **must** comply with the expectations set out in this policy when ending a physician-patient relationship, except when the end of the physician-patient relationship is due to the physician's retirement, relocation, leave of absence, or a result of disciplinary action by CPSO.[1]
2. Physicians, including specialists, **must** comply with the expectations set out in this policy when ending a physician-patient relationship *prior* to reaching the normal or expected conclusion of a patient's care. This policy does not apply when a physician's relationship with a patient reaches its normal or expected conclusion (for example, because treatment has concluded).

Circumstances where physicians may end the physician-patient relationship

3. Physicians are permitted to end a physician-patient relationship, but **must only** do so if there is a reasonable basis for ending the relationship, for example when:
    a. There has been a significant breakdown in the physician-patient relationship;
    b. They can no longer provide quality care to the patient; or
    c. They wish to decrease their practice size.[2]

Circumstances where physicians cannot end the physician-patient relationship

4. Physicians **must not** end a physician-patient relationship based on a prohibited ground of discrimination[3] or where otherwise prohibited by legislation.[4]
5. Physicians **must** respect patient autonomy with respect to lifestyle, healthcare goals, and treatment decisions, and **must not** end a physician-patient relationship solely because a patient:

[1] For more information on physician retirement, relocation, leave of absence, or disciplinary action, see CPSO's *Closing a Medical Practice* policy.
[2] Physicians need to ensure that when decreasing their practice size, they do not disproportionately discharge patients with high or complex needs. For more information on how to decrease a practice size appropriately, see the *Advice to the Profession: Ending the Physician-Patient Relationship*.
[3] The *Ontario Human Rights Code* ("*Code*") provides that every person has a right to equal treatment without discrimination, including discrimination on the grounds of age, gender, marital status, national or ethnic origin, physical or mental disability, race, religion, and sexual orientation.
[4] Physicians need to ensure that any decision to end the physician-patient relationship complies with relevant legislation. This legislation includes *The Commitment to the Future of Medicare Act, 2004*, which prohibits physicians from ending the physician-patient relationship because the patient chooses not to pay a block or annual fee, and the Professional Misconduct Regulations under the *Medicine Act, 1991*.

a. Does not follow medical advice; [5]
b. Suffers from an addiction or dependence, or is on a high dose of a prescribed controlled drug and/or substance;[6] or
c. Seeks treatment to which the physician objects for reasons of conscience or religion.[7]

Expectations when ending the physician-patient relationship

6. Prior to ending a physician-patient relationship, physicians **must:**

    a. Apply good clinical judgment and compassion to determine the most appropriate course of action;
    b. Consider the patient's specific circumstances and vulnerabilities, as well as the consequences for the patient of ending the relationship; and
    c. Make reasonable efforts to resolve the situation in the best interest of the patient, where they feel it is safe to do so.[8]

7. When ending a physician-patient relationship, physicians **must**:

    a. Inform the patient of the reasons why they are ending the physician-patient relationship, where they feel it is safe to do so;[9]
    b. Notify the patient in writing of their decision to end the physician-patient relationship and of the importance of seeking ongoing care; [10]
    c. Retain a copy of the written notification and any confirmation of receipt in the patient's medical record;
    d. Inform appropriate staff and the patient's other health-care providers, where necessary, that they are no longer providing care to the patient, unless the patient has expressly restricted the physician from sharing this information;[11]
    e. Provide necessary medical services[12] for a period of at least 3 months after ending the physician-patient relationship,[13] where they feel it is safe to do so;[14]
    f. Provide care in an emergency, where it is necessary to prevent imminent harm;
    g. Document the reasons for ending the physician-patient relationship and all the steps they have undertaken to attempt to resolve the issue(s) in the patient's medical record;

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[5] For example, with respect to smoking cessation, drug or alcohol use, or the patient's decision to refrain from being vaccinated or vaccinating their children.
[6] Controlled drugs and substances are defined in the *Controlled Drugs and Substances Act,* 1996.
[7] Expectations for physicians who limit care for reasons of conscience or religion can be found in CPSO's *Human Rights in the Provision of Health Services* policy.
[8] If there are reasonable grounds to believe there is a risk of harm to the physician, their staff and/or other patients, physicians are not required to meet with the patient prior ending the physician-patient relationship.
[9] If there are reasonable grounds to believe there is a risk of harm to the physician, their staff and/or other patients, physicians are not required to inform patients of the reason for ending the physician-patient relationship.
[10] Physicians need to consider privacy and confidentiality implications and the best method of communication to ensure the patient will receive the written notification. For more information, see the *Advice to the Profession: Ending the Physician-Patient Relationship*.
[11] Under the *Personal Health Information Protection Act*, *2004*, a physician may provide personal health information about a patient to another health care provider for the purposes of providing or assisting in the provision of health care, if the patient has not restricted the physician from doing so. If the patient has restricted the physician from providing personal health information, the physician must notify the health care provider who has requested information on the patient about this restriction and may advise them to direct any inquiry to the patient themselves for a response.
[12] This may include, for example, renewing prescriptions, where medically appropriate, and ensuring appropriate follow-up on all laboratory and test results ordered in accordance with CPSO's *Managing Tests* policy.
[13] Discontinuing professional services that are needed may constitute professional misconduct unless alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services (O. Reg. 856/93 s.1(1)7).
[14] If there are reasonable grounds to believe there is a risk of harm to the physician, their staff and/or other patients, physicians are not required to provide interim care.

h. Inform the patient that they are entitled to a copy of their medical records;[15] and
i. Ensure the timely transfer of a copy or summary of the patient's medical records, if requested.[16]

[15] Physicians are able to charge a reasonable fee for copying and transferring medical records in accordance with CPSO's *Medical Records Management* policy.
[16] For further information, refer to CPSO's *Medical Records Management* policy.

ADVICE TO THE PROFESSION: ENDING THE PHYSICIAN-PATIENT RELATIONSHIP

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.

An effective physician-patient relationship is essential for the provision of quality medical care and is based on the mutual trust and respect of the physician and the patient. While this relationship is of central importance to the practice of medicine, circumstances may arise that lead either the physician or the patient to end the physician-patient relationship.

This advice document is intended to help physicians interpret the expectations set out in the *Ending the Physician-Patient Relationship* policy and to provide guidance about how these expectations can be met.

Where the patient ends the physician-patient relationship

This policy does *not* apply when the patient ends the physician-patient relationship. The expectations in this policy apply only when a *physician* wishes to end a physician-patient relationship (prior to its normal or expected conclusion).

When a patient wishes to end a physician-patient relationship, physicians may want to discuss with the patient why they are choosing to do so. These discussions can help the physician understand any concerns the patient may have about the care they are receiving and can help the physician resolve the situation.

The physician remains responsible for documenting in the patient's medical record the patient's reasons for ending the relationship (if known) and any steps they have undertaken to try to resolve the situation. To prevent confusion, physicians may also consider providing the patient with a written notification that their physician-patient relationship has ended.

Significant breakdowns in the physician-patient relationship

Physicians will need to use their professional judgment to determine what constitutes a "significant breakdown." A breakdown in the physician-patient relationship can occur when trust and respect between a physician and their patient has been lost and/or the therapeutic relationship has deteriorated. Situations that can lead to a breakdown in the physician-patient relationship include, but are not limited to, those in which a patient:

- Commits prescription-related fraud;
- Behaves in an abusive, or disruptive manner;
- Frequently misses appointments without providing appropriate cause or notice; or
- Refuses to pay outstanding fees without providing a reasonable justification for non-payment.[1]

Resources for managing difficult patient encounters

For information on ending the physician-patient relationship and managing challenging encounters, see the external resources linked below:

- *When physicians feel bullied or threatened* (CMPA)
- *How to manage conflict and aggressive behaviour in medical practice* (CMPA)

[1] Reasonable justification for non-payment could include evidence of financial hardship. For more information on billing issues, see CPSO's *Uninsured Services: Billing and Block Fees* policy and *Advice to the Profession: Uninsured Services*.

- *Challenging patient encounters: How to safely manage and de-escalate* (CMPA)
- *Physician Safety: How to Protect Against Threats or Risk of Harm by Patients FAQ* (OMA)

The Ontario College of Family Physicians also has a Peer Connect Mentorship program which supports physicians in skillfully responding to mental health issues and addressing substance use disorders and chronic pain challenges in their practice.

Patient complaints

Patients may contact CPSO for help addressing an issue with their physician and/or to initiate a complaint. Depending on the nature of the issue, CPSO may contact the physician to try to help resolve the situation.

Often, patient concerns can be resolved when the issue is brought to the physician's attention, and the physician-patient relationship can be repaired. Physicians should not automatically end their relationship with a patient in response to the patient's contact with CPSO. If, however, a physician believes that their patient's concerns or complaints indicate a broader loss of mutual trust and respect and they feel they cannot maintain an effective therapeutic relationship with the patient, it may be appropriate to end the physician-patient relationship.

Situations where physicians may no longer be able to provide quality care

There are many reasons why physicians may feel they can no longer provide quality care to a patient including, but not limited to:

- The patient has been absent for a long period of time;
- The patient has relocated far from the physician's practice and is unable to attend in-person appointments, where necessary; or
- The physician develops a conflict of interest with the patient.

Considerations for deciding to end the physician-patient relationship

There may be specific factors to consider and/or steps to take prior to ending the relationship, depending on a physician's reasons for wanting to end their relationship with a patient. For example:

Where the patient has been absent from the practice for an extended period, the physician can:

- Make a good-faith effort to determine whether the patient would prefer to maintain the relationship.
- Send a letter of inquiry to the patient's last known address (residential or email).

Where the patient's behaviour is abusive or disruptive, the physician can:

- Consider whether the patient's behaviour is an isolated incident or part of a larger pattern.
- Consider whether there are underlying factors that may be contributing to the patient's behaviour (e.g., mental illness).
- Inform the patient of any expectations or clinic policies related to patient conduct.

Where the patient has refused to pay an outstanding fee, the physician can:

- Consider the financial burden that paying the fee could place on the patient.
- Consider waiving the fee or allowing flexibility with respect to repayment, especially if the patient is unable to pay due to personal circumstances.

Where the patient has relocated far from the physician's practice, the physician can:

- Determine whether the patient is willing and able to travel to the clinic for necessary in-person care and/or whether care can appropriately be provided virtually.[2]
- Discuss with the patient how their relocation could impact their ability to receive the care they need.

[2] See CPSO's *Virtual Care* policy and *Advice to the Profession: Virtual Care* for more information.

Where the physician wishes to decrease their practice size[3], the physician can:

- Make sure to select patients with whom to end the physician-patient relationship in a fair, transparent, and compassionate way.
- Ensure that patients with high or complex care needs are not discharged disproportionately.
- Consider each patient's medical needs and their ability to find alternative care in a timely manner.

Where the physician has a conflict of interest with a patient, the physician can:

- Inform the patient of how the conflict of interest impacts their ability to provide quality care.
- Assist the patient in finding another provider to take over their care.

Outside use and de-rostering patients

When patients who are part of a rostered practice seek care outside of that practice (e.g., by going to a walk-in clinic), there can be a financial impact on the physician. For this reason, some physicians may want to de-roster that patient and see them instead on a fee-for-service basis.

Physicians need to be conscious of the difference between *ending* a physician-patient relationship and *de-rostering* a patient, and ensure this distinction is made clear to patients. To avoid any potential confusion when de-rostering a patient, physicians may want to discuss with patients directly what de-rostering entails and why they are being de-rostered, while also making clear to them that they will not lose access to care.

It would not be reasonable for a physician to end the physician-patient relationship solely because the patient sought care outside of their rostered practice. However, there may be instances where de-rostering is not possible, or where the physician feels that the patient continually seeking care outside of the practice has led to a breakdown in their relationship or has impacted their ability to provide quality care to the patient. In these circumstances, the physician needs to do the following before ending the relationship:

- Consider the factors that may have led the patient to seek care outside the practice (including the physician's own availability),
- Provide the patient with clear information about the patient's obligations within the rostered practice,
- Provide the patient with appropriate warning, and
- Undertake reasonable efforts to resolve the situation in the best interests of the patient.

Providing written notification

Providing patients with a written notification indicating the reasons for ending the physician-patient relationship during an appointment, or sending the notification by registered mail or courier can help ensure that the patient has received it. It may also be appropriate and acceptable for a physician to inform a patient of their decision to end the physician-patient relationship using an online platform (e.g., patient portal or email) provided the physician typically uses this platform to communicate with the patient.

No matter how a physician provides written notification to their patients, they will need to ensure that patient confidentiality is maintained.

Sample termination letter

Physicians may use the following sample letter to inform their patients that they have ended the physician-patient relationship. Physicians can customize this letter to suit their needs and to help ensure that the patient can understand it.

[3] Physicians who plan to retire will need to do so in accordance with the expectations outlined in CPSO's *Closing a Medical Practice* policy.

Dear [patient's name]:

As we discussed at your appointment on [*insert date*], my first obligation as a medical doctor is to provide quality care to all my patients. To do this, you and I must cooperatively and respectfully work together towards your health and well-being.

Due to [*if appropriate, indicate reason*], it is no longer possible for me to continue our physician-patient relationship.

I urge you to obtain another physician or primary health-care provider as soon as possible. With your consent, I will be pleased to provide them with a copy or summary of your medical records [*include any additional steps, the process for obtaining a copy of their medical records and any associated fees*]. I will also ensure appropriate follow-up on all laboratory and test results still outstanding and provide interim care for [*include time period here, minimum three months*].

For primary care physicians: For assistance in locating another physician, you may wish to register with Health Care Connect which can refer you to a family physician or nurse practitioner in your area accepting new patients. You can also contact primary care clinics within your community to determine if any physicians are accepting new patients. Some physicians, including those who are new to an area or who are beginning to establish a practice, may advertise locally that they are accepting new patients.

Yours truly,

[*Signature of physician*]

Board Motion

Motion Title	Draft Policy for Consultation – *Ending the Physician-Patient Relationship*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Ending the Physician-Patient Relationship*," (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Draft Policy for Consultation: *Treatment of Self, Family Members, and Others Close to You* (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Laura Rinke-Vanderwoude, Policy Analyst Lynn Kirshin, Senior Policy Analyst
Attachments:	**Appendix A:** Draft *Treatment of Self, Family Members, and Others Close to You* policy **Appendix B:** Draft *Advice to the Profession: Treatment of Self, Family Members, and Others Close to You*
Question for Board:	Does the Board of Directors approve releasing the draft *Treatment of Self, Family Members, and Others Close to You* policy for external consultation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A newly-titled draft policy called *Treatment of Self, Family Members, and Others Close to You* ("*Treatment of Self*") (**Appendix A**) and associated *Advice (***Appendix B***)* have been developed. The Board is asked whether the draft policy and *Advice* can be released for external consultation.

- Setting appropriate expectations for physicians with respect to providing care for people close to them helps to ensure quality care for patients and supports CPSO's public interest mandate.

Current Status and Analysis

- The current *Treatment of Self* policy[1] and associated *Advice* have been revised in response to preliminary consultation feedback[2] and input from the Policy Working Group.

- As a result of the feedback received, the draft *Treatment of Self* policy has been substantially revised. Key updates include:

    - Expanding the circumstances where physicians can treat themselves, family members, and others close to them by expanding the definition of emergency treatment;

    - Clarifying who is considered close to a physician by setting out factors that the physician can consider to determine if their professional judgment is reasonably affected by the relationship; and

    - Including provisions to enable care beyond emergency treatment and treatment of minor conditions in communities with limited treatment options, including Indigenous and remote communities.

- The approach taken in the draft *Treatment of Self* policy is innovative among medical regulators and is designed to respond to the current access to care challenges in Ontario.

- The draft *Advice* document provides further clarity and guidance about circumstances in which a physician can provide treatment to those who are close to them. This includes a section highlighting the policy's application in Indigenous communities and examples of emergency and minor treatment.

[1] The *Treatment of Self* policy was last comprehensively reviewed in 2016.
[2] A preliminary consultation on the draft policy received 179 total responses. All of the written comments can be viewed on the consultation webpage, and an overview of feedback was provided to the Board in the February/March 2024 Policy Report.

TREATMENT OF SELF, FAMILY MEMBERS, AND OTHERS CLOSE TO YOU

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

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

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

Definitions

Treatment: Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose. This includes but is not limited to performing any controlled act[1]; ordering and performing tests (including blood tests and diagnostic imaging); providing a course of treatment, plan of treatment, or community treatment plan.[2]

Family member: An individual with whom the physician has a familial connection. This includes but is not limited to the physician's spouse or partner, parent, child, sibling, members of the physician's extended family, or those of the physician's spouse or partner (e.g., in-laws).

Others Close to Them: Individuals who have a close or personal relationship with the physician where the nature of the relationship could reasonably affect the physician's professional judgment as set out in Provision 1a.

Policy

1. When their professional judgment is considered reasonably affected, physicians **must only** provide treatment to themselves, family members, and others close to them in accordance with the exceptions set out in this policy.

    a. If any of the following factors apply, a physician's professional judgment is considered reasonably affected, even if the physician believes they would provide objective care:

    - There are barriers to or discomfort in sharing or hearing sensitive information;
    - There are factors that may affect the decision-making of the physician or the individual receiving treatment, for example, an individual receiving treatment feeling obligated to accept a physician's recommendations about treatment decisions;

[1] Controlled acts for physicians, as set out in s. 4 of the *Medicine Act,* S.O. 1991, c. 30.
[2] This definition is adapted from the *Health Care Consent Act.*

- The physician may be hesitant to make mandatory reports about the individual receiving care;
- The individual receiving treatment may be hesitant to voice concerns about the treatment provided or pursue legal options; or
- Any other factors that could cause a physician to lose objectivity or fail to meet the standard of care.[3]

Emergency Treatment

In this policy, "emergency treatment" is treatment that is necessary in a timely manner to prevent significant harm, suffering and/or deterioration.

2. Physicians **must only** provide emergency treatment to themselves, family members, and others close to them when no other qualified health-care professional is readily available.

   a. Where additional or ongoing treatment is necessary, physicians **must** transfer treatment of the individual to another qualified health-care professional as soon as is practical.[4]

Treatment for Minor Conditions[5]

A "minor condition" is a health condition that can be managed with minimal, short-term treatment and usually does not require ongoing care or monitoring. In addition, the treatment of the condition is unlikely to mask a more significant underlying condition.

3. Physicians **must only** provide treatment for minor conditions to themselves, family members, and others close to them when no other qualified health-care professional is readily available.

   a. Where additional or ongoing treatment is necessary, physicians **must** transfer treatment of the individual to another qualified health-care professional as soon as is practical.[6]

Treatment of Sexual or Romantic Partners

Ontario law defines who is a patient for the purpose of determining whether sexual abuse has occurred between a physician and a patient.[7] For the purposes of determining sexual abuse, a person is defined as a patient when:

1. the physician charges or receives a payment for health care services provided;
2. the physician contributes to a health record or file for the person;
3. the person has consented to a health care service recommended by the physician; or,
4. the physician prescribes a drug for which a prescription is needed to the person.

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[3] For more information about other factors which determine whether individuals may be considered close to you, see the *Advice to the Profession: Treatment of Self, Family members, and Others Close to You* document.
[4] This also includes virtual care options, where appropriate.
[5] For the purposes of this policy, "minor condition" does not include providing sick notes or completing insurance claims for themselves, family members, or others close to them.
[6] This also includes virtual care options, where appropriate.
[7] S. 1(6) of the *Health Professions Procedural Code* (*Code*) under the *Regulated Health Professions Act, 1991* (*RHPA*) and O. Reg. 260/18 under the *RHPA* provide a definition of who is a patient for the purpose of determining whether sexual abuse has occurred between a physician and a patient. The *Code* also specifies that a person continues to be considered a patient for the purposes of findings of sexual abuse for one year after the conclusion of the physician-patient relationship.

4. Providing treatment to someone with whom a physician is sexually or romantically involved, including a spouse or partner, may result in a finding that the physician engaged in sexual abuse of a patient[8], if the treatment exceeds what is permissible in the legislation and as set out in this policy (emergency treatment or treatment of a minor condition). Physicians **must not** provide treatment to a spouse, partner, or anyone else with whom they are sexually or romantically involved beyond emergency treatment and treatment of minor conditions as set out in this policy.

Practising in Communities with Limited Treatment Options

5. CPSO recognizes that in some small communities, there may be family members or others close to the physician who do not have alternative options for treatment. If faced with these circumstances, the physician may provide treatment beyond emergency treatment or treatment for minor conditions to people other than a sexual or romantic partner and **must** document the circumstances in the patient's medical record, including why treatment was provided.

a. Where additional or ongoing treatment is necessary, physicians **must** make every reasonable effort to transfer care to another qualified health-care professional as soon as is practical.

6. When determining if a person does not have alternative options for treatment, physicians **must** consider:

a. Whether the treatment is within another available qualified health-care professional's scope of practice;
b. The geographical distance and/or the person's ability to travel to other treatment options;
c. Whether virtual care can be used to provide treatment; and,
d. Any personal factors that would present a significant barrier to obtaining treatment[9] from another available qualified health-care professional, **and** which could not be managed through community supports or reasonable accommodations.

7. Despite Provision 5, physicians **must not:**

a. Provide treatment outside of an emergency or minor condition to an individual with whom they have a sexual or romantic relationship.[10]
b. Provide intimate examinations[11] outside of emergency treatment to family members; and/or,
c. Provide psychotherapy to family members.

Prescribing or Administering Drugs

8. Physicians **must not** prescribe or administer the following for themselves, family members, or others close to them:

[8] See footnote 7.
[9] For examples of personal factors that would present a significant barrier to obtaining treatment, please see the *Advice to the Profession: Treatment of Self, Family Members, and Others Close to You* document.
[10] Please see footnote 7.
[11] Intimate examinations include breast, pelvic, genital, perineal, perianal and rectal examinations of patients.

- narcotics,[12,13]
- controlled drugs or substances,[14,15] or
- monitored drugs.[16]

Facilitating Continuity of Care

9. If a physician provides treatment under this policy, they **must** take reasonable steps to facilitate continuity of care where necessary.

[12] Narcotics are defined in s. 2 of the *Narcotic Control Regulations*, C.R.C. c. 1041, enacted under the *Controlled Drugs and Substances Act,* S.C. 1996, c. 19 (hereafter the *CDSA*) *CDSA*: the term 'narcotics' includes opioids.
[13] Regulations under the *CDSA* prohibit physicians from prescribing or administering narcotics, or controlled drugs or substances for anyone other than a patient whom the physician is treating in a professional capacity, for example, in an Emergency Department. There are no exceptions under the *CDSA* for prescribing or administering these drugs or substances to non-patients. See s. 53(2) of the *Narcotic Control Regulations* C.R.C. c. 1041, and s. 58 of the *Benzodiazepines and Other Targeted Substances Regulations*, SOR/2000-217, under the *CDSA*.
[14] Controlled drugs and substances are defined in s. 2(1) of the *CDSA* and mean a drug or substance included in Schedule I, II, III, IV or V of the Act.
[15] Please see footnote 13.
[16] The Ontario Ministry of Health (Ministry) monitors a number of prescription narcotics and other controlled substance medications as part of its Narcotics Strategy. A list of monitored drugs is available on the Ministry's website https://www.ontario.ca/page/narcotics-monitoring-system#section-1. See also s. 2 of the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 for a definition of 'monitored drug'.

ADVICE TO THE PROFESSION: TREATMENT OF SELF, FAMILY MEMBERS, OR OTHERS CLOSE TO YOU

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.

Physicians may find themselves in circumstances where they must decide whether it would be appropriate to provide treatment for themselves, family members, or others close to them, including friends, colleagues, and staff.

While physicians may have a genuine desire to deliver the best possible treatment, research suggests that a physician's ability to maintain emotional and clinical objectivity may be compromised when treating themselves or others close to them. This can impact the physician's ability to meet the standard of care and compromise the quality of treatment provided to the individual.

This document is intended to help physicians interpret the expectations set out in the *Treatment of Self, Family Members, and Others Close to You* policy and provide guidance about how these expectations can be met.

How can objectivity and professional judgment be compromised when providing treatment for myself, family members or others close to me?

Research demonstrates that your objectivity and the quality of care you provide can be compromised when treating yourself or people close to you[1].

[1] See for example:

- Francisca Beigel, et al. "A systematic review documenting reasons whether physicians should provide treatment to their family and friends" (2022) Family Practice, cmac142, Oxford Academic (3 January 2023), online: https://doi.org/10.1093/fampra/cmac142.
- Vijayalakshmi S, Ramkumar S, Rajsri T, et al. "A Doctor in the House, An Ethical Consideration on Treating Their Family Members: A Mixed-Method Study" (August 27, 2023). Cureus 15(8): e44230. DOI 10.7759/cureus.44230.
- Bernard Dickens, "Ethical issues in treating family members and close friends" (2016) International Journal of Gynecology and Obstetrics 133, 247-248 (2016), online: https://obgyn.onlinelibrary.wiley.com/doi/10.1016/j.ijgo.2016.02.002
- Joseph J. Fins, "Family Portrait" (2018) Narrative Inquiry in Bioethics, Vol. 8 N. 1, p. 4-6 (Spring 2018), online: https://muse.jhu.edu/article/690189

Quality of care can be impacted in a number of different ways by compromised objectivity, including but not limited to the physician:

- feeling uncomfortable discussing sensitive issues, including the individual's personal medical history. This can also apply to the individual being treated. This is particularly relevant when the issue involves sexual health and behaviour, drug use, mental health issues, or abuse or neglect.
- feeling obligated or pressured to treat problems that are beyond their expertise or training, or to prescribe drugs that are addicting/habituating, including narcotics or controlled substances.
- having difficulty recognizing the need to obtain informed consent and to respect the individual's decision-making autonomy.
- having difficulty recognizing that the duty of confidentiality applies the same way it would for a patient. For example, the physician may experience pressure to disclose confidential information if others close to the physician insist on knowing 'what is going on' in relation to an individual's health.
- being reluctant to make a mandatory report (e.g., an impairment affecting the individual's ability to drive, or a suspicion of child abuse).

How do I know if there are other factors that could cause someone to be considered someone close to me?

Physicians need to use their professional judgment when determining whether there are other factors not set out in the policy that may affect the quality of care an individual receives. If you think that, for any reason, your objectivity may be reasonably affected, you should consider the person close to you.

Some common examples of other factors include:

- A physician being hesitant to have a frank and open consent discussion or propose specific treatment options;
- External pressure, either from the person receiving care or mutual acquaintances, to practise outside of a physician's scope or expertise or provide care beyond what they would normally provide to a patient in the same situation;
- Pressure to disclose confidential information to third parties; or,

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- Solomiya Grushchak, Jane M. Grant-Kels, "Sweetheart, you should have that looked at: Ethical implications of treating family members" (February 2019). J Am Acad Dermatol Vol. 90, N. 2. (2019). DOI: 10.1016/j.jaad.2017.12.067
- Helene Hill, Matthew Hill, "When your mother wants a script: The ethics of treating family members" (2011). JAAPA 24(2) p. 59-60 (February 2011). DOI: 10.1097/01720610-201102000-00012
- Katherine J. Gold, et al. "No Appointment Necessary? Ethical Challenges in Treating Friends and Family" (2014) N Engl J Med 2014; 371:1254-1258.
- Kathy Oxtoby, "Doctors' Self Prescribing" BMJ Careers (10 January 2012), online: BMJ Careers.

- Property or financial ties to an individual.

Why am I limited in the type of treatment I can provide to someone with whom I am sexually or romantically involved, including my spouse or partner?

If a physician provides care or treatment to a sexual or romantic partner beyond what is set out in legislation and the *Treatment of Self, Family Members and Others Close to You* policy, a physician may be found to have committed an act of professional misconduct, specifically, a finding of sexual abuse.[2] The permitted care is limited to emergency treatment or treatment of a minor condition and when no other qualified health-care professional is readily available, requiring the transfer of treatment to another qualified health-care professional as soon as is practical.

The *RHPA* also contains mandatory penalties, including the revocation of a physician's certificate of registration, for several forms of sexual abuse. At an Ontario Physicians and Surgeons Discipline Tribunal hearing, the Tribunal is required to impose these mandatory penalties (up to and including revocation or a significant period of suspension, in some cases) even if there are mitigating circumstances.

What are some examples of minor conditions under this policy?

Depending on patient-specific factors, a few examples of minor conditions may include:

- Minor skin conditions (e.g., eczema, contact dermatitis, insect bites);
- Minor uncomplicated infections (e.g., conjunctivitis, otitis media, pharyngitis, cystitis); and,
- Minor injuries (e.g., small lacerations, bruises, sprains)

Patient-specific factors include but are not limited to:

- Age;
- Past medical history; and,
- The severity of the symptoms.

For example, a laceration on an elderly person with a blood clotting disorder may not be considered a minor condition. In contrast, a similar laceration on a healthy young adult may be considered a minor condition.

Physicians are advised to use their professional judgment to determine whether a person has a minor condition, and whether treating the minor condition would be appropriate given their scope of practice.

[2] The *Regulated Health Professions Act, 1991* (*RHPA*) and its regulations prohibit the sexual abuse of patients and provide a definition of who is a patient for the purposes of determining whether sexual abuse has occurred.

What is emergency treatment under this policy?

Emergency treatment is the treatment of a condition which should be initiated in a timely manner (e.g., within 24 hours) to prevent significant harm, suffering and/or deterioration. A few examples of conditions which may require emergency treatment include severe asthma, heart failure, and fractures or dislocations.

When would a person be considered to have alternative treatment options?

Examples of when a person would have other treatment options include having:

- The ability to travel to another community within a reasonable distance where they could obtain care (even if less convenient);
- Access to virtual care options that meet their treatment needs; or,
- The ability to be treated by another qualified health-care professional provider despite personal preferences (e.g., religious, language, ethnicity, or gender preferences).

In contrast, a person may not have other treatment options if:

- They are not reasonably able to travel to another qualified health-care professional and cannot access virtual treatment options (e.g., people experiencing homelessness);
- The only available physicians are those with whom the person has had a significant breakdown in the physician-patient relationship; or,
- There are severe systemic or other issues affecting the person's trust in the health-care system that may reasonably prevent the person from seeking care elsewhere (e.g., Indigenous people or individuals with a history of sexual abuse).

How does this policy apply to physicians practising in Indigenous communities?

CPSO recognizes that physicians practising in Indigenous communities may be interconnected with or related to the entire community. Additionally, systemic inequality has deeply affected the trust many Indigenous people have in the health-care system.

Physicians practising in Indigenous communities can provide emergency treatment or treatment for minor conditions in accordance with the policy. They may also consider whether a broader scope of treatment would be appropriate because a person may have no other treatment options. One aspect that can be considered when determining if there are alternative treatment options is whether there are personal factors that would present a significant barrier to obtaining treatment from any other available qualified health-care professional which cannot be managed through community supports or reasonable accommodations.

In the case of Indigenous people, deep and pervasive mistrust of other qualified health-care providers may mean that they do not have any other viable alternative treatment options. Therefore, physicians who are trusted by Indigenous community members can provide care under this exception in the policy when appropriate.

Am I allowed to provide informal medical advice?

Yes, physicians may provide informal medical advice that does not fall under the definition of "treatment" in this policy. For example, a physician may advise a family member to see a health-care professional for a worrisome symptom or help them understand medical information they have been given by another health-care professional.

Can I prescribe narcotics, controlled drugs or substances, or monitored drugs to family members or someone close to me?

You can only prescribe these drugs if your family members or those who are close to you, become your patient, for example, if you are providing treatment in an Emergency Department. Factors to consider before prescribing include consideration of treatment options in the community and whether it is within the standard of care to prescribe these drugs/substances.

Board Motion

Motion Title	Draft Policy for Consultation: *Treatment of Self, Family Members, and Others Close to You*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft revised policy, "*Treatment of Self, Family Members, and Others Close to You*," [formerly titled *"Physician Treatment of Self, Family Members, and Others Close to Them"] (*a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Proposed Amendments: *Boundary Violations* policy (For Decision)
Main Contacts:	Lynn Kirshin, Senior Policy Analyst Laura Rinke-Vanderwoude, Policy Analyst Tanya Terzis, Manager, Policy & Governance
Attachments:	**Appendix A:** Draft Amendments to the *Boundary Violations* Policy **Appendix B:** Draft Amendments to the *Advice to the Profession: Maintaining Appropriate Boundaries* (relevant section)
Question for Board:	Does the Board of Directors (Board) approve the revised *Boundary Violations* policy as a policy of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Amendments to the *Boundary Violations* policy (**Appendix A**) are proposed to remove an expectation which states that physicians must not engage in sexual relations with a former patient for at least 5 years if psychotherapy was provided, and to revise an expectation to state that it may be professional misconduct for a physician to have a sexual relationship with a former patient.

- Removing the expectation is intended to clarify that sexual relations with former patients are likely always inappropriate if psychotherapy is provided. The proposed amendments are also intended to emphasize that engaging in sexual relations with a former patient is not just inappropriate but may also amount to professional misconduct.

Current Status & Analysis

- During the *Physician Treatment of Self, Family Members and Others Close to Them* policy ("*Treating Self*" policy) review, staff determined that amendments to the *Boundary Violations* policy were necessary after examining the sexual abuse provisions of the *Regulated Health Professions Act* (*RHPA*) (including the definition of "patient" in the legislation) and the *Boundary Violations* policy.

- Under the *Health Professions Procedural Code* (the *HPPC*)[1], a physician can be found to have sexually abused their patient if they engage in sexual relations with that individual up to one year after the date the individual ceased to be their patient. Provision 8 of the *Boundary Violations* policy extends this period to five years when psychotherapy that is more than minor or insubstantial has been provided. It is proposed that this provision be removed from the policy. In most cases, it will never be appropriate for a physician to begin having a sexual relationship with a patient to whom they have provided psychotherapy.

- Provision 9 of the policy reinforces this, and states broadly that it may never be appropriate to engage in sexual relations with a patient depending on a number of factors, including the nature of the care provided. Removing Provision 8 means Provision 9 would apply to all physicians, including those who provide psychotherapy to patients. This would remove any implicit suggestion that it may be permissible for a sexual relationship to begin after five years have elapsed. The current policy also singles out psychotherapy, while removing Provision 8 would reflect the reality that psychotherapy is not the only treatment where additional time (beyond the one-year set out in legislation) may be warranted.

    - The five-year period currently set out in Provision 8 is arbitrary and there is no consistency across Colleges in Ontario. The College of Psychotherapists of Ontario and College of Psychologists and Behaviour Analysts of Ontario set out a five-year period; the College of Social Workers and Social

[1] Subsections 1(3) and (6) of the *HPPC*, Schedule 2, to the *RHPA*, 1991, S.O. 1991, c.18. The *HPPC* provides for mandatory revocation of specific acts of sexual abuse including sexual intercourse.

Service Workers never allows their members to engage in a sexual relationship if counselling or psychotherapy has been provided; and, the College of Occupational Therapists of Ontario and the College of Nurses of Ontario rely on the legislation's one-year period.

- Additional amendments are also proposed to Provision 9 to make clear that sexual relations with a former patient may not just be inappropriate, but may also constitute professional misconduct. This amendment will clarify that such activity could be the subject of a Discipline Tribunal hearing and may result in a finding of professional misconduct.

- The proposed amendments to the policy will also help to reduce the complexity of the definition of patient in the *Treating Self* policy.

- Amendments are also being proposed to the companion *Advice to the Profession* document (**Appendix B**) to ensure the guidance aligns with the revised expectations in the policy.

BOUNDARY VIOLATIONS

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

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

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

Definitions

Boundary: Defines the limit of a safe and effective professional relationship between a physician and a patient. There are both sexual boundaries and non-sexual boundaries within a physician-patient relationship.

Boundary Violation: Occurs when a physician does not establish and/or maintain the limits of a professional relationship with their patient.

Patient: In general, a factual inquiry must be made to determine whether a physician-patient relationship exists, and when it ends. The longer the physician-patient relationship and the more dependency involved, the longer the relationship will endure.

However, for the purposes of the sexual abuse provisions of the *Health Professions Procedural Code* (*HPPC*), a person is a physician's patient if there is direct interaction and **any** of the following conditions are met:

- the physician has charged or received payment from the person (or a third party on behalf of the person) for a health care service provided by the physician,
- the physician has contributed to a health record or file for the person,
- the person has consented to the health care service recommended by the physician, or
- the physician prescribed the person a drug for which a prescription is needed.[1,2]

In addition, the physician-patient relationship endures for one year from the date on which the person ceased to be the physician's patient.[3]

Sexual Abuse: The *HPPC* defines sexual abuse as follows:

- sexual intercourse or other forms of physical sexual relations between a physician and their patient;
- touching, of a sexual nature, of a patient by their physician; or

[1] O. Reg. 260/18 under the *Regulated Health Professions Act, 1991,* S.O. 1991, c.18 (*RHPA*).

[2] A person is not a physician's patient if **all** of the following conditions are met:

- There is a sexual relationship between the person and the physician at the time the health care service is provided to the person;
- The health care service provided by the physician to the person was done due to an emergency or was minor in nature; and
- The physician has taken reasonable steps to transfer the person's care, or there is no reasonable opportunity to transfer care. (O. Reg. 260/18 under the *RHPA*)

[3] Section 1(6) of the *HPPC*, Schedule 2, to the *RHPA*.

- behaviour or remarks of a sexual nature by a physician towards their patient.[4]

Policy

1. Physicians **must** establish and maintain appropriate boundaries with their patients.

Sexual Boundary Violations

2. Physicians **must not** engage in sexual relations with a patient, touch a patient in a sexual manner or engage in behaviour or make remarks of a sexual nature towards a patient.[5]

3. To help ensure sexual boundaries are maintained and that sexual boundary violations do not occur, physicians **must**:

a. **Not** make any sexual comments or advances towards a patient.
b. **Not** respond sexually to any form of sexual advance made by a patient.
c. Explain to patients in advance, the scope and rationale of any examination, treatment or procedure and if asking questions regarding sexual matters why they are being asked.
d. Obtain consent before proceeding with an examination.[6]
e. Only touch a patient's breasts, genitals or anus when it is medically appropriate, and use appropriate examination techniques when doing so.
f. Use gloves when performing pelvic, genital, perineal, perianal, or rectal examinations.
g. Show sensitivity and respect for a patient's privacy and comfort by:
    i. Providing privacy when patients dress or undress.
    ii. Providing patients with a gown or drape during the physical examination or procedure if clothing needs to be removed, and only exposing the area specifically related to the physical examination or procedure.
    iii. Ensuring that the gown or draping adequately covers the area of the patient's body that is not actively under examination.
    iv. During an examination, only assisting patients with the adjustment or removal of clothing or draping if the patient agrees or requests the physician to do so.
h. **Not** ask or make comments about a patient's sexual history, behaviour or performance except where the information is relevant to the provision of care.
i. **Not** make any comments regarding their own sex life, sexual preferences or fantasies.
j. **Not** socialize or communicate with a patient for the purpose of pursuing a sexual relationship.
k. Use their professional judgment when using touch for comforting purposes. Supportive words or discussion may be preferable to avoid misinterpretation.

Third Party Attendance at Intimate Examinations

4. Regardless of the gender of the physician and/or the patient, physicians must give patients the option of having a third party present during an intimate examination[7], including bringing their own third party if the physician does not have one.

[4] Touching, behaviour or remarks of a clinical nature appropriate to the service provided do not constitute sexual abuse (Subsections 1(3) and (4) of the *HPPC*). It is an act of professional misconduct for a physician to sexually abuse a patient (Section 51(1), paragraph (b.1) of the *HPPC).*

[5] Such activity constitutes sexual abuse under the *HPPC*.

[6] For more information about obtaining consent, please see the *Advice to the Profession: Maintaining Appropriate Boundaries (Advice)* document.

[7] Intimate exam includes breast, pelvic, genital, perineal, perianal and rectal examinations of patients.

5. If the patient wants a third party present during an intimate examination, and a third party is unavailable or there is no agreement on who the third party should be, physicians **must**:

    a. Give patients the option to delay or reschedule the examination or be referred to another physician if the examination is not urgently needed, or
    b. Explain the risks of delaying the examination if the examination is urgently needed.

6. Physicians also have the option to request the presence of a third party during an intimate examination. If doing so, physicians **must** explain to the patient who the third party is. If the patient declines, physicians **must** consider whether to proceed with the examination based on the best interests of the patient, including whether the examination is urgently required.

Sexual Relations after the Physician-Patient Relationship has Ended

7. Under the HPPC, engaging in any of the following within one year after the date upon which an individual ceased to be the physician's patient will constitute sexual abuse:

    a. sexual relations with a patient, and/or
    b. sexual behaviour or making remarks of a sexual nature towards their patient.[8]

    Therefore, physicians **must not** engage in sexual relations with a patient or engage in sexual behaviour or make remarks of a sexual nature towards their patient during this time period.

8. ~~Where psychotherapy that is more than minor or insubstantial has been provided[9], physicians must not engage in sexual relations or engage in sexual behaviour or make remarks of a sexual nature towards their patient for a minimum of five years after the date upon which the individual ceased to be the physician's patient.[10]~~

9. Even after the one ~~or five~~ year time period has passed, it may ~~still~~ be inappropriate and/or professional misconduct for a physician to engage in sexual relations with a former patient.[11][9] Prior to engaging in sexual relations with a former patient, a physician **must** consider the following factors:

    - the length and intensity of the former professional relationship,
    - the nature of the patient's clinical problem,
    - the type of clinical care provided by the physician,
    - the extent to which the patient has confided personal or private information to the physician, and
    - the vulnerability the patient had in the physician-patient relationship.

[8] Subsections 1(3) and (6) of the *HPPC*, Schedule 2, to the *RHPA*. The *HPPC* provides for mandatory revocation for specific acts of sexual abuse including sexual intercourse. For a complete list, see *Advice*.

~~[9] Please see Advice for more information about what is considered minor or insubstantial psychotherapy.~~

~~[10] Physicians may be found to have committed disgraceful, dishonourable or unprofessional conduct if they engage in sexual relations with a patient in these circumstances. The Courts have found that certain physician-patient relationships may endure subsequent to the end of the formal relationship, for example, in the case of a long-standing psychotherapeutic relationship.~~

[9] Physicians may be found to have committed disgraceful, dishonorable, or unprofessional conduct if they engage in sexual relations with a patient in these circumstances. The Courts have found that certain physician-patient relationships may endure subsequent to the end of the formal relationship, for example, in the case of a long-standing psychotherapeutic relationship. ~~See footnote 10.~~

Sexual Relations between Physicians and Persons Closely Associated with Patients[~~12~~10]

10. It may be inappropriate for a physician to engage in sexual relations with a person closely associated with a patient. A physician may be found to have committed an act of professional misconduct if they do so.[11][~~13~~] Prior to engaging in sexual relations with a person closely associated with a patient, a physician **must** consider the following factors:

    - the nature of the patient's clinical problem,
    - the type of clinical care provided by the physician,
    - the length and intensity of the professional relationship between the physician and the patient,
    - the degree of emotional dependence the individual associated with the patient has on the physician, and
    - the degree to which the patient is reliant on the person closely associated with them.

Mandatory Duty to Report Sexual Abuse[~~14~~12]

11. Physicians **must** make a report in writing to the Registrar of the College to whom an alleged abuser belongs, if:

    a. they have reasonable grounds[13][~~15~~], obtained in the course of practising the profession, to believe that another member of the same or a different regulated health college has sexually abused a patient; and/or
    b. they have reasonable grounds to believe that a member of a regulated health college practising in the facility has sexually abused a patient.

Non-Sexual Boundaries

12. Physicians' obligations to establish and maintain appropriate boundaries with patients are not limited to sexual interactions. Physicians **must** establish and maintain appropriate boundaries with patients at all times, including with respect to social or financial/business matters and **must not** exploit the power imbalance inherent in the physician-patient relationship.

13. Physicians **must** consider the impact on the physician-patient relationship and on other patients in their practice when engaging with a patient in a non-clinical context (social or financial/business relationships).

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[10] Individuals who possess one or more of the following features:

- They are responsible for the patient's welfare and hold decision-making power on behalf of the patient.
- They are emotionally close to the patient. Their participation in the clinical encounter, more often than not, matters a great deal to the patient.
- The physician interacts and communicates with them about the patient's condition on a regular basis, and is in a position to offer information, advice and emotional support.

Examples of such individuals include but are not limited to, patients' spouses or partners, parents, guardians, substitute decision-makers and persons who hold powers of attorney for personal care.

[11] Allegations of professional misconduct could be made under the following grounds: act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and/or conduct unbecoming a physician (Section 1(1), paragraphs 33 and 34 of the *Medicine Act, Professional Misconduct Regulation).*

[12] Sections 85.1 to 85.6 of the *HPPC*.

[13] Please see *Advice* for more information about what reasonable grounds means.

For further information about maintaining appropriate boundaries, please see the *Advice to the Profession: Maintaining Appropriate Boundaries* document.

RELEVANT SECTION OF *ADVICE TO THE PROFESSION: MAINTAINING APPROPRIATE BOUNDARIES*

Sexual Relationships with Former Patients and Others Close to Patients

Why might it not be appropriate and/or professional misconduct for a physician to have sexual relations with a patient even after the physician-patient relationship has ended?

At all times, a physician has an ethical obligation not to exploit the trust, knowledge and dependence that develops during the physician-patient relationship for the physician's personal advantage. This dependence does not disappear once the physician-patient relationship has ended — the power imbalance can persist after a person ceases to be a physician's patient.

As such, for the purposes of sexual abuse, the *RHPA* treats the physician-patient relationship as continuing one year past the last physician-patient encounter. ~~It is also the College's position that if psychotherapy that is more than minor or insubstantial was provided by a physician, that physician must not engage in sexual relations with a patient for at least five years after the date of the last physician-patient encounter.~~

Prior to engaging in sexual contact, physicians are advised to verify that they have not provided treatment to the individual within the prior year ~~or the previous five year period if they have provided psychotherapy to the individual~~. Even after th~~ei~~s~~e~~ time period~~s~~ has~~ve~~ elapsed, sexual relations may be considered professional misconduct. In addition, the Courts have found that certain physician-patient relationships may endure subsequent to the end of the formal relationship, for example, in the case of a long-standing psychotherapeutic relationship. Depending on the nature and extent of the psychotherapeutic relationship, it may never be appropriate to have a sexual relationship with a former patient.

A physician who is considering having sexual relations with a former patient must use their professional judgment, acting cautiously as they consider the potentially complex issues relating to trust, power dynamics, and any transference concerns. As well, it is important for a physician to explain to a former patient the dynamics of a physician-patient relationship and the boundaries applicable to that relationship.

Where a physician is in doubt as to whether the physician-patient relationship has ended, they should refrain from any relationship with the patient until they seek advice, for example, from legal counsel.

~~What does minor or insubstantial psychotherapy mean?~~

~~It is important for physicians to use their professional judgment when determining whether psychotherapy is minor or insubstantial. Factors that physicians can consider in making this~~

~~determination include the nature of issues discussed and the time period over which the psychotherapy was provided.~~

Board Motion

Motion Title	Revised Policy for Final Approval: *Boundary Violations*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy "*Boundary Violations*" as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Revised Draft Policy for Final Approval – *Reporting Requirements* (For Decision)
Main Contacts:	Stephanie Sonawane, Policy Analyst Laura Rinke-Vanderwoude, Policy Analyst Tanya Terzis, Manager, Policy & Governance
Attachments:	**Appendix A**: Revised Draft *Reporting Requirements* Policy **Appendix B**: Revised Draft *Guide to Legal Reporting Requirements* **Appendix C**: Revised Draft *Advice to the Profession*: *Reporting Requirements*
Question for Board:	Does the Board of Directors (Board) approve the revised draft *Reporting Requirements* policy as a policy of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The newly titled draft *Reporting Requirements* policy and its companion documents, *Guide to Legal Reporting Requirements* ("*Guide*") and *Advice to the Profession: Reporting Requirements* ("*Advice*") have been revised based on feedback from the public consultation.

- The Board is provided with an overview of the key revisions made to the drafts and is asked whether the revised draft policy can be approved as a policy of CPSO.

- Creating resources that enable physicians to understand their reporting responsibilities protects patients and supports CPSO's public interest mandate.

Current Status & Analysis

- The revised draft *Reporting Requirements* policy, which now contains only professional expectations for physicians, including new expectations around notifying patients, disclosing only necessary information, reporting in a timely manner, and documenting reports, was approved for general consultation by the Board in May 2024.

- The consultation received 140 responses: 29 through written feedback and 111 via the online survey.[1] An overview of this feedback was provided to the Board in the September Policy Report.

- Given the nature of this policy and the feedback received, no substantial revisions were made to the revised draft *Reporting Requirements* policy following the consultation.

- Minor updates have been made to the companion documents based on the consultation feedback with input from the Policy Working Group. The key changes include:

    - Updating the title to "*Guide to Legal Reporting Requirements"* to indicate that the resource only provides a summary of the legal reporting requirements.
    - Using plain language to help physicians better understand their legal reporting duties.
    - Clarifying the obligations related to reporting to the Ministry of Transportation.
    - Incorporating CMPA's[2] feedback in specific provisions of the *Guide* to better align with the law.
    - Streamlining content in the revised draft *Advice* by removing redundant guidance.

[1] The consultation ended on August 6, 2024. The written feedback can be viewed on the consultation webpage.
[2] The Canadian Medical Protective Association (CMPA).

REPORTING REQUIREMENTS

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

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

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

Policy

Physicians are required to report certain events or clinical conditions regarding their patients, other regulated health professionals, and themselves to CPSO, other health regulatory bodies (i.e., colleges), and designated agencies.

Depending on the circumstances, physicians may be required or permitted[1] by law to make a report. Physicians may also be required by CPSO policy to notify an appropriate authority of specific information.

This policy outlines the professional expectations that have been set by CPSO with respect to reporting, and a list of the key reporting requirements that are set out in law can be found in the *Guide to Legal Reporting Requirements* companion resource.

General

1. In addition to complying with the professional expectations contained in this policy, physicians **must** fulfill their legislative reporting requirements, which include those that are set out in CPSO's *Guide to Legal Reporting Requirements* document.

2. Unless doing so would pose a genuine risk of harm to themselves and/or others,[2] physicians **must** notify patients about their duty to report at the earliest opportunity, and where possible, before making a report.[3]

3. When making a report about a patient, physicians **must** disclose only the information as required by law or necessary to address the risk of harm.

[1] Some laws allow (but do not require) physicians to make a report even if it means disclosing confidential patient information.
[2] This includes harm that may result to the physician, the physician's staff, the patient, etc.
[3] For more information on when to notify patients of a duty to report see the *Advice to the Profession: Reporting Requirements*.

4. While most legislative reports must be made within a specified period of time, where a timeline is not set out in law, physicians **must** file a report in a timely manner[4] once a requirement to report arises.

Incompetence and Incapacity

5. While facility operators[5] are legally required to report concerns of incapacity and incompetence, all physicians **must** take appropriate and timely action when they have reasonable grounds to believe that another physician or regulated health professional is incapacitated[6] or incompetent,[7] including circumstances where the individual's pattern of care, physical or mental health, or behaviour poses a likely risk of injury or harm to patients.[8]

Documentation

6. Physicians **must** capture in the medical record relevant details of any report made about a patient (e.g., including a copy of the report made to the Ministry of Transportation in the patient's medical record).[9]

[4] What constitutes "timely" will depend on the circumstances of each case, including the level and nature of the risk inherent in the situation.
[5] For more information on facility operators see the *Guide to Legal Reporting Requirements*.
[6] "Incapacitated" means that a regulated health professional is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that their certificate of registration be subject to terms, conditions, or limitations, or that they no longer be permitted to practise. See s. 1(1) of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1001, c.18 ("*HPPC*").
[7] "Incompetent" means that a regulated health professional's care of a patient displayed a lack of knowledge, skill, or judgment of a nature or to an extent that demonstrates that they are unfit to continue to practise or that their practice should be restricted. See s. 52(1) of the *HPPC*.
[8] For more information on how to take "appropriate and timely" action see the *Advice to the Profession: Reporting Requirements*.
[9] For more information on the details that must be captured in the patient record see the *Advice to the Profession: Reporting Requirements*.

GUIDE TO LEGAL REPORTING REQUIREMENTS

The law requires physicians to report certain events and clinical conditions either to the College of Physicians and Surgeons of Ontario ("CPSO") or other health regulatory bodies (i.e., colleges) and agencies. While not exhaustive, this document provides an overview of some of the key laws and is meant to assist physicians in navigating their legal reporting duties.

Refer to the legislation directly and contact the Canadian Medical Protective Association for advice about your specific reporting requirements. In case of any inconsistency between this document and applicable legislation, the legislation will always prevail.

Listed below are the legal reporting requirements captured in this document:

Reports to CPSO and Other Health Regulatory Colleges

- Sexual Abuse of Patients
- Professional Misconduct, Incompetence or Incapacity
- Privacy Breaches
- Self-Reporting

Reports to Other Agencies

- Children in Need of Protection
- Transportation
- Births, Still-Births and Deaths
- Privacy Breaches – Information and Privacy Commissioner
- Occupational Health and Safety
- Controlled Drugs and Substances
- Diseases and Vaccines
- Long-Term Care and Retirement Homes
- Preferential Access to Health Care
- Health Card Fraud
- Community Treatment Orders
- Provincial Correctional Facilities

Reports to CPSO and Other Health Regulatory Colleges

Sexual Abuse of Patients

Physicians who have reasonable grounds to believe that another regulated health professional may have sexually abused[1] a patient must:[2]

- file a written report with the appropriate college within 30 days, or immediately if they have reasonable grounds to believe the sexual abuse will continue or other patients will be sexually abused
- make best efforts to tell the patient before submitting a report.

Physicians providing psychotherapy to the subject regulated health professional have additional reporting requirements, including providing an opinion, if possible, about the likelihood of the regulated health professional sexually abusing patients in the future.

See sections 1(3), 85.1, 85.2(1) and 85.3(1), (2), (4) and (5) *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991*.

Professional Misconduct, Incompetence, or Incapacity

Facility Operators

Physicians who operate a facility and have reasonable grounds to believe that a regulated health professional practising in the facility is incompetent or incapacitated must file a written report with the appropriate college within 30 days, or immediately if patients are likely to be harmed or injured.

See sections 85.2 and 85.3(1) and (2) *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991*.

Employers and Affiliates

Physicians who employ, offer privileges to, or associate with regulated health professionals must file a written report with the appropriate college within 30 days when, for reasons of professional misconduct, incompetence or incapacity:

- the physician takes disciplinary action against (e.g., terminates employment, restricts privileges) or ends a business association with (e.g., dissolves a partnership) a regulated health professional
- a regulated health professional voluntarily gives up their employment or privileges.

See section 85.5 *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991*.

[1] Sexual abuse includes behaviour or remarks of a sexual nature.
[2] This reporting requirement only applies when this information is obtained in the course of practising the profession.

Public Hospitals

Physicians who are hospital administrators[3] must file a report with CPSO when, for reasons of incompetence, negligence, or misconduct:

- a physician's application to work in a hospital is rejected, or their employment or privileges are restricted or cancelled
- a physician resigns or limits their practice in a hospital.

See section 33 *Public Hospitals Act*.

Privacy Breaches

Physicians who employ, offer privileges to, or are otherwise affiliated with regulated health professionals[4] must file a written report with the appropriate college within 30 days when, as a result of a privacy breach:[5]

- they take disciplinary action against (e.g., terminate employment, restrict privileges) or end an affiliation with a regulated health professional
- a regulated health professional voluntarily gives up their employment, privileges or affiliation.

See sections 17.1(2) and (5) *Personal Health Information Protection Act, 2004* (*PHIPA*).

Self-Reporting

Physicians must file a written report with CPSO as soon as possible regarding:

- charges and/or findings of guilt for the following offences, as well as any related conditions of release or restrictions:
  - offences under the *Criminal Code*, the *Controlled Drugs and Substances Act*, the *Food and Drugs Act*, the *Health Insurance Act* and/or under comparable legislation in any province or jurisdiction, and
  - any other offences related to the practice of medicine.
- findings of professional negligence or malpractice
- findings of professional misconduct or incompetence by a professional regulatory body in any jurisdiction.

Physicians must also file a report if there is a change in any of the above.

See sections 85.6.1 to 85.6.4 *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*.

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[3] The person who has direct supervision and control of a hospital (s. 1 *Public Hospitals Act*).
[4] This reporting requirement applies only to physicians who are health information custodians (custodians). See s. 3 of *PHIPA* for more information on custodians. Agents of custodians have separate reporting requirements under s. 17(4)(b) *PHIPA*.
[5] This includes the unauthorized collection, use, disclosure, retention, or disposal of personal health information by the employee.

Reports to Other Agencies

Children in Need of Protection

Physicians who have reasonable grounds to suspect that a child younger than 16 years old has experienced or is at risk of experiencing abuse[6] or neglect must:

- immediately and directly report to a Children's Aid Society (CAS)[7]
- not rely on anyone else to report on their behalf
- file a further report if there are additional grounds to believe the child is experiencing or is at risk of experiencing abuse or neglect.

Physicians who have concerns about a child who is 16 or 17 years old are permitted, but not required, to make a report to the CAS.

See sections 125(1) to (4) *Child, Youth and Family Services Act, 2017*.

Transportation

Impaired Driving Ability

Physicians who treat a patient who is at least 16 years old must report to the Registrar of Motor Vehicles[8] if the patient is diagnosed with a medical condition that can impair the ability to drive despite treatment.[9]

Physicians are not required to report:

- impairments that are temporary or unlikely to recur (e.g., a broken ankle, recovering from anesthesia after surgery)
- small or gradual changes in a patient's ability due to aging (unless they amount to a medical condition that can impair the ability to drive despite treatment).

Physicians who have reasonable grounds to believe that a patient has other medical conditions and issues that may make it dangerous to drive are permitted, but not required, to make a report.

See sections 203(1) to (4) *Highway Traffic Act* (*HTA*) and section 14.1 *Drivers' Licences Regulation*, enacted under the *HTA*.

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[6] Abuse includes but is not limited to physical harm, sexual abuse or exploitation, and emotional harm.
[7] A list of CAS offices can be found on the Ontario Association of Children's Aid Societies' website.
[8] See the Government of Ontario's website for more information on how to make a report, including how to complete and access the Medical Condition Report Form. Physicians may also consider the CCMTA Medical Standards for Drivers published by the Canadian Council of Motor Transport Administrators and the Driver's Guide: Determining Medical Fitness to Operate Motor Vehicles published by the Canadian Medical Association when determining whether a person has or appears to have a prescribed condition.
[9] The prescribed conditions are outlined in s. 14.1(3) of the *Drivers' Licences Regulation* enacted under the *Highway Traffic Act*. See the *Advice to the Profession: Reporting Requirements* for guidance on reporting to the Ministry of Transportation.

Pilots or Air Traffic Controllers

Physicians who have reasonable grounds to believe that a patient working as a flight crew member, air traffic controller, or in another aviation job that requires standards of medical fitness, may have a medical condition that might pose a danger to aviation safety, must report to a medical advisor designated by the Minister of Transport[10] immediately.

See section 6.5(1) *Aeronautics Act*.

Maritime Safety

Physicians who have reasonable grounds to believe that a patient with a certificate issued under the *Canada Shipping Act, 2001* may have a medical condition that might pose a danger to maritime safety must report to the Minister of Transport[11] without delay.

See section 90(1) *Canada Shipping Act, 2001*.

Railway Safety

Physicians who have reasonable grounds to believe that a patient working in a job related to railway safety may have a medical condition that might pose a danger to safe railway operations must report to a physician specified by the relevant railway company without delay.

Physicians must also:

- take reasonable steps to inform the patient before making the report
- send the patient a copy of the report without delay.

See section 35(2) *Railway Safety Act*.

Births, Still-Births and Deaths

Live Births

Physicians who are present when a baby is born must give notice of the birth to the Registrar General within two business days.[12]

See section 8 *Vital Statistics Act* (VSA) and section 1 *General Regulation*, enacted under the VSA.

Still-Births

Physicians who are present at a still-birth must:

- give notice of the still-birth to the Registrar General within two business days[13]

[10] See the Transport Canada website for information on reporting concerns related to aircraft safety.
[11] See the Transport Canada website for contact information.
[12] Notices of live birth may be completed by paper and submitted by mail, or completed and submitted online. See the Government of Ontario's website for contact information for the Registrar General.
[13] There is no online process for still-birth registration. See the Government of Ontario's website for contact information for the Registrar General.

- complete and deliver a medical certificate of still-birth to the funeral director.[14]

In certain circumstances, coroners must complete the medical certificate of still-birth.

See section 9.1 *Vital Statistics Act* (*VSA*) and sections 19 and 20(1) *General Regulation*, enacted under the *VSA*.

Deaths[15]

Unless there is reason to notify the coroner, physicians who are either present during or have enough knowledge of the illness that led to a person's death must immediately:

- complete and sign a medical certificate of death[16]
- deliver the medical certificate of death to the funeral director.[17]

See sections 21(1), (2) and (5) *Vital Statistics Act* (*VSA*) and sections 35(2) and 70 *General Regulation*, enacted under the *VSA*.

Notification of Coroner

Physicians who have reason to believe a person died under circumstances that may require investigation, including in an unnatural or unexpected way (e.g., due to violence or an accident), must immediately notify a coroner or police officer.

See section 10(1) *Coroners Act*.

Privacy Breaches – Information and Privacy Commissioner (IPC)

Physicians who are health information custodians (custodians) must report certain privacy breaches to the IPC at the first reasonable opportunity.[18] This includes but is not limited to when:

- personal health information is stolen, or used or disclosed without authority
- the privacy breach is part of a pattern of similar breaches
- the privacy breach is significant.[19]

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[14] See the Government of Ontario's Handbook on Medical Certification of Death & Stillbirth for more information on how to complete a medical certificate of still-birth.
[15] For guidance on reporting deaths resulting from medical assistance in dying (MAID) and completing medical certificates of death in the MAID context, see CPSO's *Legal Requirements: MAID* and *Advice to the Profession: MAID*.
[16] Coroners and physicians providing palliative care outside a hospital setting (e.g., a patient's residence, hospice, long-term care home) can complete and submit a medical certificate of death electronically. See the Government of Ontario's Handbook on Medical Certification of Death & Stillbirth and CPSO's *Advice to the Profession: End-of-Life Care* for more information on medical certificates of death.
[17] For situations where there is no funeral director involved, see the Government of Ontario's website.
[18] Reports can be submitted via the privacy breach reporting form. For more information, see the IPC's Reporting a Privacy Breach to the IPC: Guidelines for the Health Sector.
[19] See IPC's Report a Privacy Breach or s. 6.3(1) of the *General Regulation* enacted under *PHIPA* for information on what constitutes a "significant breach".

Custodians must also:

- notify the individual(s) whose privacy has been breached at the first reasonable opportunity
- submit statistics to the IPC on or before March 1 each year setting out the number of privacy breaches that occurred.[20]

See sections 3, 12(2) and (3), and 55.5(7) *Personal Health Information Protection Act, 2004* (*PHIPA*) and sections 6.3, 6.4, and 18.3 *General Regulation*, enacted under *PHIPA*.

Occupational Health and Safety

Physicians who conduct medical examinations on workers who work with designated substances[21] or in a compressed air environment must promptly file a report with the Provincial Physician[22] of the Ministry of Labour, Immigration, Training and Skills Development if they determine a worker is: (1) fit to work with limitations, or (2) not fit to continue working.

See sections 29(1), (2) and (7) *Designated Substances Regulation*, enacted under the *Occupational Health and Safety Act* (*OHSA*), and sections 352(9) and (11) *Construction Projects Regulation*, enacted under the *OHSA*.

Controlled Drugs and Substances

Physicians who know that a controlled substance[23] was lost or stolen from their office must submit a written report to Health Canada's Office of Controlled Substances[24] within 10 days.

See sections 61(2) and 72(2) *Benzodiazepines and Other Targeted Substances Regulations* enacted under *Controlled Drugs and Substances Act* (*CDSA*), section 55(g) *Narcotic Control Regulations* enacted under *CDSA*; and section G.04.002A(g) *Food and Drug Regulations* enacted under *Food and Drugs Act*.

Diseases and Vaccines

Communicable Diseases and Diseases of Public Health Significance

Physicians must file a report with the medical officer of health of the local health unit[25] as soon as possible when:

[20] Reports can be submitted using the IPC's Online Statistics Submission website. For more information, see the IPC's Annual Reporting of Privacy Breach Statistics to the Commissioner.
[21] See s. 2 *Designated Substances Regulation* enacted under the *OHSA* for the list of designated substances.
[22] See the Government of Ontario's website for the Provincial Physician's contact information.
[23] Schedules I, II, III, IV and V of the CDSA outline the items that constitute a "controlled substance," which include a targeted substance, narcotic, or controlled drug.
[24] See Health Canada's website to access the Loss or Theft Reporting Form and E-Services Portal.
[25] See the Ministry of Health's website for a list of public health units.

- the physician signs a death certificate indicating that a disease of public health significance[26] caused or contributed to a patient's death
- a person who is not a patient at a hospital[27] has or may have a disease of public health significance
- a person who is under the physician's care has or may have a designated communicable disease.[28]

Physicians must also file a report when a person who is under their care for a designated communicable disease does not follow recommended treatment.

See sections 25(1), 26, 30 and 34(1) and (2) *Health Protection and Promotion Act* (*HPPA*).

Eyes of Newborns

Physicians who are present when a baby is born and know the baby's eye(s) are red, inflamed or swollen must file a written report with the medical officer of health within two weeks.

See section 33(1) *Health Protection and Promotion Act*, (*HPPA*) and section 1 *Communicable Diseases – General Regulation*, enacted under the *HPPA*.

Rabies

Physicians must file a report with the medical officer of health as soon as possible when they know a person:

- was bitten by a mammal
- had contact with a mammal that could result in the person getting rabies.

See section 2(1) *Communicable Diseases – General Regulation*, enacted under the *Health Protection and Promotion Act*.

Reactions to Vaccines

Physicians must file a report with the medical officer of health of the local health unit[29] within seven days if they believe a patient who received a vaccine subsequently experienced a particular reaction to the vaccine, including but not limited to:

- persistent crying or screaming, or anaphylaxis or anaphylactic shock within 48 hours
- collapsing, a high fever or a seizure within three days
- arthritis within 42 days
- death following a symptom above.

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[26] See the *Designation of Diseases Regulation*, enacted under the *HPPA* for a list of diseases of public health significance and designated communicable diseases.
[27] A hospital administrator's reporting duty arises if the hospital record states that a patient or an out-patient of the hospital has or may have a disease of public health significance or a designated communicable disease (s. 27(1) *HPPA*).
[28] See the *Designation of Diseases Regulation*, enacted under the *HPPA* for the list of designated communicable diseases.
[29] See the Ministry of Health's website for a list of public health units.

- See sections 38(1) and (3) *Health Protection and Promotion Act*.

Long-Term Care and Retirement Homes

Physicians must immediately report to the Director of the Ministry of Long-Term Care[30] (in the case of long-term care homes) or the Registrar of the Retirement Homes Regulatory Authority[31] (in the case of retirement homes) when they suspect:

- a resident may have experienced or may experience harm as a result of improper or incompetent care, unlawful conduct, abuse or neglect
- a resident's money may have been misused or misappropriated.

Physicians who suspect funding for a long-term care home may have been misused or misappropriated must also immediately report to the Director of the Ministry of Long-Term Care.[32]

See sections 2(1), 28(1) and (4) *Fixing Long-Term Care Act, 2021* and sections 75(1) and (3) *Retirement Homes Act, 2010*.

Preferential Access to Health Care

Physicians must promptly file a report with the General Manager of the Ontario Health Insurance Plan[33] if they have reason to believe that a person:

- received preferred access to an insured medical service in exchange for money or another benefit
- accepted payment or another benefit to provide patients preferred access to an insured medical service.

See sections 17(1) and (2) *Commitment to the Future of Medicare Act, 2004, (CFMA)* and section 7(1) *General Regulation*, enacted under the *CFMA*.

Health Card Fraud

Physicians who know health card fraud has been committed must promptly report to the General Manager (GM) of the Ontario Health Insurance Plan (OHIP).[34] This includes when a person who is not insured under OHIP:

- receives or tries to receive an insured service

[30] See the Government of Ontario's website for information on filing a report.
[31] See the Retirement Homes Regulatory Authority website for information on filing a report.
[32] While reporting misused or misappropriated funding is only required in the context of long-term care homes, the Retirement Homes Regulatory Authority also encourages physicians to make reports on such issues.
[33] See the Government of Ontario's website for contact information for the Health Insurance Branch of the Health Programs and Delivery Division.
[34] See the Ministry of Health's website for more information on OHIP fraud. See also the Government of Ontario's website for contact information for the Health Insurance Branch of the Health Programs and Delivery Division.

- receives or tries to receive payment for money they spent on an insured service
- gives false information about their residency to the GM or OHIP.

Physicians are permitted, but not required, to report any concerns that relate to the administration of the *Health Insurance Act*.

See section 43.1 *Health Insurance Act* (*HIA*) and section 1(1) *Health Fraud Regulation*, enacted under the *HIA*.

Community Treatment Orders

Physicians involved in the care of mentally ill patients following community treatment orders and who issue an order for examination must provide the police with:

- up-to-date contact information of the physician responsible for completing the examination required under the order
- immediate notice if the patient voluntarily goes to the examination or if the order is cancelled for any other reason before it expires.

See section 7.4 *General Regulation*, enacted under *Mental Health Act*.

Provincial Correctional Facilities

Physicians who treat inmates in a correctional facility[35] must file a report with the Superintendent:

- immediately when an inmate is seriously ill
- in writing when an inmate is injured
- immediately and in writing when the physician determines an inmate is unfit to work or that their work should be changed.

Physicians who treat inmates in a correctional facility must immediately file a report with the medical officer of health of the local health unit[36] when an inmate has or may have a designated communicable disease.[37]

See sections 4(3) to (5), *General Regulation*, enacted under the *Ministry of Correctional Services Act*, and section 37(1) *Health Protection and Promotion Act* (*HPPA*).

[35] See the Government of Ontario website for contact information for correctional and detention centres.
[36] See the Ministry of Health's website for a list of public health units.
[37] See the *Designation of Diseases Regulation*, enacted under the *HPPA* for the list of designated communicable diseases.

ADVICE TO THE PROFESSION: REPORTING REQUIREMENTS

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.

Physicians have legal and professional reporting requirements. The *Reporting Requirements* policy outlines the professional expectations the College of Physicians and Surgeons of Ontario ("CPSO") has set. The *Guide to Legal Reporting Requirements* companion resource contains a non-exhaustive list of clinical conditions and events that physicians are legally required to report.

This document is intended to help physicians interpret and effectively discharge those reporting obligations and provide physicians with advice on how to address issues that may arise in practice.

General

What do I do if I have questions about my reporting requirements?

Physicians can contact the Canadian Medical Protective Association with any questions. Physicians may also wish to consult with the Office of the Information and Privacy Commissioner of Ontario, and/or CPSO's Physician Advisory Service.

What will happen if my patient complains to CPSO about a report I made?

Physicians are generally protected from legal action and complaints that arise when complying with their reporting requirements in good faith.

What will happen if I do not comply with my reporting requirements?

Failing to comply with a reporting requirement may have serious repercussions and may amount to professional misconduct or professional negligence.

What about my duty to maintain patient confidentiality?

As a general rule, personal health information cannot be disclosed without patient consent. However, this duty is not absolute and is overridden when there is a requirement to report, or a disclosure that is permitted by law, because a potential threat to public safety outweighs the need to preserve confidentiality.

What details do I need to capture in the medical record when I make a report about a patient?

In general, documentation describing a report made about a patient will include:

- the rationale for the decision to report
- the date and time the report was made
- the person or agency to whom the report was made
- the information disclosed in the report that was made and
- if the report was discussed with the patient (and if the patient was not informed, the reasons for not informing them).

Many reports are made in writing (i.e., letter or form). Including a copy of the report in the patient's medical record will often be sufficient to discharge this requirement, but physicians still need to ensure the record contains all the relevant details.

Where a report is not made in writing, it can be helpful to follow up on a verbal conversation by sending the other party a letter confirming what was discussed, and then including a copy of the letter in the patient's medical record.

The Canadian Medical Protective Association notes that physicians may wish to document their rationale for *not* reporting a patient in situations where they have considered whether a reporting requirement exists. If the situation relates to a non-patient (e.g., another regulated health professional), it may also be helpful to document the rationale for reporting or not reporting them in a personal and confidential file.

Can I disclose a patient's personal health information (PHI) to the police?

Generally, physicians are not permitted to disclose PHI to the police (or any other third party) unless they have patient consent, or the disclosure is required by law. Disclosure required by law may include a legal requirement to report to the police under a legislation, a police request for information in the course of certain authorized investigations, or pursuant to a court order or warrant. Under section 40(1) of the *Personal Health Information Protection Act, 2004*,[1] physicians may also disclose PHI to the police without consent if they believe on reasonable grounds that the disclosure to the police is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

Absent patient consent, physicians will need to carefully consider any request for information and take steps to confirm that there is a lawful basis for disclosing PHI, which may include seeking advice from the Canadian Medical Protective Association (CMPA).[2]

What can I tell patients to best support them when I make a report?

It is important to explain anything the patient might find helpful, including:

- where a report is required by law, that the report must or had to be made, and that the reporting requirement overrides the duty of confidentiality

[1] S.O. 2004, c. 3, Sched. A.
[2] For more information see CMPA's guidance on physician interactions with police.

- the information that was or will be contained in the report and
- to whom the report was or will be made.

Being upfront and transparent about a report helps support and preserve a trusting physician-patient relationship. In addition, it may help avoid unnecessary complaints to CPSO and prevent patients from endangering themselves and others.

Timing and Notification of Reports

How and when do I notify patients of a reporting requirement?

While it is best practice to notify patients directly and in person, depending on the situation, it may be appropriate to inform the patient by telephone or in writing, or for a staff member or colleague to speak with the patient instead. In deciding how to notify patients of a duty to report, physicians will need to consider factors such as the immediacy of the risk and sensitivity of the personal health information involved.

Although it is ideal to notify patients before making a report, this may not always be possible. For example, a physician might notify a patient after making a report if the physician only realizes they must make a report after the patient leaves their office and the patient cannot be reached by telephone in a timely manner.

Importantly, it may not be appropriate to notify a patient of a report – either before or after it is made – where doing so would pose a genuine risk of harm to the physician or others, including staff, the patient, and the patient's family members (e.g., where the physician is unable to have a discussion with the patient as a result of the patient's abusive, erratic, and/or aggressive behaviour).

Specific Reporting Scenarios

Do I have a "duty to warn" if I suspect my patient is going to harm themselves or someone else?

There is no mandatory legal "duty to warn" in Ontario. However, that does not mean that physicians cannot, or should not, take action when they believe that a patient may pose a danger to themselves or others.

Section 40(1) of *PHIPA*[3] allows physicians to disclose a patient's personal health information (PHI) without consent if there is a significant risk of serious bodily harm to a person or group of persons, and the disclosure is necessary to eliminate or reduce the risk of harm. For example, as the Information and Privacy Commissioner (IPC) notes, a psychologist at a university could disclose a student's PHI to the student's family and physician if the psychologist believed it was necessary to reduce the risk of suicide.

As always, physicians will need to use their professional judgment to decide if disclosure without consent is required and share only the information necessary to address the risk of

[3] The *Personal Health Information Protection Act,* S.O. 2004, c. 3, Sched. A (*PHIPA*).

harm in such cases. The IPC also suggests documenting that PHI was shared.[4] While there are no restrictions in *PHIPA* on the types of persons to whom the information may be disclosed, the disclosure must be made to someone who is in a position to reduce or eliminate the risk of harm.

Physicians are reminded that s. 40(1) of *PHIPA* does not apply in situations where the law already requires a physician to make a report (e.g. if the person who may be harmed is the patient's child, a report to the Children's Aid Society is required).

Am I required to report gunshot wounds?

According to the *Mandatory Gunshot Wounds Reporting Act, 2005,*[5] every facility (e.g., a public hospital) that treats a person for a gunshot wound must report to the police.

While this requirement does not apply to physicians directly, physicians have a general professional duty to comply with their facilities' policies, including policies that enable the facility to report gunshot wounds.

What do I tell individuals who have been affected by a privacy breach?

Among other things, the Information and Privacy Commissioner recommends disclosing:

- details of the breach, including the personal health information (PHI) involved
- the steps taken to address the breach, including if the breach was reported to the IPC, and
- contact information for a person in the organization who can address inquiries.

The IPC notes that there are many factors physicians may consider, such as the sensitivity of the PHI involved, when deciding how to notify a patient of a privacy breach (i.e., by telephone, in writing, or in person at the next appointment).

What can I tell patients when reporting to the Ministry of Transportation (MTO)?

Recognizing how impactful a report to the MTO may be, it can be helpful to explain that:

- the law requires physicians to report to the MTO when a patient has certain conditions and/or impairments that make it dangerous for them to drive – even if the patient does not have a valid driver's licence or says they will not drive.
- These reports result in an automatic licence suspension. However, the patient has the right to appeal the suspension.

Physicians are also allowed to report other conditions that they believe might make it dangerous to drive, even if it involves disclosing confidential patient information. These reports do *not* always result in a licence suspension.[6]

[4] For more details on sharing PHI without consent see IPC's guidance.
[5] S.O. 2005, c. 9. See s. 2(1).
[6] For example, where an individual is reported to have a condition or impairment that is well-controlled, the MTO states that it will not necessarily suspend that individual's licence.

Can I give personal health information (PHI) about a patient to the Children's Aid Society (CAS) to assist in an investigation?

Yes. Both the *Personal Health Information Protection Act, 2004*,[7] and *Child, Youth and Family Services Act*[8] allow physicians to disclose PHI to help the CAS carry out its statutory functions. For more information, see: Yes, You Can. Dispelling the Myths About Sharing Information with Children's Aid Societies.

What can I tell patients or caregivers when reporting to the Children's Aid Society (CAS)?

Physicians can support patients by explaining, among other things:

- the threshold for reporting, which is based on a belief, not actual proof
- that they are legally required to report to the CAS once this threshold is met, and
- their role, which is to factually report their concerns to the CAS.

What can I do if I suspect a patient is a victim of elder abuse or intimate partner violence?

Physicians can support patients who may be experiencing elder abuse or intimate partner violence, by:

- talking to the patient and expressing concerns
- helping the patient access local resources and available services
- supporting the patient with filing a report with the relevant authority, where appropriate
- encouraging the patient to develop a safety plan (e.g., compiling a list of emergency numbers, taking out money), and
- arranging for a follow-up appointment to monitor the patient's situation and provide ongoing support.

Physicians are reminded that they cannot file a report without consent unless:

- they are legally required to report (i.e., a child, or a resident of a long-term care or retirement home, has experienced or is at risk of experiencing harm), or
- the patient is at significant risk of serious bodily harm, and disclosure is necessary to eliminate or reduce the risk of harm.[9]

Physicians may also find the following websites helpful:

- the Information and Privacy Commissioner has guidance to help health professionals make informed decisions about privacy in situations of intimate partner violence risk
- the Ministry of Children, Community and Social Services provides information and resources regarding intimate partner violence and elder abuse

[7] S.O. 2004, c. 3, Sched. A. See s. 43(1)(e).
[8] S.O. 2017, c. 14, Sched. 1. See s. 125(1) to (12): Duty to report child in need of protection.
[9] S. 40(1) *PHIPA*.

- the Canadian Network for the Prevention of Elder Abuse and Elder Abuse Prevention Ontario both provide information about elder abuse

How do I take "appropriate and timely action" when I believe another physician or regulated health professional is incapacitated or incompetent?

When determining which action(s) are appropriate to take, it is important to choose action(s) that are proportionate to the risk, considering factors such as the regulated health professional's level of awareness and insight, and whether there is a single concern or apparent pattern. Depending on the circumstances, "appropriate" action may include:

- facilitating the physician to contact the Physician Health Program (PHP) at the Ontario Medical Association
- contacting the Canadian Medical Protective Association (CMPA) for advice
- notifying the individual to whom the regulated health professional is accountable (e.g., a manager, employer, Medical Director, or Director of Care), or
- notifying the individual's health regulatory college.

It can also be helpful to first have a conversation with the physician or regulated health professional directly, although this may not always be possible or appropriate.

In terms of taking "timely" action, what constitutes "timely" will depend on the circumstances, and the level of risk will guide how quickly the physician acts. For example, taking "timely" action may mean taking immediate action if another regulated health professional appears to be practising while under the influence of alcohol or drugs.

CPSO's webpage on physician wellness has information on programs and resources that are available to support physicians struggling with their physical or mental health.

Board Motion

Motion Title	Revised Policy for Final Approval: *Reporting Requirements*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy "*Reporting Requirements*", formerly titled "*Mandatory and Permissive Reporting*", as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Minor Amendments: *Professional Responsibilities in Medical Education* and *Social Media* Policies (For Decision)
Main Contacts:	Courtney Brown, Team Lead, Policy Kaitlin McWhinney, Junior Policy Analyst Tanya Terzis, Manager, Policy & Governance
Attachments:	**Appendix A:** Draft Amendments to the *Professional Responsibilities in Medical Education* policy and *Advice to the Profession* **Appendix B:** Draft Amendments to the *Social Media* policy and *Advice to the Profession*
Question for Board:	Does the Board of Directors (Board) approve the revised *Professional Responsibilities in Medical Education* and *Social Media* policies as policies of CPSO?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Minor amendments are proposed to the *Professional Responsibilities in Medical Education* **(Appendix A)** and *Social Media* **(Appendix B)** policies and their accompanying *Advice to the Profession ("Advice")* documents to align with language changes in the newly updated *Professional Behaviour* policy. The Board is asked whether they approve the proposed amendments.

- Aligning policy expectations and language to provide clear and consistent guidance supports physician understanding of CPSO's expectations.

Current Status & Analysis

- The *Professional Behaviour* policy, which was approved by CPSO's Board of Directors in September 2024, sets out high-level expectations for physicians' professionalism and now uses the term "unprofessional behaviour" instead of "disruptive behaviour" to describe specific prohibited behaviours. Minor amendments were also made to the definition of "unprofessional behaviour."

- Two of CPSO's existing policies related to professionalism currently use the term "disruptive behaviour." Amendments to the *Professional Responsibilities in Medical Education* and *Social Media* policies, along with their *Advice* documents are proposed to align the language used in these policies with the *Professional Behaviour* policy. The proposed changes are not substantive in nature, but purely reflect the updated terminology and definition.

- Below is an overview of the specific sections in the policy and *Advice* documents to be amended:

    - The *Professional Responsibilities in Medical Education* policy sets out expectations for physicians involved in medical education and training. **Provision 9** prohibits physicians from engaging in disruptive behaviour and is reiterated in the *Advice* at **Line 45**. In addition, **Provision 14** requires most responsible physicians and supervisors to provide medical students and trainees with support and direction to address disruptive behaviour, with guidance and examples provided in the *Advice* **(Lines 58—82)**.

    - The *Social Media* policy sets out expectations for physicians' use of social media. The policy defines disruptive behaviour and prohibits physicians from engaging in disruptive behaviour while using social media **(Provision 2)**. The *Advice* elaborates on what is considered disruptive behaviour **(Lines 32—45)**.

PROFESSIONAL RESPONSIBILITIES IN MEDICAL EDUCATION

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

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

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

Definitions

Undergraduate medical students ("medical students"): Students enrolled in an undergraduate medical education program. They are not members of the College of Physicians and Surgeons of Ontario.[1]

Postgraduate trainees[2]: Physicians who hold a degree in medicine and are continuing in postgraduate medical education (commonly referred to as "residents" or "fellows" in most teaching sites). Postgraduate trainees often serve in the role of supervisors but do not act as the most responsible physician for patient care. If postgraduate trainees are supervisors, then the provisions of the policy regarding supervisors apply to them.

Most responsible physicians ("MRP"): Physicians who have overall responsibility for directing and coordinating the care and management of a patient at a specific point in time, regardless of the amount of involvement that a medical student or postgraduate trainee has in that patient's care.

Supervisors: Physicians who have taken on the responsibility to observe, teach, and evaluate medical students and/or postgraduate trainees. The supervisor of a medical student or postgraduate trainee who is involved in the care of a patient may or may not be the most responsible physician for that patient.

Policy

Supervision of Medical Students

1. MRPs and/or supervisors[3] **must** provide appropriate supervision to medical students which is proportionate to the medical student's level of training and experience. This includes:

   a. assessing interactions (which may include observation) between medical students and patients to determine:

      i. whether a medical student has the ability and readiness to safely participate in a patient's care without compromising that care;

[1] The *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (*RHPA*) permits students to participate in the delivery of health care by allowing them to carry out controlled acts "while 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 done under the supervision or direction of a member of the profession".

[2] The majority of postgraduate trainees in Ontario hold a certificate of registration authorizing postgraduate education, but regardless of the class of certificate of registration held, postgraduate trainees cannot practise independently in the discipline in which they are currently training.

[3] A postgraduate trainee may also be a supervisor.

ii. a medical student's performance, abilities, and educational needs; and
iii. whether a medical student is capable of safely interacting with patients in circumstances where the supervisor is not present in the room;

b. meeting at appropriate intervals with a medical student to discuss their assessments of patients and any care provided to them;
c. ensuring that a medical student only engages in patient care based on previously agreed-upon arrangements with the MRP and/or supervisor;
d. reviewing and providing feedback on a medical student's documentation, including any progress notes written by a medical student;
e. subject to any institutional policies, using their professional judgment to determine whether to countersign a medical student's documentation;
f. countersigning all orders written under the supervision or direction of a physician;[4] and
g. managing and documenting patient care, regardless of the level of involvement of medical students.

Supervision of Postgraduate Trainees

2. MRPs and/or supervisors **must** provide appropriate supervision to postgraduate trainees. This includes:

a. regularly assessing a postgraduate trainee's ability and learning needs, and assigning graduated responsibility accordingly;
b. ensuring that relevant clinical information is made available to a postgraduate trainee;
c. communicating regularly with a postgraduate trainee to discuss and review their patient assessments, management, and documentation of patient care in the medical record; and
d. directly assessing the patient as appropriate.

3. Postgraduate trainees **must**:

a. only take on clinical responsibility in a graduated manner, proportionate with their abilities, although never completely independent of appropriate supervision;
b. communicate with a supervisor and/or MRP:

i. in accordance with the guidelines of their postgraduate program and/or clinical placement setting;
ii. about their clinical findings, investigations, and treatment plans;
iii. in a timely manner, urgently if necessary, when there is a significant change in a patient's condition;
iv. when the postgraduate trainee is considering a significant change in a patient's treatment plan or has a question about the proper treatment plan;
v. about a patient discharge;
vi. when a patient or family expresses concerns; or
vii. in an emergency or when there is significant risk to the patient's well-being;

c. document their clinical findings and treatment plans; and
d. identify the MRP or supervisor who has reviewed their consultation reports and indicate the MRP's or supervisor's approval of the report.

Availability of MRP and/or Supervisor

4. MRPs and/or supervisors **must** ensure that they are identified and available to assist medical students and/or postgraduate trainees when they are not directly supervising them (i.e., in the same room) or if

[4] Prescriptions, telephone or other transmitted orders may be transcribed by the medical student but must be countersigned.

unavailable, they **must** ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.

5. The degree of availability of an MRP and/or supervisor and the means of availability (by phone, pager or in-person) **must** be appropriate and reflective of the following factors:

a. the patient's specific circumstances (e.g., clinical status, specific health-care needs);
b. the setting where the care will be provided and the available resources and environmental supports in place; and
c. the education, training and experience of the medical student and/or postgraduate trainee.

Involvement in Patient Care

Informing Patients about the Health-Care Team

6. MRPs or supervisors **must** ensure that patients[5] are informed of their name and roles, the fact that the MRP is ultimately responsible for their care, and that patient care often relies on a collaborative, team-based approach involving both medical students and postgraduate trainees.

a. As medical students or postgraduate trainees are often the first point of contact with a patient, the information above can be provided by them where appropriate.

Obtaining Consent

Medical student and postgraduate trainee involvement in patient care are necessary elements of medical education and training, as well as essential components of how care is delivered in teaching hospitals and other affiliated sites. Respect for patient autonomy may warrant obtaining consent to the involvement of medical students and postgraduate trainees. Whether the consent is implied or express[6] will depend on the circumstances.

7. In situations where medical students or postgraduate trainees are involved in patient care solely for their own education (e.g., observation, examinations unrelated to the provision of patient care[7], etc.), physicians responsible for providing that care **must** ensure consent to medical student or postgraduate trainee participation is obtained, either by obtaining consent themselves or, where appropriate, by another member of the health care team (including the medical student or postgraduate trainee involved).

8. Where medical students provide care to patients, physicians responsible for that care **must** ensure that consent for the participation of the medical student is obtained in appropriate circumstances, and **must** determine who from the health-care team (including the medical student) will obtain it, taking into account the:

a. type of examination, procedure or care that is being provided (e.g. complexity, intrusiveness, sensitivity);
b. patient's characteristics/attributes, including their vulnerability;
c. increasing responsibilities medical students have in participating in patient care;
d. level of involvement of the MRP/supervisor in the care being provided; and

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[5] Throughout this policy, where "patient" is referred to, it should be interpreted as "patient or substitute decision-maker" where applicable.

[6] Express consent is direct, explicit, and unequivocal, and can be given orally or in writing. Implied consent can be inferred from the words or behaviour of the patient, or the surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given. Obtaining consent for involvement of medical students and postgraduate trainees is different than that of obtaining consent in the context of the *Health Care Consent Act* regarding treatment decisions. More information is provided in the *Advice*.

[7] See *Advice* for examples.

e. best interests of the patient.

Professional Behaviour

9. MRPs and supervisors **must** demonstrate a model of compassionate and ethical care while educating and training medical students and postgraduate trainees.

10. MRPs, supervisors, and postgraduate trainees **must** demonstrate professional behaviour in their interactions with:

a. each other
b. medical students,
c. patients and their families,
d. colleagues, and
e. support staff.

11. MRPs, supervisors, and postgraduate trainees **must not** engage in unprofessional~~disruptive~~ behaviour that interferes with or is likely to interfere with quality health-care delivery or quality medical education (e.g., the use of ~~inappropriate~~ words, actions, or inactions that interfere with a physician's ability to function well with others.[8])

Violence, Harassment, and Discrimination

12. Physicians (including MRPs, supervisors, and postgraduate trainees) involved in medical education and/or training **must not** engage in violence, harassment (including intimidation) or discrimination (e.g., racism, transphobia, sexism) against medical students and/or postgraduate trainees.

13. Physicians **must** take reasonable steps to stop violence, harassment or discrimination (e.g., racism, transphobia, sexism) against medical students and/or postgraduate trainees if they see it occurring in the learning environment and **must** take any other steps as may be required under applicable legislation[9], policies, institutional codes of conduct or by-laws.

14. MRPs and/or supervisors **must** provide medical students and/or postgraduate trainees with support and direction in addressing ~~disruptive~~ unprofessional behaviour (including violence, harassment and discrimination) in the learning environment, including but not limited to taking any steps as may be required under applicable legislation[10], policies, institutional codes of conduct or by-laws.

Professional Relationships/Boundaries

15. MRPs and supervisors **must not**:

a. enter into a sexual relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating the medical student and/or postgraduate trainee; or
b. enter into a relationship[11] with a medical student and/or postgraduate trainee that could present a risk of bias, coercion, or actual or perceived conflict of interest, while responsible for mentoring, teaching, supervising or evaluating the medical student and/or postgraduate trainee.

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[8] For more information, please refer to the College policy on *Professional Behaviour*, as well as the *Guidebook for Managing Disruptive Physician Behaviour*.
[9] For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 ("*OHSA*") and the *Human Rights Code*, R.S.O. 1990, c. H.19 (the "*Code*").
[10] Physicians may have other obligations under *OHSA* and the *Code* in regard to their own behaviour in the workplace, as well as specific obligations if they are employers as defined by *OHSA* or the *Code*.
[11] Including but not limited to, family, dating, business, treating/clinical, and close personal relationships.

16. MRPs and/or supervisors (including postgraduate trainees who are supervisors) **must**, subject to applicable privacy legislation[12], disclose any sexual or other relationship[13] between themselves and a medical student and/or postgraduate trainee which pre-dates the mentoring, teaching, supervising or evaluating role of the MRP and/or supervisor to the appropriate member of faculty (e.g., the department or division head or undergraduate/postgraduate program director) in order for the faculty member to decide whether alternate arrangements are warranted.

Reporting Responsibilities

17. Physicians (including MRPs, supervisors and postgraduate trainees) involved in the education and/or training of medical students and/or postgraduate trainees **must** report to the medical school and/or to the health-care institution, if applicable, when a medical student and/or postgraduate trainee:

a. exhibits behaviours that would suggest incompetence, incapacity, or abuse of a patient;
b. fails to behave professionally and ethically in interactions with patients and their families, supervisors, and/or colleagues; or
c. otherwise engages in inappropriate behaviour.[14]

18. Physicians involved in administration at medical schools, or health-care institutions that train physicians **must** contribute to providing:

a. a safe and supportive environment that allows medical students and/or postgraduate trainees to make a report if they believe the MRP and/or their supervisor:

    i. exhibits any behaviours that would suggest incompetence, incapacity, or abuse of a patient;
    ii. fails to behave professionally and ethically in interactions with patients and their families, supervisors or colleagues; or
    iii. otherwise engages in inappropriate behaviour, including violence, harassment, and discrimination against medical students and/or postgraduate trainees; and

b. an environment where medical students and/or postgraduate trainees will not face intimidation or academic penalties for reporting such behaviours.

Supervision of Medical Students for Educational Experiences not Part of an Ontario Undergraduate Medical Education Program

19. In addition to fulfilling the expectations set out above, physicians who choose to supervise medical students for educational experiences that are not part of an Ontario undergraduate medical education program **must**:

a. comply with the *Delegation of Controlled Acts* policy,[15]
b. ensure that they have liability protection for that student to be in the office,
c. ensure that the student:

[12] If the relevant information to be disclosed contains personal health information or is otherwise protected by privacy legislation, the MRP and/or supervisor may either obtain consent from the medical student and/or postgraduate trainee to disclose this information or state that alternate arrangements are warranted.
[13] Including but not limited to family, dating, business, treating/clinical and close personal relationships.
[14] The College's *Disclosure of Harm* policy also contains expectations which may be relevant to these circumstances.
[15] The College's *Delegation of Controlled Acts* policy applies to any physician who supervises:
1. an Ontario medical student completing an extra rotation that is not part of their MD program, and
2. a student from outside Ontario completing an Ontario educational experience where the student will be performing controlled acts.

i. is enrolled in and in good standing at an undergraduate medical education program at an acceptable medical school,[16]
ii. has liability protection that provides coverage for the educational experience,
iii. has personal health coverage in Ontario, and
iv. has up-to-date immunizations.[17]

20. Where physicians do not have experience supervising medical students or are unable to fulfill the expectations outlined above, they **must** limit the activities of the medical student to the observation of patient care only.

[16] For the purposes of this policy, an "acceptable medical school" is a medical school that is accredited by the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America, or is listed in the World Directory of Medical School's online registry.
[17] Please refer to the Council of Ontario Faculties of Medicine's Immunization policy.

ADVICE TO THE PROFESSION: PROFESSIONAL RESPONSIBILITIES IN MEDICAL EDUCATION

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

The *Professional Responsibilities in Medical Education* policy sets out expectations for physicians involved in medical education and training, including most responsible physicians (MRPs), supervisors, and postgraduate trainees. This *Advice to the Profession (Advice)* document is intended to help physicians interpret their obligations as set out in this policy and to provide guidance around how these obligations may be effectively discharged. In addition, this document provides links to relevant resources.

Does an MRP and/or Supervisor need to provide direct supervision at all times?

An MRP and/or supervisor do not need to provide direct supervision at all times; however, as the policy states, MRPs and/or supervisors must ensure that they are identified and available to assist medical students and/or postgraduate trainees when they are not directly supervising them (i.e. in the same room). If unavailable, they must ensure that an appropriate alternative supervisor is available and has agreed to provide supervision.

If an MRP and/or supervisor is not available in person and they are called or paged, the MRP and/or supervisor's responsiveness needs to be appropriate to the circumstances. What is appropriate will depend on a number of factors including: the level of training and experience of the medical student and/or postgraduate trainee, the clinical status of the patient, other available support, etc.

It may also be beneficial to ensure that on-call schedules be structured to provide continuous supervision to medical students. For postgraduate trainees, it may be beneficial to provide guidance with respect to on-call interactions as sometimes postgraduate trainees are off-service and may not know what is expected of them. For example, it may be helpful to have a phone call/in-person meeting at the start of a shift to determine the postgraduate trainee's PGY level, home program, how long they have been on the particular service, what procedures they have done, when staff would like to be called overnight, etc.

It is also important for medical students and postgraduate trainees to develop awareness of their limitations and inform the Most Responsible Physician and/or supervisor and, seek appropriate assistance when necessary if they are unable to carry out their duties. Good communication is vital to facilitating appropriate supervision and optimal patient care.

How can physicians demonstrate a model of compassionate and ethical care to medical students and trainees?

Medical students and postgraduate trainees often gain knowledge and develop attitudes about professionalism through role modeling. MRPs and supervisors have a duty to lead by example and to translate into action the principles of professionalism taught to medical students and postgraduate trainees.

Characteristics of effective role models are well established. They include availability, clinical excellence, empathy, good communication skills, interest in teaching, self-reflection, transparency and respect for others.[1] Being an effective role model is not only beneficial to medical students and postgraduate trainees, but it is also an important part of ensuring the best possible care for patients.

[1] *Canadian Family Physician*, Vol.66. February 2020, e55-61.

Engaging in favouritism of medical students and/or postgraduate trainees is detrimental to the learning environment. In addition, predatory behaviour is unacceptable anywhere, but it is particularly problematic in a learning environment where medical students and postgraduate trainees model the behaviour of their teachers. For these reasons, it is imperative that clinical teachers consistently uphold and display the highest values of the medical profession.

The policy requires physicians to not engage in unprofessional~~disruptive~~ behaviour including, violence, harassment, and discrimination against medical students and postgraduate trainees. These behaviours are the antithesis to being a positive role model and physicians must not engage in them.

What does the policy say about intimidation?

Expectations around harassment are an important addition to this policy. Both the *Ontario Human Rights Code* and the *Occupational Health and Safety Act* (*OHSA*) set out definitions of harassment. Harassment means engaging in a course of vexatious comment or conduct that is known or ought to be reasonably known to be unwelcome. Harassment can include behaviour that intimidates.

Unfortunately, intimidation of medical students and postgraduate trainees is still an issue that arises in medical school education. Increasingly, the culture of medical education, and prevalence of bullying and harassment are contributing to the rise of depression, anxiety, burnout and suicidality amongst medical students and postgraduate trainees. The policy is clear that physicians must not engage in this type of behaviour.

How can I provide support and direction to medical students and/or postgraduate trainees in addressing unprofessional ~~disruptive~~ behaviour (including violence, harassment and discrimination)?

MRPs and supervisors may see, or become aware, that a learner has experienced violence, harassment and/or discrimination in the learning environment. When physicians see this occurring, the policy requires that they take reasonable steps to stop violence, harassment or discrimination against medical students and/or postgraduate trainees and take any steps as may be required under applicable legislation[2], policies, institutional codes of conduct or by-laws.

MRPs and supervisors can also acknowledge the unprofessional ~~disruptive~~ behaviour that has taken place and ask the learner how you can support them. The support and direction you provide could include, but is not limited to:

- Naming the ~~disruptive~~ unprofessional behaviour as violent, harassing and/or discriminatory;
- Addressing the unprofessional ~~disruptive~~ behaviour directly with the patient, health-care professional, or staff who engaged in the behaviour, or supporting the learner in doing so;
- Explicitly stating that the unprofessional ~~disruptive~~ behaviour is not appropriate and will not be tolerated;
- Acknowledging the learner's feelings and giving them the time and space they need to deal with the unprofessional ~~disruptive~~ behaviour;
- Offering to remove the learner and/or patient, health-care professional or staff from the physical environment in which the unprofessional ~~disruptive~~ behaviour occurred, where appropriate (e.g., by not assigning the learner to that patient, not having the learner work on the same shift as that health-care professional or staff, etc.);
- Reporting the act(s) to the appropriate authority, or supporting the learner in doing so; and

[2] Physicians may have other obligations under *OHSA* and the *Code* in regard to their own behaviour in the workplace, as well as specific obligations if they are employers as defined by *OHSA* or the *Code*.

- Providing the learner with the opportunity to debrief with a person who has the necessary skills required to do the debriefing.

In what situations will patients need to be asked for consent to have medical students participate in their care?

The policy requires consent to be obtained when the participation of medical students (or postgraduate trainees) is solely for their own education (e.g. observation, examinations unnecessary for patient care, etc.).

Where medical students provide care to patients, the policy requires consent to be obtained in appropriate circumstances, taking into account: the type of examination, the patient's characteristics, the increasing responsibilities medical students have in patient care, the level of involvement of the MRP/supervisor, and the best interests of the patient.

While the factors listed are general in nature and are meant to capture a variety of scenarios, some specific examples of when it would be appropriate to obtain consent include, but are not limited to the following:

- Medical student will be performing a sensitive examination e.g. pelvic or genital examinations.[3]
- Patient is a member of a vulnerable population who may have had negative experiences in health care system.
- Patient has experienced trauma.
- Patient is fearful of the examination, investigation or procedure.
- Medical student is early on in their medical school education.
- Examination, investigation or procedure is invasive or painful.
- Supervisor or Most Responsible Physician will not be present.

If the medical student's involvement is minimal or the task is very low risk, such as taking a patient history, consent may not be required.

Is posting a sign informing patients that medical students and/or postgraduate trainees may be involved in their care sufficient?

Having a sign posted in a teaching hospital or other clinical placement setting is helpful and promotes patient education and understanding, but it is not sufficient in terms of meeting the policy expectations.

How can consent be obtained for medical student and/or postgraduate trainee participation in patient care?

Obtaining patient consent is not meant to be burdensome or time-consuming. Depending on the circumstances, simply explaining what you will be doing and why in a concise, easily understood, and non-coercive manner, and then asking, "is this okay?" may be sufficient.

If asking to participate in their care, it may be helpful to let the patient know that they can ask the Most Responsible Physician/supervisor or the physician responsible for providing their care questions after you participate in their care – this may be very helpful for patients and may contribute to their willingness to have you to participate in their care.

It is good practice to document in the patient's medical record whether the patient consented to the participation of the medical student and/or postgraduate trainee in their care.[4]

[3] For further information about medical students performing pelvic examinations, please see the Society of Obstetricians and Gynaecologists of Canada's Guideline #246.
[4] For more information about medical record keeping, please see CPSO's *Medical Records Documentation* policy.

What if patients are reluctant to have medical students and/or postgraduate trainees participate in their care?

Research shows that it's unlikely that this will happen, but when it does it is important to respect a patient's preferences. A patient's care should not be jeopardized as a result of their refusal. In addition, if a patient does consent, they may at some point change their mind.

If a patient does not want to be involved in any activity that would be solely for the medical student's or postgraduate trainee's education, for example, observation of care, the medical student or postgraduate trainee can leave the room. It is more likely than not that another patient would be willing to have them observe the same procedure, examination, investigation at another time. Medical students and/or postgraduate trainees can also discuss the fact that they were not able to observe a procedure, examination or investigation with the MRP/supervisor for guidance about other ways to learn about the procedure, examination or investigation.

There may be additional considerations when postgraduate trainees participate in care. The *Professional Responsibilities in Medical Education* policy does not require that consent be obtained for their participation, but it requires MRPs or supervisors to ensure patients are informed that their care relies on a team-based approach involving both medical students and postgraduate trainees. In rare circumstances, when patients initially decline or appear ambivalent about having postgraduate trainees involved in their care, formalizing the consent process may be prudent.

What are some examples of procedures/exams/investigations unrelated to the provision of patient care?

This happens often with learners, especially medical students - a physician performs a procedure/exam/investigation and then the medical student and/or postgraduate trainee repeats it. For example, learners can be asked to examine a skin rash, check peripheral circulation, or do an eye or ear exam for educational purposes. If a patient has an unusual history, learners may be asked to question and/or examine the patient for educational purposes. Intimate examinations are also sometimes done by medical students and postgraduate trainees and can be unnecessary for the provision of patient care.

Resources

The information below provides additional information related to professional responsibilities in medical education as well as information that may be helpful to medical students and/or postgraduate trainees. It is important for MRPs and/or supervisors to encourage medical students, who are not yet members of the CPSO, to become familiar with this information.

Medical schools and institutions where learning takes place also have relevant policies, guidelines, statements and procedures which are relevant to medical students and/or postgraduate trainees. MRPs and/or supervisors are advised to be familiar with this information and direct their medical students and/or postgraduate trainees to it.

Dialogue Articles

Dialogue, the College's quarterly publication for members, regularly addresses themes or issues relating medical education.

Competency-Based Medical Education

Competency-based medical education (CBME) is the current approach being used within Canadian medical education with the objective of having physicians graduate with the competencies required to meet local health

needs. It aims to enhance patient care by improving learning and assessment in residency. For more information about CBME in Canada please see the following resources:

- Royal College of Physicians and Surgeons of Canada – Competence by Design
- College of Family Physicians of Canada – Triple C Competency-Based Curriculum

Canadian Medical Protective Association (CMPA)

The CMPA is a national organization and provides broad advice about a number of medico-legal issues. For Ontario specific information physicians are advised to look at the CPSO policy and advice document regarding professional responsibilities in medical education. However, the CMPA has a number of resources on the issues generally that physicians may find helpful.

For example:

- Delegation and Supervision of Medical Trainees
- Responsibilities of Physicians as Teachers

SOCIAL MEDIA

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

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

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

Definitions

Social media[1]**:** Online platforms, technologies, and practices that people use to share content, opinions, insights, experiences, and perspectives. Examples of social media include, but are not limited to, Twitter, Facebook, YouTube, Instagram, LinkedIn, and discussion forums.

Unprofessional ~~Disruptive~~ behaviour: ~~Inappropriate~~ W~~w~~ords, actions, or inactions by a physician that interfere with (or may interfere with) ~~the physician's ability to collaborate,~~ the delivery of quality ~~health~~ care, public trust in the profession, ~~or~~ the safety or perceived safety of others, or the physician's ability to collaborate. ~~Disruptive~~ Unprofessional behaviour may be demonstrated through a single act, a pattern of events, or a number of separate events~~but will more commonly be identified through a pattern of events~~. ~~Disruptive~~ Unprofessional behaviour may include, for example, bullying, abusing~~attacking~~, or ~~harassing~~ threatening others or~~and~~ making discriminatory comments.[2] An example of behaviour that is not likely to be considered ~~disruptive~~ unprofessional behaviour includes constructive criticism offered in good faith with the intention of improving patient care or the health-care system.[3]

Policy

This policy sets out expectations to help physicians navigate the online environment and prevent conduct that could harm the public's trust in individual physicians and the profession as a whole. The focus of this policy is on a physician's professional use of social media, but it can also apply to personal use depending on several factors, for example, the connection between the physician's conduct and their professional role.[4]

The College recognises that physicians have rights and freedoms under the *Canadian Charter of Rights and Freedoms*, including the freedom of expression, subject to reasonable limits. Physicians hold a respected position in society. Professional conduct and communication are important to preserve the reputation of the profession, foster a culture of respect, not adversely impact patient care, and avoid harm to the public while using social media.

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[1] For the purposes of this policy, the term "social media" may also refer to other electronic or digital communications such as email, websites, and text messaging, depending on the context in which it is used and its impact. For more information, see the *Advice to the Profession*.

[2] Discriminatory comments can take various forms, but may involve the expression of negative attitudes, stereotypes, and biases on the basis of protected grounds in the Ontario *Human Rights Code* (e.g., race, ethnic origin, creed, ancestry, colour, sexual orientation, gender identity, sex, disability, etc.) as well as other categories (e.g. socioeconomic status, education, weight, etc.).

[3] For more information on ~~disruptive~~ unprofessional behaviour see the *Advice to the Profession*. The *Professional Behaviour* policy and the *Guidebook for Managing Disruptive Physician Behaviour* contain further information on unprofessional ~~disruptive~~ behaviour in the workplace environment.

[4] For more information, see the *Advice to the Profession*.

1. Physicians **must** comply with the expectations set out in this policy, other College policies,[5] and other relevant legislative and regulatory requirements[6] when using social media.

Professionalism

2. Physicians **must** uphold the standards of medical professionalism, conduct themselves in a professional manner, and **not** engage in unprofessional~~disruptive~~ behaviour while using social media.

3. Physicians **must** consider the potential impact of their conduct on the reputation of the profession and the public trust.

4. Advocacy for patients and for an improved health care system is an important component of the physician's role. While advocacy may sometimes lead to disagreement or conflict with others, physicians **must** continue to conduct themselves in a professional manner while using social media for advocacy.

Health-related information and clinical advice

5. When disseminating general health information on social media for educational or information-sharing purposes, physicians **must:**

    a. disseminate information that is:

        i. verifiable and supported by available evidence and science, if making statistical, scientific, or clinical claims; and
        ii. **not** false, misleading, or deceptive.

    b. be aware of and transparent about the limits of their knowledge and expertise; and
    c. **not** misrepresent their qualifications.

6. When disseminating information on social media, physicians **must** be mindful of the risks of creating a physician-patient relationship or creating the reasonable perception that a physician-patient relationship exists.[7]

    a. Physicians **must not** provide specific clinical advice to others on social media unless they are able and willing to meet the professional obligations that apply to a physician-patient relationship and the requirements in the *Virtual Care* policy and the *Personal Health Information Protection Act, 2004* (*PHIPA*).[8]

Professional Relationships and Boundaries

7. Physicians **must** maintain professional and respectful relationships and boundaries with patients, persons closely associated with patients, and medical students and/or postgraduate trainees over whom they have responsibilities while using social media.[9]

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[5] Including *Advertising*, *Boundary Violations*, *Professional Behaviour*, *Human Rights in the Provision of Health Services*, *Protecting Personal Health Information*, *Virtual Care*, and *Conflicts of Interest and Industry Relationships*.
[6] Including the *Personal Health Information Protection Act, 2004*, S.O. 2004, the *Medicine Act, 1991*, the *Libel and Slander Act,* R.S.O. 1990, the *Copyright Act*, and the *Criminal Code* (e.g., hatred offences under sections 318 – 320.1), and their regulations.
[7] For example, by providing information in a manner that would lead a reasonable person to rely on it as clinical advice. If asked a medical question, physicians can direct individuals to the appropriate channels to obtain care. See the *Advice to the Profession* for more information.
[8] The provision of clinical advice through information and communication technologies is considered providing virtual care. Physicians must continue to meet the standard of care, which can include performing a comprehensive assessment, considering risks and benefits of treatment options, obtaining consent, etc.
[9] Boundaries can be sexual, financial/business, social, or other. For the definition of a "patient", see the *Boundary Violations* policy. For more information on maintaining appropriate boundaries, see the *Advice*.

8. While using social media, physicians **must** consider the impact on and **must not** exploit the power imbalance inherent in:

a. the physician-patient relationship when engaging with a patient or persons closely associated with them; and
b. any relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating a medical student and/or trainee.[10]

Privacy and Confidentiality

9. Physicians **must** comply with the requirements set out in *PHIPA* and its regulations and the expectations set out in the College's *Protecting Personal Health Information* policy while using social media.

Posting patient health information

10. If a physician is posting original content on social media containing health information about a patient, physicians **must**:

a. de-identify the patient information;[11] and/or
b. obtain and document express and valid consent from the patient or substitute decision-maker (SDM) for the publication of the content on social media, including when there is any doubt that the anonymity of a patient can be maintained.[12]

11. In fulfilling the requirement to obtain express and valid consent from the patient or SDM, physicians **must**:

a. show them the content to be published;
b. inform them that consent to publication can be withdrawn at any point;
c. inform them about the risks of publication of the content (for example, that once posted on social media it may be unable to be completely withdrawn);
d. engage in a dialogue with them about the publication of the content, such as the purposes of posting the content, where it will be posted, and any other relevant information, regardless of whether supporting documents (such as consent forms, patient education materials or pamphlets) are used; and
e. consider how the power imbalance inherent in the physician-patient relationship could cause patients to feel pressured to consent and take reasonable steps to mitigate this potential effect (for example, by informing the patient that if they do not consent, it will not impact their care).

Seeking out patient health information

12. Physicians **must** refrain from seeking out a patient's health information online[13] without a patient's consent unless:

a. the information is necessary for providing health care;
b. there is an appropriate clinical rationale related to safety concerns;[14]

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[10] For more information on professional relationships with students and trainees, see the *Professional Responsibilities in Medical Education* policy.
[11] A privacy breach can occur if the sum of the information available is sufficient for the patient to be identified, even if only by themselves. For more information on de-identification see the *Advice to the Profession*.
[12] If relying on consent, physicians must only post a patient's personal health information, to the best of their knowledge, for a lawful purpose (in accordance with s.29(a) of *PHIPA*). For content posted for the purposes of advertising, physicians must comply with the General Regulation under the *Medicine Act, 1991*, S.O. 1991 and the *Advertising* policy.
[13] This excludes authorized use of electronic health tools, such as patient databases, for the delivery of health care.
[14] For more information on what may be considered a clinical rationale related to safety concerns, see the *Advice to the Profession*.

c. the information cannot be obtained from the patient and relied on as accurate and complete, or cannot be obtained from the patient in a timely manner;
d. they have considered whether it is appropriate to ask the patient for consent to seek out the information online; and
e. they have considered how the search may impact the physician-patient relationship (for example, whether it would lead to a breakdown in trust).

13. Physicians **must** document the rationale for conducting the search, the limitations (if any) on the accuracy, completeness or up-to-date character of the information, and any other relevant information (for example, search findings and the nature of search) in the patient's record.

14. Physicians relying on patient health information found online for clinical decision-making **must**:

a. take reasonable steps to confirm the information is accurate, complete, and up-to-date, as is necessary for its purposes, prior to using the information; and
b. if it is safe and appropriate to do so, disclose to the patient the source of the information, the clinical rationale for obtaining the information, and any other relevant information.

ADVICE TO THE PROFESSION: SOCIAL MEDIA

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

Many physicians use social media to interact with others, share content with a broad audience, and seek out medical information online. Social media can present important opportunities to enhance education and facilitate discourse and knowledge translation. The use of social media, which is highly accessible, informal, fast-paced, and constantly evolving, raises questions about how physicians can uphold their professional obligations. This companion *Advice* document provides further guidance around how the expectations in the *Social Media* policy can be met.

General

Do these professional expectations apply to my personal use of social media?

The focus of the policy is on a physician's professional use of social media, but it can also apply to personal use. Several factors impact whether personal use of social media may be considered unprofessional, including, but not limited to, the nature and seriousness of the conduct and/or communication itself, whether or not the physician was known to be, could reasonably be known to be, or represented themselves as a member of the profession, and the connection between the conduct and/or communication and the physician's role and/or the profession.

Physicians may decide to use professional and personal accounts, but it is important to keep in mind that the professional and personal are not always easily separated. Even when posting in a personal capacity, others may know of your status as a physician, or physicians may sometimes share personal details on professional accounts. As such, it is important that physicians act professionally in both contexts.

Does the policy apply to other forms of electronic communications such as emails, text messaging, video conferencing, and messaging applications?

Depending on the purposes and contexts for which they are used, electronic communications that are not traditionally considered social media can have a broad impact and involve interaction with others in a manner similar to that of social media. In these circumstances, the policy is more likely to be applicable to a physician's conduct. For instance, responding to an email list or sending out an email newsletter can reach a wide network of people online, similar to posting on a discussion forum or a group page on a social media platform.

Professionalism

What is considered ~~disruptive~~ unprofessional behaviour?

Although the term "unprofessional~~disruptive~~" may have different meanings in other contexts, in this policy ~~disruptive~~ unprofessional behaviour is demonstrated when ~~inappropriate~~ conduct interferes with, or has the potential to interfere with, ~~quality~~health care delivery, public trust in the profession, the ~~physician's ability to collaborate, or the~~ safety or perceived safety of others, or physician's ability to collaborate.

Unprofessional ~~Disruptive~~ behaviour poses a threat to patients and outcomes by inhibiting the collegiality and collaboration essential to teamwork, impeding communication, undermining morale, and inhibiting compliance with and implementation of new practices. Whether behaviour is truly ~~disruptive~~ unprofessional depends on its

nature, the context in which it arises, and the consequences flowing from it. Some examples which are not likely to be considered unprofessional ~~disruptive~~ behaviour include constructive criticism offered in good faith with the intention of improving patient care or facilities or good faith patient advocacy.

Sometimes inappropriate conduct may occur concurrently with other problems, for example, health issues, or may be influenced by different stressors and/or physician burnout. A list of resources and supports is available on the CPSO's website for physicians if they have concerns about their health and well-being.

What does the CPSO mean by "professionalism" and "reputation of the profession" when using social media?

Professionalism is a fluid and contextual concept. It can require physicians to navigate and balance their duties towards individual patients, the public, the health care system, colleagues, and themselves. CPSO's commitment to integrating equity, diversity, and inclusion is also relevant to how we may conceptualize professionalism, given that traditional concepts of professionalism have often centred around the identities and cultural norms of dominant groups.

In general, what is considered professional behaviour will be informed and guided by College resources, including *Essentials of Medical Professionalism* and policies, and other professional resources, such as the Canadian Medical Association's Code of Ethics and Professionalism and the Royal College of Physicians and Surgeons of Canada's CanMEDS Framework.

Maintaining trust is an important aspect of medical professionalism. Physician conduct can impact the reputation of the profession when it undermines public trust and confidence in the profession. This in turn can adversely impact patient access to health care and patient care itself. The evaluation of the potential impact of a physician's conduct and/or communication on the reputation of the profession will be based on an analysis of the facts and circumstances. In addition to communicating in accordance with the tenets of professionalism as outlined above, upholding the reputation of the profession includes:

- acting in accordance with the law
- participating in professional regulation
- adhering to clinical standards and demonstrating professional competence
- maintaining the same standard of professional conduct in an online environment as expected elsewhere

What do I have to consider when engaging in health advocacy on social media?

CPSO, as well as the Royal College of Physicians and Surgeons of Canada's CanMEDS framework, recognizes that advocacy is a key component of a physician's role.

If you practise in an institutional setting, you may be subject to their policies or guidelines around social media use. Some institutions may require express permission before engaging in advocacy activities on social media that could be interpreted as directly involving them. You may also wish to consider whether it is appropriate to notify your institution's administration and/or members of the care team prior to engaging in advocacy online, even if no policies or guidelines require it.

On occasion, while engaged in advocacy intended for the betterment of patients, an institution, or the health-care system, physicians may find themselves in conflict with others, including colleagues or the administration of the institution where they work. In such cases, it may be necessary to consider the impact of the physician's conduct on their ability to deliver quality health care, their ability to collaborate, or the safety of others. When these are impaired by a physician's advocacy, it is important to consider whether the advocacy efforts are in fact in the best interests of patients and the public.

The College recognizes that, unfortunately, physicians may find themselves experiencing personal attacks or harassment online with respect to their advocacy. Physicians can familiarize themselves with and use privacy controls and reporting mechanisms to help address this conduct. The College also recognizes that these

interactions can be harmful and distressing to physicians. A list of health and wellness resources for physicians can be found on the CPSO's website.

How can I support equity, diversity, and inclusion goals through my social media use?

There is a growing commitment to integrating cultural humility and cultural safety within the health-care system and the medical profession. Cultural humility is a perspective that involves exercising self-reflection and acknowledging oneself as a learner when it comes to understanding another's experience. Cultural safety is an outcome that recognizes and strives to address power imbalances inherent in the health care system. The goal is an environment free of racism and other forms of discrimination, where people feel safe when receiving and accessing health care, and where providers feel safe and respected providing health care.

With these goals in mind, CPSO supports physicians striving to foster an environment that is inclusive. It is also important for physicians to be aware that their conduct on social media (including liking, sharing, or commenting on other content) may be visible to others and that unprofessional comments and behaviour (which can be overt, or more subtle, like microaggressions) have the potential to make others feel marginalized and impact their feelings of safety and trust, and potentially impact patients' willingness to access care. For more information, please visit CMPA's guidance related to cultural safety and CPSO's Equity, Diversity, and Inclusion resources.

What do I do if an individual reaches out to me on social media with a medical question?

Physicians are permitted to share health information that is intended for general education and not patient-specific. For example, information on a physician's blog on diabetic self-care or information on a business page that encourages patients to get a seasonal flu shot are not intended as a substitute for a physician's clinical advice. Clinical advice refers to individualized advice given to a specific patient for a particular health concern.

You can respond to questions without providing clinical advice. For instance, you can inform the individual that you do not provide advice on social media and direct them to make an appointment through appropriate channels, or you can provide information for emergency or urgent care services, if applicable.

Physicians interacting with patients online must meet privacy and confidentiality obligations, as outlined in the *Protecting Personal Health Information* policy. Physicians who provide clinical advice to patients online must comply with the *Virtual Care* policy and other relevant College policies.

What should I consider when sharing general health information that involves statistical, scientific, or clinical claims?

The policy requires that physicians disseminate information that is verifiable and supported by available evidence and science if making statistical, scientific, or clinical claims. It is important for physicians to also consider the potential associated risks of sharing such information.

When physicians share information online, it is likely to be given significant weight or value by many, especially when that information makes statistical, scientific, or clinical claims. Sharing information without strong scientific evidence can introduce risks, including that patients and members of the public will act on this information in a way that could jeopardize their health.

For instance, if a physician shares information about a potential new or unconventional drug or treatment, the risks of sharing this could include influencing members of the public to seek that drug when it may be inappropriate for them and when it may have unexpected negative consequences (e.g., side-effects). As when making treatment decisions for patients, generally speaking, the higher the potential risk, the higher the level of evidence required.

Keeping in mind the relationship between risks associated with specific claims and the strength of evidence appropriate to support those claims, the *Advice to the Profession: Complementary and Alternative*

Medicine document may be informative. It provides additional information regarding how to evaluate the strength of evidence and various factors to consider.

What kind of information would be considered misleading or deceptive?

Sharing false information would be a breach of the expectations in the policy. What is considered "misleading or deceptive" is broader than this. Physicians can avoid being misleading or deceptive by thinking carefully about whether the wording of posts includes content that may lead the reader to an incorrect conclusion, create a false impression, or that leaves out key information or context.

In some circumstances, such as during a public health crisis, information may change and evolve rapidly, and information that may have been shared at one time may subsequently be inaccurate or no longer applicable. The policy is not intended to capture such instances where physicians share what was the best available information at the time.

The policy is also not intended to prevent reasonable debate and/or exploration of new developments in medicine. However, physicians who make statements that contradict scientific consensus, including in the context of a public health crisis, can create confusion, increase mistrust, and impact overall public health and safety. As a physician, it is important to keep in mind that your statements, particularly those containing statistical, scientific, or clinical claims, can be very influential and be perceived as more credible, regardless of whether you are speaking about an issue within your expertise or not.

Professional Relationships and Boundaries

How can I maintain appropriate boundaries with patients on social media?

As a physician, there is an increased risk associated with managing a dual relationship with a patient, including the potential for compromised professional judgment and/or unreasonable patient expectations. Personal information is more readily accessible on social media and connecting online can lead to inappropriate self-disclosure by patients and/or physicians.

The College recognizes that, especially in smaller communities, physicians and patients may interact within the same social network. What entails maintaining appropriate boundaries may therefore differ depending on the circumstances. Maintaining appropriate boundaries may mean refraining from connecting with patients and persons closely associated with them on social media. Patients may feel pressured into accepting an invitation from their physician due to the inherent power imbalance in the physician-patient relationship. If a patient or a person closely associated with them requests to connect on social media, you must consider the potential impact on the physician-patient relationship. Relevant factors include the type of clinical care provided, the length and intensity of the relationship, and the vulnerability of the patient. When declining an invitation, you can discuss with the patient the reasons for doing so to prevent harm to the physician-patient relationship. Since personal content is generally limited on a professional social media account, using one can also help you connect with patients without compromising the therapeutic relationship.

Physicians must also comply with the expectations in the *Boundary Violations* policy when engaging with patients and persons closely associated with them.

Privacy and Confidentiality

How do I de-identify information if I want to post about a patient on social media?

To de-identify the personal health information of an individual means to remove any circumstances that it could be utilized, either alone or with other information, to identify the individual.

An unnamed patient may still be identified through a range of information, such as a description of their clinical condition, or date, time, and/or location. When posting photographs, even if a patient is not directly pictured,

other details such as the timestamp or location (which may be found in a photograph's metadata), can be used to reveal information about an individual. Even if only the patient can identify themselves from the information, that may be deemed a breach of confidentiality.

Given the increased risks of identification and the highly accessible and permanent nature of the internet, protection of patient privacy is paramount and physicians may wish to consider obtaining consent for posting even de-identified information whenever possible. Physicians must obtain and document consent before publishing patient information where there is any doubt that the patient can be kept anonymous (for example, posting a photograph with an identifiable part of a patient's body).

Why must I refrain from seeking out patient health information if it is publicly available?

The policy aligns with the requirements in the *Personal Health Information Protection Act, 2004* (PHIPA), which only permits indirect collection of personal health information without consent in limited circumstances. In addition, physicians preserve patient trust and protect the physician-patient relationship by refraining from seeking out patient health information online without consent. Many patients hold a reasonable expectation of privacy that their physicians will not search for their information online. Patients may perceive this to be a boundary violation, a lack of trust, or a lack of respect for their autonomy, which may lead to a breakdown in the physician-patient relationship.

What are appropriate clinical rationales related to safety concerns for seeking out patient health information online?

Situations where there is a risk of serious bodily harm to a patient or to others and danger is imminent would most clearly establish an appropriate clinical rationale related to safety concerns, for instance, where there are concerns about the risk of suicide or serious harm to a patient. There are also circumstances which, in the physician's professional judgment, may include urgent or emergent factors and it may be reasonable to search for information about them online in order to deliver appropriate care to the patient. For instance, this may occur when a patient presents to the emergency room unresponsive or otherwise unable to provide critical information.

What can I do to protect my privacy while using social media?

It is important to keep in mind that privacy can never be fully guaranteed online, even when posting in a closed forum. Posts can be shared more widely than originally intended (for example, screenshots of posts and messages can be shared on other platforms) and can be hard to remove once online. Resources from the Office of the Privacy Commissioner of Canada below provide useful guidance on how physicians can customize account privacy settings to better maintain control over and limit access to their personal information when posting online.

Resources

Canadian Medical Protective Association

- *Social media: The opportunities, the realities*
- *Top 10 tips for using social media in professional practice*
- *Good Practices Guide: Social Media*
- *Protecting patient privacy when delivering care virtually*
- *Participating in health advocacy*
- *Advocacy for change: An important role to undertake with care*

Office of the Privacy Commissioner of Canada

- *Staying safe on social media*

- *Privacy and social media in the workplace*
- *Tips for using privacy settings*

Office of the Information and Privacy Commissioner of Ontario

- *De-identification*
- *Privacy and Security Considerations for Virtual Health Care Visits*
- *Frequently Asked Questions: Personal Health Information Protection Act*

Board Motion

Motion Title	Revised Policy for Final Approval: *Professional Responsibilities in Medical Education*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy, "*Professional Responsibilities in Medical Education*" as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

Board Motion

Motion Title	Revised Policy for Final Approval: *Social Media*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario approves the revised policy, "*Social Media*" as a policy of the College (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Draft Policy for Circulation: *Alternative Pathways to Registration for Physicians Trained in the United States* (For Decision)
Main Contacts:	Samantha Tulipano, Director, Registration and Membership Rachel Dunn, Supervisor, Registration and Membership Mike Fontaine, Policy Analyst Stephanie Sonawane, Policy Analyst
Attachment:	**Appendix A:** Draft *Alternative Pathways to Registration for Physicians Trained in the United States* policy
Question for Board:	Does the Board of Directors (Board) approve the draft policy for circulation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The *Alternative Pathways to Registration for Physicians Trained in the United States* ("*Alternative Pathways*") policy has been revised and the Board of Directors is asked whether the draft can be approved for circulation. The draft policy allows physicians certified by an American specialty board and who have practised continuously in Ontario for five years under a restricted certificate of registration to apply for an independent practice certificate.
- This amendment brings CPSO's *Alternative Pathways* policy into alignment with FMRAC Model Standards for Medical Registration in Canada.

Current Status & Analysis

- The current *Alternative Pathways* policy offers three pathways (Pathway A, B, and C) for US physicians applying outside the regular registration requirements to gain licensure in Ontario.
- Under Pathway A, US board-certified physicians can obtain a restricted certificate to practise independently in Ontario.
- The FMRAC Model Standards outline that Canadian medical regulatory authorities provide a route from a provisional license to a full license to qualified individuals, where possible.
- The *Alternative Pathways* policy (**Appendix A**) has been revised in order to allow physicians registered under Pathway A to apply for an independent practice certificate (i.e. a full license) after five years of continuous practice, provided they are otherwise fully qualified for this certificate.
- This amendment will align CPSO with other Canadian provinces which already have pathways that allow US-trained and board-certified physicians to apply for a full license either with or without previous practise (under a provisional/restricted license) in the province.
- Should the Board approve the proposed policy amendment, the policy will be circulated for notice in accordance with Section 22.21 of the *Health Professions Procedural Code* (the *Code*).
- Additionally, pending direction from the Board, we will seek the Executive Committee's approval of the final policy (subject to feedback received) pursuant to its authority under Section 12 of the *Code* and Section 30 of the General By-Law.

ALTERNATIVE PATHWAYS TO REGISTRATION FOR PHYSICIANS TRAINED IN THE UNITED STATES

CPSO offers three alternative pathways for physicians trained in the United States (US) looking to gain licensure in the province of Ontario but who are applying outside of our regular registration requirements.

Pathway A

This pathway is for physicians who are certified by a US Specialty Board.

If you gain licensure under this pathway, you will be issued a restricted certificate of registration to practice independently limited to your scope of practice.

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 (AOA) at the time it granted you your degree;
- successfully completed a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME);
- been certified by
  - A specialty member board of the American Board of Medical Specialties (ABMS); **or**
  - A specialty certifying board of the American Osteopathic Association (AOA);
- 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.

Physicians who are issued a restricted certificate of registration under this pathway may apply for an independent practice certificate of registration after five years of

continuous practice in Ontario provided they are otherwise fully qualified for an independent practice certificate.

Pathway B

This pathway is for physicians who are missing RCPSC or CFPC certification and do not currently hold a certificate in a Canadian jurisdiction while having five or more continuous years of practice in Canada or the US.

If you gain licensure under this pathway, 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 restricted certificate of registration to practice independently limited to your scope of practice.

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.

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; and
- practised for five or more continuous years in Canada or the US while holding an independent or full license or certificate of registration without restrictions but do not currently hold a certificate in a Canadian jurisdiction.

Pathway C

This pathway is for physicians who are missing US Specialty Board certification but are eligible to take the board examinations.

If you gain licensure under this pathway, you will be issued a time-limited, restricted certificate of registration to practice under supervision. Your initial certificate automatically expires within three years from the date of issuance.

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 (AOA) at the time it granted you your degree;
- successfully completed a residency program accredited by the ACGME in the last five years;
- been deemed officially eligible to take the certification examination of
    - A specialty member board of the American Board of Medical Specialties (ABMS); **or**
    - A specialty certifying board of the American Osteopathic Association (AOA); and
- successfully completed the US Medical Licensing Examination or successfully completed an acceptable qualifying exam.

This restricted certificate is subject to the following conditions:

1. You must practice with a supervisor.
2. Your restricted certificate will expire the earlier of:
    a. three years from the date it is issued, if you do not successfully complete all outstanding examinations of a US Specialty Board;
    b. when you have been certified by a US Specialty Board; or
    c. when you are no longer eligible to write a US Specialty Board certification examination.

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

Once candidates have been certified by a US Specialty Board, they will be eligible for a restricted certificate of registration under Pathway A.

Board Motion

Motion Title	Draft Revised Policy for Notice and Consultation: *Alternative Pathways to Registration for Physicians Trained in the United States*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario engage in the notice and consultation process in accordance with Section 22.21 of the *Health Professions Procedural Code* in respect of the draft revised policy, "*Alternative Pathways to Registration for Physicians Trained in the United States*," (a copy of which forms Appendix " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	Draft Policies for Circulation: *Restricted Certificate of Registration for Royal College of Physicians and Surgeons of Canada (RCPSC) Practice Eligibility Route* and *Specialist Recognition Criteria in Ontario* (For Decision)
Main Contacts:	Samantha Tulipano, Director, Registration and Membership Rachel Dunn, Supervisor, Registration and Membership Mike Fontaine, Policy Analyst Stephanie Sonawane, Policy Analyst
Attachments:	**Appendix A:** Draft *Restricted Certificate of Registration for RCPSC Practice Eligibility Route* policy **Appendix B:** Draft *Specialist Recognition Criteria in Ontario* policy
Question for Board:	Does the Board of Directors approve the draft policy for circulation?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- A draft *Restricted Certificate of Registration for RCPSC Practice Eligibility Route* policy (**Appendix A**) has been developed and the Board of Directors is asked whether the draft can be approved for circulation. The draft policy creates a new pathway to licensure for internationally-trained physicians registered in the Royal College of Physicians and Surgeons of Canada's (RCPSC) Practice Eligibility Route (PER).

- Removing barriers to licensure and exploring new pathways to registration aligns with CPSO's commitment to right-touch regulation.

Current Status & Analysis

- The RCPSC's PER offers physicians trained outside Canada, the United States, or other approved jurisdictions a pathway to certification. Under PER, physicians trained in a recognized primary specialty can receive RCPSC certification after successfully completing RCPSC's specialty examination and a minimum of two years of independent practice in Canada.

- Under the draft *Restricted Certificate of Registration for RCPSC Practice Eligibility Route* policy, physicians who have passed an RCPSC specialty examination through PER may be granted a restricted certificate of registration to complete the two-year time in practice requirement.

- Physicians issued a certificate under the draft policy will be required to practise under supervision, and the certificate will expire no more than three years from the date it is issued.

- Once physicians have completed the PER requirements and gained certification from the RCPSC, they may be eligible for an independent practice certificate.

- Physicians not certified by the RCPSC cannot use the specialist title unless CPSO grants them the ability to do so. As such, the *Specialist Recognition Criteria in Ontario* policy (**Appendix B**) has been revised to allow physicians registered under the draft policy to use the specialist designation.

- Should the Board approve the draft policies, they will be circulated for notice in accordance with Section 22.21 of the *Health Professions Procedural Code* (the *Code*).

- Additionally, pending direction from the Board, we will seek the Executive Committee's approval of the final policies (subject to feedback received) pursuant to its authority under Section 12 of the *Code* and Section 30 of the General By-Law.

RESTRICTED CERTIFICATE OF REGISTRATION FOR RCPSC PRACTICE ELIGIBILITY ROUTE

The Royal College of Physicians and Surgeons of Canada's (RCPSC) Practice Eligibility Route (PER) offers physicians trained outside Canada, the United States, and RCPSC-approved jurisdictions a pathway to RCPSC certification.

CPSO may issue you a restricted certificate of registration to practise if you have:

1. a medical degree from an acceptable medical school;
2. obtained the Licentiate of the Medical Council of Canada (LMCC) or successfully completed an acceptable qualifying examination;
3. had your training evaluated and accepted by the RCPSC; and
4. successfully completed the RCPSC specialty examination via the RCPSC Practice Eligibility Route.

In addition to the eligibility requirements above, you must satisfy the non-exemptible requirements set out in *Section 2(1)* of *Ontario Regulation 865/93* to be issued a certificate of registration.

This restricted certificate is subject to the following conditions:

1. You must practice with a supervisor until you have received certification from the RCPSC.
2. Your restricted certificate will expire the earlier of:
    a. three years from the date it is issued; or
    b. when you have received certification from the RCPSC.

Once you have received certification from the RCPSC through the Practice Eligibility Route, you may be eligible for an independent practice certificate provided you meet all other requirements for registration.

SPECIALIST RECOGNITION CRITERIA IN ONTARIO

Approved by Council: April 2005
Reviewed and Updated: November 2011, September 2022, April 2023, July 2023

Purpose

In order to practise medicine in Ontario, an individual must hold a valid certificate of registration issued by the College. Specialty recognition is distinct from registration.

The Ontario Regulation 114/94 provides that no member shall use a term, title or designation relating to a specialty or subspecialty of the profession in respect of their practice of the profession unless the member has been,

1. certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) in a specialty or subspecialty of the profession to which the term, title or designation relates;
2. certified by the College of Family Physicians of Canada (CFPC) in a specialty or subspecialty of the profession to which the term, title or designation relates; or
3. formally recognized in writing by the College as specialist in the specialty or subspecialty of the profession to which the term, title or designation

This policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College of Physicians and Surgeons of Ontario.

Scope

This policy applies to individuals who have met the criteria for registration and have been issued a certificate of registration to practise medicine in Ontario.

Under this policy, the College will recognize specialty titles only in areas for which specialties and sub-specialties are granted by the RCPSC and the CFPC.

This policy does not apply to physicians who hold certification by RCPSC or the CFPC who are requesting sub-specialist recognition at a time when the sub-specialty examination is available.

Specialist recognition granted under paragraph 3 above is tied to the physician's practice in Ontario and will automatically expire upon expiry of the physician's certificate of registration.

The determination as to which specialists should be paid as specialists under the Ontario Health Insurance Plan will be made by the Ministry of Health and Long-Term Care of Ontario.

Policy

A physician who meets any of the requirements below will be recognized by the College as a **specialist**:

1. holds certification by the RCPSC; or
2. holds certification in family medicine by the CFPC; or
3. holds specialist certification, obtained by examination, by the Collège des médecins du Québec; or
4. holds certification by a specialty member board of the American Board of Medical Specialties (ABMS), and:
    a. ABMS certification was obtained by examination, and
    b. ABMS certification was obtained following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); or
5. holds certification by a specialty certifying board of the American Osteopathic Association (AOA), and:
    a. AOA certification was obtained by examination, and
    b. AOA certification was obtained following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); or
6. holds a restricted certificate of registration authorizing academic practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training, by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC, and
    c. holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor; or
7. holds a restricted certificate of registration that has been issued under the College's *Academic Registration* policy, and:
    a. has completed a minimum of five years of clinical practice in an academic setting in Ontario, and

    b. has provided evidence of satisfactory clinical performance, knowledge, skill, judgement, and professional conduct from the medical school where the academic appointment was held; or
8. has completed a minimum of one year of independent or supervised practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the RCPSC or the CFPC, and
    c. has successfully completed a practice assessment that has been directed by the Registration Committee[1]; or
9. holds a restricted certificate of registration in Ontario that has been issued under the College's *Alternative Pathways to Registration for Physicians Trained in the United States* policy, and:
    a. has received written confirmation from a certifying board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) of eligibility to take the certification examination on the basis of satisfactory completion of a residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) within the last five years; or
10. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificates of Registration for Exam Eligible Candidates* policy, and:
    a. has received written confirmation from the RCPSC of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a RCPSC-accredited residency program in Canada or a RCPSC recognized program outside of Canada; or
11. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificates of Registration for Exam Eligible Candidates* policy, and:
    a. has received written confirmation from the CFPC of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a CFPC-accredited residency program in Canada or a CFPC recognized program outside of Canada; or
12. holds a restricted certificate of registration in Ontario that has been issued under the College's *Recognition of RCPSC Subspecialist Affiliate Status* policy;[2] or
13. holds a restricted certificate of registration in Ontario that has been issued under the College's *Restricted Certificate of Registration for RCPSC Practice Eligibility Route* policy.

Endnotes

1. The physician shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from request for specialist recognition.

2. Physicians who have been granted Subspecialist Affiliate status from RCPSC must only identify themselves as specialists in the subspecialty in which their Subspecialist Affiliate attestation was granted. CPSO does not recognize these physicians in a primary/core specialty.

Board Motion

Motion Title	Draft Policies for Notice and Consultation: *Restricted Certificate of Registration for RCPSC Practice Eligibility Route* and *Specialist Recognition Criteria in Ontario*
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario 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, "*Restricted Certificate of Registration for RCPSC Practice Eligibility Route*," and the draft revised policy "*Specialist Recognition Criteria in Ontario*," (copies of which forms Appendices " " and " " to the minutes of this meeting).

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	By-law Amendments: Committee Appointments (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Marcia Cooper, Senior Corporate Counsel and Privacy Officer Carolyn Silver, Chief Legal Officer
Attachments:	**Appendix A:** Proposed By-law Amendments Regarding Committee Appointments
Question for Board:	Does the Board of Directors (Board) approve the proposed By-law amendments as outlined in this Briefing Note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- By-law amendments are proposed to enable non-Board committees (e.g., member-specific committees such as the Inquiries, Complaints, and Reports Committee (ICRC)) to recommend their own appointments for approval to the Board, an activity that is currently undertaken by the Governance and Nominating Committee (GNC).

- The proposed amendments support effective and efficient governance processes and align with CPSO's focus on continuous improvement.

Current Status & Analysis

- Currently the GNC's mandate includes recommending committee appointments to the Board for approval.

- Amendments to the CPSO By-laws are proposed to make it the mandate of the Chairs and Vice-Chairs of non-Board committees (member-specific committees, such as ICRC), rather than GNC, to make recommendations to the Board for appointments of their committee members, Chairs and Vice-Chairs. The mandate of GNC is proposed to be amended to remove this responsibility.

- Committees seeking appointments are in the best position to know which skills and expertise are required for their committees and are thus in the best position to make recommendations about appointments. The change is intended to streamline the recruitment and appointment process and empower non-Board committees to make recommendations that impact their work.

- In keeping with this change, recommendations to the Board for rescission of member appointments and requests for exceptional circumstances to re-appoint a committee member beyond the term limit will also come from the Chair/Vice-Chair of non-Board committees rather than the GNC.

- Appointment recommendations, as well as rescission and exceptional circumstances requests, will first go to the Executive Committee for review prior to the Board, as per usual processes for Board agenda items.

- Additionally, the proposed By-law amendments have moved the provisions addressing the Executive Committee, the GNC and the Finance and Audit Committee together in a Section titled *Board Committees*.

- If approved, the proposed By-law amendments will become effective at the close of this meeting.

    - The By-law amendments discussed above are not required by the Health Professions Procedural Code to be circulated to the profession before being approved.

APPENDIX A

PROPOSED BY-LAW AMENDMENTS FOR COMMITTEE APPOINTMENTS AND CHANGE IN GNC ROLE

7.2 Appointment to Committees

7.2.1 The ~~Governance~~chair and ~~Nominating Committee~~ vice-chair (if any) of each committee shall identify the skills, expertise and diversity that are needed or desired for ~~each~~the committee when filling upcoming positions on ~~committees~~the committee.

7.2.2 ~~The Governance~~For each committee, the chair and ~~Nominating Committee~~vice-chair (if any) of the committee shall review expressions of interest received ~~by~~from Registrants or other persons interested in serving as a committee member, chair or vice-chair of ~~a committee (other than for the Governance and Nominating Committee and the Executive Committee)~~ the committee, and any other candidates identified by the ~~Governance and Nominating Committee~~chair or vice-chair (if any) of the committee to (a) verify that each candidate satisfies the eligibility criteria prescribed in Section 7.3, and (b) assess whether each candidate has skills, expertise and diversity that will meet the needs of the ~~applicable~~ committee as identified ~~by the Governance and Nominating Committee~~ pursuant to Section 7.2.1. ~~To support the Governance and Nominating Committee in its deliberations, the Governance and Nominating Committee~~The chair and vice-chair (if any) of the committee may interview short-listed candidates for the committee.

7.2.3 ~~The Governance and Nominating Committee~~For each committee, the chair and vice-chair (if any) of the committee shall consider, no less than annually, the upcoming needs for positions on the committee, and shall propose nominees for committee members, chairs and vice-chairs to be submitted to the Board for appointment as needed for ~~each~~the committee ~~(other than for the Governance and Nominating Committee and the Executive Committee), but no less than annually~~. The ~~Governance and Nominating Committee~~chair and vice-chair (if any) of the committee shall only propose nominees who (a) satisfy the eligibility criteria prescribed in Section 7.3, and (b) have skills, expertise and diversity that will meet the needs of the ~~applicable~~ committee as identified ~~by the Governance and Nominating Committee~~ pursuant to Section 7.2.1.

7.2.4 Sections 7.2.1, 7.2.2, and 7.2.3 do not apply to filling positions on the Finance and Audit Committee, Governance and Nominating Committee or the Executive Committee.

~~7.2.4~~ 7.2.5 The Board may appoint to a committee a person who is not a Registrant or a Director.

~~7.2.5~~ ~~This Section 7.2 does not apply to filling positions on the Governance and Nominating Committee or the Executive Committee.~~

…

7.4 Rescission of Committee Appointment

7.4.1 The Board may rescind the appointment of a committee member prior to the expiry of the appointment at any time upon recommendation from ~~the Governance and~~

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~~Nominating Committee~~ chair or vice-chair (if any) of the committee. This Section 7.4.1 does not apply to members of the Governance and Nominating Committee, the Executive Committee, or individuals who are committee members by virtue of the office they hold.

…

8.1 Statutory and Standing Committees

8.1.1 The Code provides that the College shall have the following committees:

(a) Executive Committee;

(b) Registration Committee;

(c) Inquiries, Complaints and Reports Committee;

(d) Discipline Committee;

(e) Fitness to Practise Committee;

(f) Quality Assurance Committee; and

(g) Patient Relations Committee.

8.1.2 The following committees are the standing committees established pursuant to By-laws:

(a) Finance and Audit Committee;

(b) Governance and Nominating Committee; and

(c) Premises Inspection Committee.

…

ARTICLE 9 BOARD COMMITTEES

~~8.2~~9.1 Executive Committee *[NOTE: Executive Committee provisions moved ~~here~~ under this Article now titled Board Committees]*

~~8.2~~9.1.1 The Executive Committee shall be composed of the following six members:

(a) the Board Chair;

(b) the Board Vice-Chair; and

(c) four Directors (each, an "**Executive Member Representative**").

A minimum of three members of the Executive Committee (regardless of their position on the Executive Committee) shall be ~~Physician~~Registrant Directors. A minimum of two members of the Executive Committee (regardless of their position on the Executive Committee) shall be Public Directors.

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APPENDIX A

…

~~9.3~~9.4 Governance and Nominating Committee

9.~~3~~4.7 The Governance and Nominating Committee shall:

…

(g) engage in a process, in accordance with Section ~~8.2.2,~~9.1.2, to propose nominees for the Executive Member Representative positions and submit the nominations to the Board for appointment; and

~~(h) engage in a process, in accordance with Section 7.2, to identify and propose nominees for committee members, chairs and vice-chairs, and submit the nominations to the Board for appointment; and~~

~~(i)~~(h) make recommendations to the Board regarding any other officers, officials or other people acting on behalf of the College.

NOVEMBER 2024

Title:	By-law Amendments: Enabling PAs to stand for election to the Board and incorporating PAs into CPSO's Governance Structure (For Decision)
Main Contacts:	Tanya Terzis, Manager, Policy & Governance Marcia Cooper, Senior Corporate Counsel and Privacy Officer Carolyn Silver, Chief Legal Officer
Attachment:	**Appendix A:** Proposed By-law Amendments
Question for Board:	Does the Board of Directors (Board) approve the proposed By-law amendments as outlined in this Briefing Note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- By-law amendments are being proposed to enable physician assistants (PAs) to stand for election to the Board and incorporate PAs into CPSO's governance structure. The Board is asked whether it approves the proposed By-law amendments.

- Incorporating PAs into CPSO's governance structure promotes equitable governance practices and thus supports CPSO's public interest mandate.

Current Status & Analysis

- CPSO will begin regulating PAs on April 1, 2025. Currently, there are over 600 PAs in Ontario, and this number is expected to increase with regulation of the profession by CPSO and as PA programs continue to expand across Canada.

- As a result of the advocacy efforts undertaken by the Canadian Association of Physician Assistants (CAPA), the Minister of Health strongly encouraged CPSO to consider representation of PAs on the Board as well as on other decision-making bodies of the College.

- In response, CPSO leadership met with CAPA leadership in May of 2024 to discuss how PAs could be incorporated into CPSO's governance structure and agreed to the possibility of enabling PAs to stand for election.

- In light of this, By-law amendments are proposed to allow PAs to stand for election to the Board, and subsequently to be on Board committees and be elected to executive positions within Board committees (i.e., Board Chair/Vice-Chair)[1].

- Under the proposed By-law amendments, PAs would have to meet the eligibility criteria and be considered for the election slate and for executive positions in the same manner as physician candidates. The selected PAs would be included on the same slate of election nominees as the selected physicians. There would not be a dedicated seat(s) for PAs or an election specifically for PA Directors.

- Of note, the next election is on April 25, 2025. Since PA regulation takes effect on April 1, 2025, PAs will be able to participate starting with the 2026 elections[2].

- A few amendments are also required to various other By-law provisions to reflect the inclusion of PAs in CPSO's governance structure and to align terminology for PAs.

[1] This is consistent with the opportunities provided to all Board Directors.
[2] PAs would also be able to participate in a by-election (if any) later in 2025.

- If the Board approves the proposed By-law amendments, they will take effect as of the close of the Annual Organizational Meeting.
    - The proposed By-law amendments are not required to be circulated to the profession under the *Health Professions Procedural Code* before being approved.

APPENDIX A

PROPOSED BY-LAW AMENDMENTS FOR PHYSICIAN ASSISTANTS TO BE ELIGIBLE TO STAND FOR ELECTION

1.1 Definitions

1.1.1 In this By-law and all other By-laws, unless otherwise defined:

(a) "Academic Directors" means Physician Registrants~~, other than physician assistants,~~ who are members of a faculty of medicine of a university in Ontario and who are selected and appointed to the Board as contemplated by Section 2.1.1(c), and "Academic Director" means any one of them;

…

(v) "Elected Directors" means Registrants~~, other than physician assistants,~~ who are elected to the Board as contemplated by Section 2.2.1(a), and "Elected Director" means any one of them;

…

(hh) ~~"Physician Director~~"PA Registrant" means a ~~Director~~Registrant who is ~~a Registrant, other than a~~ in the physician assistant~~, and unless stated otherwise, includes an Elected Director or an Academic Director~~ class of Registrants;

(ii) "Physician Registrant" means a Registrant other than a PA Registrant;

…

(mm) "Registrant Director" means a Director who is a Registrant;

…

2.2 Eligibility Criteria

2.2.1 To be eligible to be elected to the Board as an Elected Director or selected and appointed to the Board as an Academic Director, a Registrant, on the date of the election or appointment, as the case may be:

…

(d) is not, and has not been within one year before the date of the election or appointment, as the case may be, 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~~, the Ontario Specialists Association, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

…

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APPENDIX A

2.3 Disqualification Criteria

2.3.1 An Elected Director or Academic Director is automatically disqualified from sitting on the Board if the Director:

…

(c) 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~~;~~, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

…

3.6 Eligibility to Vote and Ballots

3.6.1 A Registrant is eligible to vote in an election if, on the 45th day prior to the date of the election~~, the Registrant's Business Address is in Ontario, or if the Registrant is not engaged in the practice of medicine, the Registrant resides in Ontario.~~ :

(a) the Registrant's Business Address is in Ontario; or

(b) if the Registrant is not engaged in the practice of medicine, in the case of a Physician Registrant, or practice as a physician assistant, in the case of a PA Registrant, the Registrant resides in Ontario.

…

4.1 Selection of Academic Directors

4.1.3 At the direction of the Governance and Nominating Committee, the Registrar shall invite the dean of each faculty of medicine of a university in Ontario to propose one or more Physician Registrants who are members of the faculty to be considered as candidates for selection and appointment as an Academic Director. All candidates shall complete and submit an application in the form required by the Governance and Nominating Committee no later than the deadline specified by the Registrar.

…

4.3 Disqualification of Academic Directors

4.3.1 If an Academic Director is disqualified from sitting on the Board under Section 2.4, a Physician Registrant who is a member of a faculty of medicine of a university in Ontario shall be selected to fill the vacancy in accordance with Section 4.1.

…

APPENDIX A

7.3 Eligibility of Committee Members

7.3.1 To be eligible to be appointed to a committee, a Registrant or other person (other than a Public Director), on the date of the appointment:

…

(c) in the case of a Registrant, is not 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~~;~~, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

…

7.5 Disqualification of Members from Committees

7.5.1 A committee member (other than a Public Director) is automatically disqualified from sitting on the committee if the committee member:

(b) 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~~;~~, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

…

Article 9 BOARD COMMITTEES

9.1 Executive Committee

9.1.1 The Executive Committee shall be composed of the following six members:

(a) the Board Chair;

(b) the Board Vice-Chair; and

(c) four Directors (each, an "**Executive Member Representative**").

A minimum of three members of the Executive Committee (regardless of their position on the Executive Committee) shall be ~~Physician~~Registrant Directors. A minimum of two members of the Executive Committee (regardless of their position on the Executive Committee) shall be Public Directors.

…

9.~~2~~3.1 The Finance and Audit Committee shall be composed of a minimum of five members, including the following:

(a) the Board Chair; and

(b) four Directors.

A minimum of two members of the Finance and Audit Committee (regardless of their position on the Finance and Audit Committee) shall be ~~Physician~~Registrant Directors. A minimum of two members of the Finance and Audit Committee (regardless of their position on the Finance and Audit Committee) shall be Public Directors. The number of members on the Finance and Audit Committee shall be determined by the Board annually to meet the needs of the Finance and Audit Committee.

…

~~9.3~~9.4 Governance and Nominating Committee

~~9.3.1~~9.4.1 The Governance and Nominating Committee shall be composed of a minimum of five persons, including the following:

(a) the Board Vice-Chair;

(b) two ~~Physician~~Registrant Directors who are not members of the Executive Committee; and

(c) two Public Directors who are not members of the Executive Committee.

…

11.2 Emergency Measures and Limitations

11.2.1 The following provisions shall apply only in the event of a declared emergency under this Article 11:

…

(b) three members of the Executive Committee, at least one of which shall be a ~~Physician~~Registrant Director and at least one of which shall be a Public Director, shall constitute a quorum, and this Section 11.2.1(b) also applies for the purpose of the Executive Committee declaring an emergency;

(c) in the event that during the declared emergency there shall be one or more vacancies on the Executive Committee, each such vacancy shall be deemed to be filled by a Director in the following order:

(i) if the vacancy is the Board Chair position, the Board Vice-Chair shall become the Board Chair;

(ii) if the vacancy is the Board Vice-Chair position, the member of the Executive Committee (other than the Board Chair or past Board Chair, if on the Executive Committee) who has been on the Board the longest shall become the Board Vice-Chair;

(iii) except as set out in Sections 11.2.1(c)(i) and (ii), fill each Public Director vacancy with a Public Director (other than a Public Director who is appointed to the Governance and Nominating

Committee) based on their seniority on the Board (for greater certainty, length of term);

(iv) except as set out in Sections 11.2.1(c)(i) and (ii), fill each ~~Physician~~Registrant Director vacancy with a ~~Physician~~Registrant Director (other than a ~~Physician~~Registrant Director who is appointed to the Governance and Nominating Committee) based on their seniority on the Board (for greater certainty, length of term); and

(v) subject to the quorum requirements in Section 11.2.1(b), if a vacancy on the Executive Committee is not able to be filled in accordance with Sections 11.2.1(c)(iii) or (iv), such vacancy may be filled by either a Public Director or a ~~Physician~~Registrant Director, despite Section 8.2.1;

NOVEMBER 2024

Title:	By-law Amendment: Remuneration and Reimbursement (For Decision), and Introduction of Operational Reimbursement Rules (For Information)
Main Contacts:	Sandra Califaretti, Corporate Controller Marcia Cooper, Senior Corporate Counsel and Privacy Officer Tanya Terzis, Manager, Policy & Governance
Attachments:	**Appendix A:** Proposed By-law Amendments: Remuneration and Indemnification **Appendix B**: *Board and Committee Member Expense Reimbursement Policy* (Board Policy) **Appendix C:** *Board Director and Committee Member Remuneration and Expense Reimbursement Rules*
Questions for Board:	1. Does the Board of Directors approve the proposed By-law amendments as outlined in this Briefing Note? 2. Does the Board of Directors approve rescinding the *Board and Committee Member Expense Reimbursement* Board policy?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- It is proposed that Article 12 of CPSO By-law 168 (**Appendix A**) be amended to clarify that Board Physician Director and committee member remuneration and expense reimbursement are subject to limits, rules, and processes established by CPSO in accordance with usual approvals processes and financial management practices. It is also proposed that the *Board and Committee Member Expense Reimbursement* Board policy (**Appendix B**) be rescinded.
- A *Board Director and Committee Member Remuneration and Expense Reimbursement Rules* document (**Appendix C**) has been developed, as an operational tool, to increase clarity and consistency related to remuneration and reimbursement rules.

Current Status and Analysis

- Board Physician Director and committee member remuneration and expense reimbursement eligibility are currently set out in CPSO By-law No. 168 and the *Board and Committee Member Expense Reimbursement* Board policy. The Board policy was established so that the By-laws were not unnecessarily detailed.
- However, the Board policy only provides broad guidance about which types of expenses are eligible to be reimbursed. Further details are needed for consistent application and understanding.
- As noted above, the By-law is proposed to be amended to indicate that the remuneration and reimbursement of Board Physician Directors and committee members is subject to the limits, rules, and processes made by CPSO in the *Rules* document. Minor language revisions have also been proposed to ensure consistency with the *Rules* document.
    - The By-law does not need to be circulated to the profession before final approval.
- With the revisions of the By-law, there is no longer a need for a Board policy. Since detailed rules and guidance are operational in nature, it is more appropriate that they be set out in an internal finance document, which would not need to be approved by the Board. Accordingly, the Board policy is no longer necessary, and it is proposed to be rescinded.
- The *Rules* document sets out expenses for which Board Physician Directors and committee members may be reimbursed (e.g., transportation, meals, accommodation) as well as activities for which they will be remunerated (e.g., meeting attendance, preparation time, travel time). The *Rules* document also includes information about the process for submitting expense claims and being reimbursed.
- In keeping with financial management norms, the *Rules* document sets out maximum reimbursement amounts for eligible expenses and established rules and limits for Board Physician Directors and committee members claiming expenses and remuneration for work conducted on behalf of CPSO.

- The *Rules* document will be reviewed annually and updated as necessary based on changes to rates, maximum values, or other relevant factors.

APPENDIX A
PROPOSED BY-LAW AMENDMENTS: REMUNERATION AND INDEMNIFICATION

ARTICLE 12 REMUNERATION

12.1 Board and Committee Remuneration

12.1.1 In ~~Section~~Article 12~~.1~~, **"committee"** includes, in addition to committees (as defined in Section 1.1.1), a special committee, task force or other similar body established by the Board or the Executive Committee by resolution.

12.1.2 Nothing in Article 12 applies to a Public Director or to an employee of the College.

12.1.3 Except as provided in Section ~~12.2, Physician~~12.2, Registrant Directors and ~~members of a~~ committee members shall be remunerated for conducting College business, including attendance at, and preparation for, meetings ~~to transact College business~~of the Board or committees, at the hourly rate authorized in the budget approved by the Board for the fiscal year for which such remuneration is payable (the **"Hourly Rate~~").~~"**) in accordance with, and subject to, such limits, rules and processes established by the College from time to time.

12.1.4 ~~Physician~~Registrant Directors and ~~members of a~~ committee members shall be remunerated for time spent travelling to or from ~~home, or both~~College locations, in connection with the conduct of ~~Board or committee~~ College business at the Hourly Rate.

12.1.5 ~~Physician~~Registrant Directors and committee members ~~of a committee~~ shall be reimbursed for eligible expenses for transportation, accommodations and meals they incur in the conduct of ~~the Board's or committee's~~College business in accordance with ~~the Board and Committee Member Expense Reimbursement Policy as approved~~, and subject to, such limits, rules and processes established by the ~~Board~~College from time to time.

12.1.6 No person shall be paid under Section 12.1 or Section 12.2 except in accordance with properly submitted ~~vouchers or receipts~~receipts or other supporting documents, in accordance with rules and processes established by the College from time to time.

CPSO Board Policy

Board and Committee Member Expense Reimbursement Policy

Terms used in this Policy that are defined in the CPSO By-law No. 168 shall have the meanings set out in the CPSO By-law No. 168, unless stated otherwise.

Nothing in this Policy applies to a Public Director or to an employee of the College.

The following are the expenses for which Physician Directors and members of a committee will be reimbursed if they are incurred in the conduct of the Board's or Committee's business:

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

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

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

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

Effective date: November 2024
Updated: November 2024

Purpose and Scope

Board Directors and Committee members who conduct work on behalf of the College of Physicians and Surgeons of Ontario (CPSO) are entitled to remuneration for time spent conducting CPSO business and reimbursement for reasonable and necessary expenses as set out in CPSO By-law No. 168.

Eligibility Criteria

Original receipts are required for all reimbursement requests and must contain details such as vendor name, HST number, date of purchase, and itemized account of items purchased, including applicable taxes. Screen prints are acceptable for small dollar-value items. A credit card acknowledgement cannot be submitted in place of a detailed receipt. Receipts are not required for use of public transit and where it is impractical to obtain receipts for reimbursement requests under $10.

Rate Chart

Eligible Expense	Reimbursement Criteria
Accommodations	Individuals attending in-person meetings at the CPSO location are requested to use accommodations negotiated with corporate partners. Stays at other locations will be reimbursed at the maximum room block rate for the same period, or $450 where a room block is not available. Individuals conducting CSPO business at an external function, such as a conference, will be reimbursed for accommodation at the conference hotel or similarly priced accommodation. Accommodation will be paid for one night's stay before and after the meeting, if required due to travel arrangements.
Meals	Meals, and supplemental snacks and beverages will be reimbursed while: • Travelling to and from in-person CPSO business meetings or functions, one day prior to and after, depending on travel arrangements and meeting start/adjournment times • Attending a conference or event where suitable meals are not provided • The maximum reimbursement for meals is $150 CDN per day
Charges for Time	***Attendance:*** Refers to in-person or virtual presence. Individuals will be compensated for the scheduled attendance time, or actual end time, whichever is later. Time spent attending conferences or business dinners *will not* be reimbursed.

	Preparation Time: Preparation includes reading and reviewing meeting materials provided in advance. Preparation time will be remunerated to half the meeting duration unless specified by the Committee/CPSO Director. The time submitted for preparation should be rounded to the nearest 30 minutes. ***Travel Time:*** Individuals will be reimbursed for actual time spent travelling to and from CPSO locations. When travelling by air or train, where advance arrival at the airport/station is required, individuals may claim one additional hour of waiting time only. Significant travel delays can be discussed on a case-by-case basis. ***Performing other work:*** A minimum of one hour of work must be performed before a reimbursement request is made. This includes checking and reading emails or obtaining support from IT/Helpdesk.
Transportation	Individuals will be reimbursed for the cost of transportation expenses, whether by airplane, bus, train, taxi, or rideshare. The most economical method of travel must be sought. Air travel costs will only be compensated up to the cost of the most economical ticket. Rail travel costs will only be reimbursed up to the cost of a business class ticket. Personal vehicle use costs will be reimbursed by kilometre based on annual rates established by the CRA. Reasonable parking costs will be reimbursed.
Gratuities	Gratuities paid for meals, taxi, Uber or rideshare programs will be reimbursed to a maximum of 20%.

Reimbursement Process

- All expense reimbursement requests must be submitted to the CPSO with original receipts and relevant support information within ten (10) business days of the end of each month.
- Please ensure accurate electronic funds transfer (EFT) information is provided to Finance, as cheques will not be issued.
- If you have questions regarding this process, CPSO will respond within two (2) business days.
- Once an expense reimbursement has been approved internally, payment will be complete within (2) business days.

- Expense reimbursement requests and associated approvals will be considered by Finance following their usual approvals process. Finance may also consult with the Governance Office, as needed.
- Any dispute involving a claim will be addressed directly with the claimant by CPSO staff, and, if not resolved, CPSO's Board Chair. The Board Chair will serve as final arbiter in all remuneration and reimbursement disputes.

NOVEMBER 2024

Title:	By-law Amendments: Minor Housekeeping Changes (For Decision)
Main Contacts:	Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy Officer Tanya Terzis, Manager, Policy & Governance
Attachment:	**Appendix A:** Select Proposed Housekeeping By-law Amendments
Question for Board:	Does the Board of Directors (Board) approve the proposed By-law amendments as outlined in this Briefing Note?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- Clarifications and housekeeping amendments to the CPSO By-law are being proposed.
- The proposed amendments streamline and clarify the College By-laws. This supports effective and efficient governance processes and aligns with CPSO's focus on continuous improvement.

Current Status & Analysis

- As previously mentioned, it was expected that clarification and minor changes to the CPSO By-laws would likely be needed as we started working with the new By-laws, given the breadth of the project.
- The key proposed changes are indicated in the redlined document attached as **Appendix A**. Changes to punctuations, minor corrections and drafting adjustments are not included in the Appendix.

SELECT PROPOSED HOUSEKEEPING BY-LAW AMENDMENTS

2.2 Eligibility Criteria

…

2.2.4 A Registrant who has been disqualified from the Board or from one or more committees, or has resigned from the Board or from one or more committees where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the ~~member~~Registrant from the Board or from one or more committees, for disqualification criteria prescribed in Section 2.3.1(k) or Section 2.3.1(o), is not ineligible under Section 2.2.1(k) or Section 2.2.1(l) to be elected to the Board as an Elected Director or selected and appointed to the Board as an Academic Director if on the date of the election or appointment, as the case may be:

3.1 Election

3.1.1 A regular election shall be held each year to elect Registrants to the Board as Elected Directors for the number of Elected Directors whose terms are to expire at the close of the Annual Organizational Meeting that year plus the number of vacancies (if any) in Elected Director positions at the time of the election to be filled under Section 3.10.1(a).

…

3.2 Term of Office

3.2.1 The term of office of an Elected Director elected in a regular election is three years, starting at the close of the first Annual Organizational Meeting held after the election and expiring at the close of the Annual Organizational Meeting held after the regular election three years later.

…

4.1 Selection of Academic Directors

…

4.1.7 The Governance and Nominating Committee shall propose nominees for appointment as Academic Directors for the number of Academic Directors whose terms are to expire at the close of the Annual Organizational Meeting that year plus the number of vacancies (if any) in Academic Director positions at the time of proposing the nominees. The Governance and Nominating Committee shall only propose nominees who (a) satisfy the eligibility criteria prescribed in Section 2.2, and (b) have skills, expertise and diversity that were identified by the Governance and Nominating Committee as needed or desired for the Board pursuant to Section 4.1.2.

4.1.8 At a meeting of the Board prior to the Annual Organizational Meeting for that year, the Board shall consider a motion to select and appoint the nominees proposed by the Governance and Nominating Committee as Academic Directors, starting upon the ~~adjournment~~close of the Annual Organizational Meeting for the year until the close of the third Annual Organizational Meeting thereafter or until such earlier time as specified in the appointment.

…

5.1 Officers

5.1.1 The Board shall annually elect a Board Chair and Board Vice-Chair to hold office starting upon the ~~adjournment~~close of the next Annual Organizational Meeting (or if elected at an Annual Organizational Meeting, starting upon the ~~adjournment~~close of such meeting) until the next Annual Organizational Meeting and, if an election is not so held, the Board Chair and Board Vice-Chair shall continue in office until their successors are elected. The procedure for election of the Board Chair and Board Vice-Chair shall be in accordance with Section 6.2.10.

…

7.6 Committee Member Terms

7.6.2 Except as provided in Section 7.6.3, the term of office of a committee member automatically expires at the close of the third Annual Organizational Meeting of the Board which occurs after the appointment or at such earlier time as the Board specifies in the appointment.

7.6.3 The term of office of each member of the Governance and Nominating Committee and the Executive Committee automatically expires at the close of the Annual Organizational Meeting of the Board which occurs next after the appointment.

…

~~8.2~~9.1 Executive Committee

…

~~8.2~~9.1.2 The Board shall annually appoint the Executive Member Representatives to the Executive Committee starting upon the ~~adjournment~~ close of the next Annual Organizational Meeting (or if appointed at an Annual Organizational Meeting, starting upon the ~~adjournment~~ close of such meeting) until the close of the following Annual Organizational Meeting. The nominees for the Executive Member Representatives shall be determined by the Governance and Nominating Committee in accordance with the following:

…

9.4 Governance and Nominating Committee

…

9.~~3~~4.2 The Governance and Nominating Committee may ~~engage~~use consultants with expertise relating to corporate governance, professional regulation or any other area of expertise as the Governance and Nominating Committee deems appropriate to advise the Governance and Nominating Committee with performing its mandate.

…

9.~~3~~4.5 The Board shall annually appoint to the Governance and Nominating Committee the Board Vice-Chair and the members elected by the Board starting upon the ~~adjournment~~close of the next Annual Organizational Meeting (or if appointed at an Annual Organizational Meeting, starting upon the ~~adjournment~~close of such meeting) until the following Annual Organizational Meeting.

Board Motion

Motion Title	For Approval: CPSO By-law Amendments
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario:

1. revokes By-law No. 168 (the CPSO By-laws) and substitutes it with the revised By-law No. 168 (the CPSO By-laws) set out in Appendix A to this motion; and

2. revokes the CPSO Board Policy titled "Board and Committee Member Expense Reimbursement Policy" set out in Appendix B to this motion.

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

BY-LAWS

of

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

By-law No. 168
Enacted: December 7, 2023
Last Amended: November 29, 2024

TABLE OF CONTENTS

BY-LAW NO. 168

PART 1. GENERAL

ARTICLE 1 DEFINITIONS AND INTERPRETATIONS

1.1 Definitions

1.1.1 In this By-law and all other By-laws, unless otherwise defined:

(a) **"Academic Directors"** means Physician Registrants who are members of a faculty of medicine of a university in Ontario and who are selected and appointed to the Board as contemplated by Section 2.1.1(c), and **"Academic Director"** means any one of them;

(b) **"Act"** means the *Regulated Health Professions Act, 1991,* S.O. 1991, c.18, and the regulations thereunder, as amended from time to time;

(c) **"Administrative Suspension"** means a suspension of a certificate of registration pursuant to section 24 of the Code or subsection 2(6) or subsection 2(7) of Ontario Regulation 865/93 under the *Medicine Act*;

(d) **"Annual Financial Meeting"** has the meaning set out in Section 6.1.1(b);

(e) **"Annual Organizational Meeting"** has the meaning set out in Section 6.1.1(a);

(f) **"Auditor(s)"** has the meaning set out in Section 6.1.4(b);

(g) **"Board"** means the board of directors of the College, and each reference to the Board shall be deemed to be a reference to the Council of the College as specified in the Code and the Medicine Act, and any other legislation or policy where the context requires;

(h) **"Board Chair"** means the chair of the Board elected pursuant to Section 5.1, and each reference to the Board Chair shall be deemed to be a reference to the President of the College as specified in the Code and the Medicine Act, and any other legislation or policy where the context requires;

(i) **"Board Profile"** means the profile or matrix of skills, expertise and diversity attributes desired for Directors and committee members, as approved by the Board from time to time;

(j) **"Board Vice-Chair"** means the vice-chair of the Board elected pursuant to Section 5.1, and each reference to the Board Vice-Chair shall be deemed to be a reference to the Vice-President of the College as specified in the Code and the Medicine Act, and any other legislation or policy where the context requires;

(k) **"Business Address"** means a Registrant's principal place of practice reported by the Registrant to the College, as may be posted on the Register;

(l) **"By-law"** or **"By-laws"** means the By-laws of the College, as the same may be amended from time to time;

(m) **"chair"** means the chair of a committee;

(n) **"Code"** means the *Health Professions Procedural Code* in Schedule 2 of the Act, as amended from time to time;

(o) **"College"** means the College of Physicians and Surgeons of Ontario;

(p) **"committee"** means any committee of the College, whether established by or under the Code, the regulations or the By-laws;

(q) **"Conflict of Interest"** has the meaning set out in Section 10.1.1;

(r) **"Controlled Drugs and Substances Act"** means the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19, and the regulations thereunder, as amended from time to time;

(s) **"Criminal Code"** means the *Criminal Code*, R.S.C. 1985, c. C-46, and the regulations thereunder, as amended from time to time;

(t) **"Delegated Signatory"** has the meaning set out in Section 14.6.2;

(u) **"Directors"** means the persons elected or appointed to be members of the Board and includes the Elected Directors, the Public Directors and the Academic Directors, and **"Director"** means any one of them;

(v) **"Elected Directors"** means Registrants who are elected to the Board as contemplated by Section 2.2.1(a), and **"Elected Director"** means any one of them;

(w) **"Executive Committee"** means the Executive Committee as set out in Section 9.1.1;

(x) "**Executive Member Representatives**" has the meaning set out in Section 9.1.1(c), and **"Executive Member Representative"** means any one of them;

(y) **"Health Insurance Act"** means the *Health Insurance Act*, R.S.O. 1990, c. H.6, and the regulations thereunder, as amended from time to time;

(z) **"Hourly Rate"** has the meaning set out in Section 12.1.3;

(aa) **"ICRC"** has the meaning set out in Section 8.3.1;

(bb) **"Indemnified Party"** has the meaning set out in Section 13.1.1;

(cc) "**Medicine Act**" means the *Medicine Act,* 1991*,* S.O. 1991, c.30, and the regulations thereunder, as amended from time to time;

(dd) **"Member Portal"** has the meaning set out in Section 23.5.1;

(ee) **"Mental Health Act"** means the *Mental Health Act*, R.S.O., 1990, c. M.7, and the regulations thereunder, as amended from time to time;

(ff) **"Obligations"** has the meaning set out in Section 14.6.6;

(gg) **"Ontario Physicians and Surgeons Discipline Tribunal"** and "**OPSDT**" have the meanings set out under Section 8.7.1;

(hh) **"PA Registrant"** means a Registrant who is in the physician assistant class of Registrants;

(ii) **"Physician Registrant"** means a Registrant other than a PA Registrant;

(jj) **"Public Directors"** has the meaning set out in Section 2.1.1(b), and **"Public Director"** means any one of them;

(kk) **"Register"** means the register of the College;

(ll) **"Registrant"** means a member of the College, and each reference to a Registrant shall be deemed to be a reference to a member of the College as specified in the Code and the Medicine Act, and any other legislation or policy where the context requires;

(mm) **"Registrant Director"** means a Director who is a Registrant;

(nn) **"Registrar"** means the Registrar of the College;

(oo) **"Relative"** with respect to another person, means a person who is related to that other person as immediate or extended family, or a variation thereof, or who is a member of the household of that other person, and includes a spouse, child, grandchild, parent, grandparent, sibling, aunt, uncle, nephew, niece, cousin or a spouse of any of the foregoing;

(pp) **"Signing Officers"** has the meaning set out in Section 14.6.1, and **"Signing Officer"** means any one of them;

(qq) **"SCERP"** means a specified continuing education or remediation program;

(rr) **"Subject Committee Member"** has the meaning set out in Section 7.5.7;

(ss) **"Subject Director"** has the meaning set out in Section 2.4.5;

(tt) **"Substitute Decisions Act"** means the *Substitute Decisions Act*, *1992*, S.O. 1992, c.30, and the regulations thereunder, as amended from time to time; and

(uu) **"vice-chair"** means the vice-chair of a Committee.

1.2 Interpretation

1.2.1 All terms defined in the Act, the Code and the Medicine Act have the same meaning in this By-law and all other By-laws, unless stated otherwise.

1.2.2 References containing terms such as “includes” and “including”, whether or not used with the words “without limitation” or “but not limited to”, shall not be deemed limited by the specific enumeration of items but shall, in all cases, be deemed to be without limitation and construed and interpreted to mean “includes without limitation” and “including without limitation”.

1.2.3 All monetary references in the By-laws are to Canadian Dollars, unless stated otherwise.

1.2.4 References in the By-laws to a statute, regulation or by-law, or a section or provision thereof, shall be deemed to extend and apply to any amendment or re-enactment of such statute, regulation or by-law, or section or provision thereof.

1.2.5 The division of this By-law into Parts, Articles and Sections and the insertion of headings are for convenience of reference only and shall not affect the construction or interpretation hereof.

PART 2. THE BOARD

ARTICLE 2 BOARD COMPOSITION, ELIGIBILITY AND DISQUALIFICATION

2.1 Composition

2.1.1 In accordance with the Medicine Act, the Board shall be composed of:

(a) at least 15 and no more than 16 persons who are Registrants elected in accordance with the by-laws;

(b) at least 13 and no more than 15 persons appointed by the Lieutenant Governor in Council who are not:

(i) Registrants;

(ii) members of a College as defined in the Act; or

(iii) members of a Council as defined in the Act,

(the “**Public Directors**”); and

(c) three persons selected, in accordance with a by-law made under section 12.1 of the Medicine Act, from among Registrants who are members of a faculty of medicine of a university in Ontario, and appointed by the Board.

2.2 Eligibility Criteria

2.2.1 To be eligible to be elected to the Board as an Elected Director or selected and appointed to the Board as an Academic Director, a Registrant, on the date of the election or appointment, as the case may be:

(a) in the case of eligibility to be an Elected Director, has their Business Address (if any) in Ontario and resides in Ontario;

(b) in the case of eligibility to be an Academic Director, is a member of a faculty of medicine of a university in Ontario;

(c) is not in default of payment of any fee payable to the College;

(d) is not, and has not been within one year before the date of the election or appointment, as the case may be, 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, the Ontario Specialists Association, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

(e) does not hold, and has not held within one year before the date of the election or appointment, as the case may be:

(i) an employment position or any position of responsibility with any organization whose mandate conflicts with the mandate of the College; or

(ii) a position with any organization which would cause the Registrant, if elected or appointed as a Director, to have a Conflict of Interest, including by virtue of having competing fiduciary obligations to both the College and the other organization;

(f) is not, and has not been within five years before the date of the election or appointment, as the case may be, an employee of the College (whether on contract or permanent, and whether on a full-time or part-time basis);

(g) has completed and filed with the Registrar, by the deadline set by the Registrar, a Conflict of Interest declaration form specified by the College;

(h) prior to the deadline specified by the Registrar, in the case of an election, or prior to appointment, as the case may be, the Registrant 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 the Board and committee members;

(i) is not a Relative of an employee of the College or another Director;

(j) is not, and has never been, a party to civil litigation or arbitration adverse in interest against the College, the Board, a committee, a Director or a College officer, employee or agent, provided that the litigation or arbitration against a

College employee or agent relates to the College or their role as an employee or agent of the College;

(k) subject to Section 2.2.4, has never been disqualified from the Board or from one or more committees;

(l) subject to Section 2.2.4, has never resigned from the Board or from one or more committees where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the Registrant from the Board or one or more committees;

(m) holds a certificate of registration that has never been revoked or suspended, other than an Administrative Suspension more than six years before the date of the election or appointment, as the case may be;

(n) holds a certificate of registration that is not subject to a term, condition or limitation other than one prescribed by a regulation made under the Act or the Medicine Act or imposed by the Registration Committee pursuant to a College registration policy;

(o) has not been found to have committed an act of professional misconduct or to be incompetent by a panel of the Ontario Physicians and Surgeons Discipline Tribunal or found to be incapacitated by a panel of the Fitness to Practise Committee, unless the notation of such finding has been removed from the Register pursuant to section 23(11) of the Code;

(p) is not the subject of any disciplinary or incapacity proceeding;

(q) is not subject to an outstanding interim order by the ICRC under the Code;

(r) has not been required by the ICRC to complete a SCERP within five years before the date of the election or appointment, as the case may be;

(s) has not been required to appear before a panel of the ICRC to be cautioned within five years before the date of the election or appointment, as the case may be;

(t) has no findings of guilt (unless a pardon was granted or a record suspension was ordered in respect of the findings) or outstanding charges made against the Registrant under the Health Insurance Act, the Criminal Code or the Controlled Drugs and Substances Act or under any comparable legislation or criminal laws of another jurisdiction;

(u) is in compliance with all continuing professional development required by the Medicine Act;

(v) is not an undischarged bankrupt;

(w) is not a person who has been found to be incapable of managing property under the Substitute Decisions Act or under the Mental Health Act; and

(x) is not a person who has been declared incapable by any court in Canada or elsewhere.

2.2.2 A Registrant is not eligible for election to the Board who, if elected, would be unable to serve completely the three-year term prescribed by Section 3.2.1 by reason of:

(a) the nine-consecutive-year term limit prescribed by subsection 5(2) of the Code; or

(b) the total nine-year term limit prescribed by Section 3.2.2.

2.2.3 A Registrant is not eligible to be an Academic Director if the total of the following equals or exceeds nine years:

(a) the number of years of the proposed appointment;

(b) the number of years the Registrant was an Elected Director (if any); and

(c) the number of years the Registrant attended Board meetings as an academic representative in a non-voting capacity (if any).

2.2.4 A Registrant who has been disqualified from the Board or from one or more committees, or has resigned from the Board or from one or more committees where there are reasonable grounds to believe that the resignation is related to a proposed disqualification of the Registrant from the Board or from one or more committees, for disqualification criteria prescribed in Section 2.3.1(k) or Section 2.3.1(o), is not ineligible under Section 2.2.1(k) or Section 2.2.1(l) to be elected to the Board as an Elected Director or selected and appointed to the Board as an Academic Director if on the date of the election or appointment, as the case may be:

(a) in the case of disqualification under Section 2.3.1(k), the disciplinary or incapacity proceeding, as the case may be, has been finally completed, and the Registrant was not found in such proceeding to have committed an act of professional misconduct or to be incompetent by a panel of the Ontario Physicians and Surgeons Discipline Tribunal or to be incapacitated by a panel of the Fitness to Practise Committee; or

(b) in the case of disqualification under Section 2.3.1(o), all of the charges have been disposed of such that the Registrant was not found guilty of any of the charges.

For greater certainty, this Section 2.2.4 does not affect the eligibility of a Registrant to be elected to the Board as an Elected Director or selected and appointed to the Board as an Academic Director under any other eligibility criteria prescribed in Section 2.2.

2.3 Disqualification Criteria

2.3.1 An Elected Director or Academic Director is automatically disqualified from sitting on the Board if the Director:

(a) in the case of an Elected Director, ceases to have their Business Address (if any) in Ontario or ceases to reside in Ontario;

(b) in the case of an Academic Director, ceases to be a member of a faculty of medicine of a university in Ontario;

(c) 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, the Ontario Specialists Association, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

(d) becomes an employee of the College;

(e) becomes a Relative of an employee of the College or another Director;

(f) becomes a party to civil litigation or arbitration adverse in interest against the College, the Board, a committee, a Director or a College officer, employee or agent, provided that the litigation or arbitration against a College employee or agent relates to the College or their role as an employee or agent of the College;

(g) has had their certificate of registration revoked or suspended, including an Administrative Suspension;

(h) has one or more terms, conditions and limitations imposed on their certificate of registration other than one prescribed in any regulation made under the Act or the Medicine Act or imposed by the Registration Committee pursuant to a College registration policy;

(i) is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the Ontario Physicians and Surgeons Discipline Tribunal;

(j) is found to be incapacitated by a panel of the Fitness to Practise Committee;

(k) becomes the subject of any disciplinary or incapacity proceeding;

(l) becomes subject to an interim order by the ICRC under the Code;

(m) is required by the ICRC to complete a SCERP;

(n) is required to appear before a panel of the ICRC to be cautioned;

(o) is charged with an offence under the Health Insurance Act, the Criminal Code or the Controlled Drugs and Substances Act or under any comparable legislation or criminal laws of another jurisdiction;

(p) is found guilty of an offence under the Health Insurance Act, the Criminal Code or the Controlled Drugs and Substances Act or under any comparable legislation or criminal laws of another jurisdiction;

(q) is not in compliance with all continuing professional development required by the Medicine Act;

(r) becomes an undischarged bankrupt;

(s) is found to be incapable of managing property under the Substitute Decisions Act or under the Mental Health Act; or

(t) is declared incapable by any court in Canada or elsewhere.

2.3.2 An Elected Director or Academic Director may be disqualified from sitting on the Board if the Director:

(a) fails to attend three consecutive meetings of the Board;

(b) fails to attend three consecutive meetings of a committee of which the Elected Director or Academic Director is a member or all or part of a hearing for which the Elected Director or Academic has been selected;

(c) is in default of payment of any fee payable to the College for more than 30 days;

(d) fails, in the opinion of the Board, to discharge their duties to the College, including having acted in a Conflict of Interest or otherwise in breach of a By-law, the Act or the College's governance policies;

(e) except as provided in Section 2.3.1(c):

(i) becomes an employee or holds any position of responsibility with any organization whose mandate conflicts with the mandate of the College; or

(ii) holds a position with any organization which would cause the Director to have a Conflict of Interest, including by virtue of having competing fiduciary obligations to both the College and the other organization; or

(f) did not satisfy one or more of the criteria for eligibility prescribed in Section 2.2.1 at the date of the election or appointment, and the Director did not disclose same to the College or the Director was untruthful or misled the College about same.

2.4 Disqualification of Elected Directors and Academic Directors

2.4.1 A Director shall immediately notify the Registrar in writing if any of the criteria for disqualification prescribed in Section 2.3.1 or Section 2.3.2 arise regarding that Director.

2.4.2 A Director shall advise the Registrar in writing if such Director believes that another Director meets one or more of the criteria for disqualification prescribed in Section 2.3.1 or Section 2.3.2.

2.4.3 If the Registrar receives information in writing that suggests an Elected Director or Academic Director meets any of the criteria for disqualification prescribed in Section 2.3.1 or Section 2.3.2, the Registrar shall report the matter to the Executive Committee.

2.4.4 If the Executive Committee receives information that suggests an Elected Director or Academic Director meets any of the criteria for disqualification prescribed in Section 2.3.1, the Executive Committee shall notify such Director and the Board in writing that such Director has been disqualified from the Board.

2.4.5 If the Executive Committee believes that an Elected Director or Academic Director meets any of the criteria for disqualification prescribed in Section 2.3.2, the Executive Committee shall notify such Director (the **"Subject Director"**) of the nature of the concern and provide the Subject Director a reasonable opportunity to respond to the concern before making a decision to refer the matter to the Board.

2.4.6 If the Executive Committee decides that the matter warrants the Board's consideration, the Executive Committee shall place the matter on the agenda of the Board's next meeting, or the Board Chair shall call a special Board meeting for the purpose of determining whether the Subject Director meets any of the criteria for disqualification prescribed in Section 2.3.2. The Registrar shall advise the Subject Director of the date of the meeting and that the Subject Director may make written or oral submissions to the Board at the meeting.

2.4.7 Disqualification of an Elected Director or Academic Director pursuant to the disqualification criteria prescribed in Section 2.3.2 requires a motion passed by at least a two-thirds majority of the votes cast at the Board meeting by the Directors in attendance. The Subject Director shall not be present during the discussion following submissions, if any, or during the vote, and shall not vote on the motion. The Board shall not count the Subject Director for the purpose of establishing quorum or calculating votes.

2.4.8 If an Elected Director or Academic Director is disqualified from sitting on the Board, whether automatically pursuant to Section 2.3.1 or by decision of the Board as provided in Section 2.4.7, the disqualified Director thereupon ceases to be a Director, the Registrant's seat becomes vacant, and the vacancy shall be filled in the manner described in Section 3.10, in the case of an Elected Director, or Section 4.3.1, in the case of an Academic Director.

2.4.9 A disqualified Elected Director or Academic Director ceases to be a member of any committees.

2.5 Public Directors

2.5.1 If any of the criteria for disqualification prescribed in Section 2.3.1 or Section 2.3.2 occur with respect to a Public Director, the College may report this to the Ministry of Health and may request that such Public Director's appointment to the Board be revoked.

ARTICLE 3 ELECTIONS AND ELECTED DIRECTORS

3.1 Election

3.1.1 A regular election shall be held each year to elect Registrants to the Board as Elected Directors for the number of Elected Directors whose terms are to expire at the close of the Annual Organizational Meeting that year plus the number of vacancies (if any) in Elected Director positions at the time of the election to be filled under Section 3.10.1(a).

3.1.2 The Board shall set the date for each regular election and each by-election of Registrants to the Board.

3.2 Term of Office

3.2.1 The term of office of an Elected Director elected in a regular election is three years, starting at the close of the first Annual Organizational Meeting held after the election and expiring at the close of the Annual Organizational Meeting held after the regular election three years later.

3.2.2 A Registrant may not be a Director for more than a total of nine years, whether consecutively or non-consecutively. For greater certainty, following the maximum term of nine years as a Director, a Registrant may not stand for election as an Elected Director or be appointed as an Academic Director.

3.2.3 For greater certainty, the term of office for an Elected Director who was elected pursuant to an election held under the electoral district system, shall expire on the date of expiry of the term that the Elected Director was serving at the time the district was eliminated.

3.3 Notice of Election and Election Applications

3.3.1 No later than 120 days before the date of each regular election, the Governance and Nominating Committee shall review the skills, expertise and diversity of incumbent Directors against the Board Profile and identify the skills, expertise and diversity based on the Board Profile that are needed or desired for the Board when filling upcoming positions for Elected Directors.

3.3.2 No later than 90 days prior to the date of an election, the Registrar shall notify every Registrant of the date, time and place of the election and the application procedure for seeking to be a candidate for election as an Elected Director, including the deadline by which applications must be received by the Registrar. The deadline by which applications must be received by the Registrar shall be no later than 70 days prior to the date of an election.

3.3.3 The Governance and Nominating Committee may also identify and solicit candidates for election to the Board.

3.3.4 Registrants seeking to be a candidate for election as an Elected Director (including those identified and solicited by the Governance and Nominating Committee) shall

complete and submit an application in the form required by the Governance and Nomination Committee no later than the deadline specified by the Registrar.

3.3.5 The Registrar shall forward all applications received by the deadline to the chair of the Governance and Nominating Committee for consideration.

3.3.6 The Governance and Nominating Committee shall review all applications received by the deadline to verify that each candidate satisfies the eligibility criteria prescribed in Section 2.2.

3.3.7 The Governance and Nominating Committee shall review all applications received by the deadline to assess whether each candidate has skills, expertise and diversity that are within the Board Profile and identified by the Governance and Nominating Committee as needed or desired for the Board pursuant to Section 3.3.1. If an incumbent Director is seeking re-election, the Governance and Nominating Committee shall also take into consideration the incumbent Director's performance as a Director in determining if the incumbent Director is qualified to be a candidate in the election. To support the Governance and Nominating Committee in its deliberations, the Governance and Nominating Committee may interview short-listed candidates.

3.3.8 No later than 45 days prior to the date of the election, the Governance and Nominating Committee shall approve, and provide to the Registrar, a slate of nominees for election as Elected Directors comprised of candidates who (a) satisfy the eligibility criteria prescribed in Section 2.2, and (b) have skills, expertise and diversity that were identified by the Governance and Nominating Committee as needed or desired for the Board pursuant to Section 3.3.1. No later than 40 days prior to the date of the election, the Registrar shall inform all Registrants who submitted an application whether they are on the approved slate of nominees for the upcoming election or have not been nominated for the upcoming election. Subject to Section 3.3.9, a Registrant who is not on the approved slate of nominees for the upcoming election shall not stand for election to the Board in the upcoming election.

3.3.9 No later than 35 days prior to the date of the election, a candidate who was not approved by the Governance and Nominating Committee to be on the slate of nominees for election may dispute the decision of the Governance and Nominating Committee by submitting to the Registrar a written notice of dispute that sets out the basis and particulars of the dispute. In the event of a dispute, the Executive Committee, excluding those individuals who are on the Governance and Nominating Committee, shall review the candidate's eligibility and qualifications, decide if the candidate is eligible and qualified to stand for the upcoming election, and if the candidate is determined to be eligible and qualified, add the candidate to the slate of nominees for the election. The Executive Committee shall inform the candidate of their decision and reasons. The Executive Committee's decision shall be final and not subject to challenge. For greater certainty, if the Executive Committee does not add the candidate to the slate of nominees for the election, such candidate shall not stand for election to the Board in the upcoming election.

3.4 Acclamation or Election

3.4.1 If the number of nominees on the slate is less than or equal to the number of Elected Director positions available for the election, the Registrar shall declare the nominees to be elected as Elected Directors by acclamation.

3.4.2 If the number of nominees on the slate is less than or equal to the number of Elected Director positions available for the election:

(a) and if the number of Elected Directors on the Board after the election will be less than the minimum number required by law, the Board shall direct the Registrar to hold a by-election to fill at minimum the number of Elected Director positions needed so that the number of Elected Directors is not less than the minimum number required by law; or

(b) and if the number of Elected Directors on the Board after the election will be equal to or greater than the minimum number required by law, the Board may leave the Elected Director positions remaining after the election vacant until the next election or direct the Registrar to hold a by-election to fill the remaining Elected Director positions.

3.4.3 If the number of nominees on the slate is greater than the number of Elected Director positions available for the election, the Registrar shall administer an election process for Registrants to vote on the nominees for election as Elected Directors.

3.5 Registrar's Electoral Duties

3.5.1 The Registrar shall supervise and administer the election process and may, for the purpose of carrying out that duty, subject to any other applicable provision in the By-laws:

(a) appoint one or more returning officers and scrutineers;

(b) establish a deadline for the receiving of ballots;

(c) establish procedures for the opening, counting and verification of ballots;

(d) establish reliable and secure voting processes, subject to Section 3.5.2;

(e) provide for the notification to Registrants of the results of the elections; and

(f) provide for the destruction of ballots or records of ballots following an election.

3.5.2 Voting by electronic access to ballots may be used if the Registrar is satisfied that the proceedings and voting may proceed with adequate security and confidentiality and if the votes may be verified as having been made by the Registrants.

3.5.3 If there is an interruption of electronic service provided for or by the College or mail during an election, the Registrar shall extend the holding of the election for such

minimum period of time as the Registrar considers necessary to compensate for the interruption.

3.6 Eligibility to Vote and Ballots

3.6.1 A Registrant is eligible to vote in an election if, on the 45th day prior to the date of the election:

(a) the Registrant's Business Address is in Ontario; or

(b) if the Registrant is not engaged in the practice of medicine, in the case of a Physician Registrant, or practice as a physician assistant, in the case of a PA Registrant, the Registrant resides in Ontario.

3.6.2 No later than 21 days before the date of an election, the Registrar shall send to every Registrant eligible to vote a list of nominees, a ballot or electronic access to a ballot and an explanation of the voting procedure as set out in the By-laws or as determined by the Registrar.

3.7 Number of Votes to be Cast

3.7.1 A Registrant may cast as many votes on a ballot in an election of Registrants to the Board as there are Registrants to be elected to the Board.

3.7.2 A Registrant shall not cast more than one vote for any one nominee.

3.8 Voting Results and Tie Votes

3.8.1 The nominees with the highest number of votes shall be declared elected in accordance with the number of positions open for election.

3.8.2 If there is a tie between two or more nominees in an election to the Board and it is necessary to break the tie to determine who will be the successful nominee(s), the Registrar shall break the tie by lot.

3.9 Recounts

3.9.1 A nominee may require a recount by giving a written request to the Registrar no more than three business days after the date of an election and paying a fee of $500.

3.9.2 The Registrar shall hold the recount no more than 30 days after receiving the request.

3.10 Filling of Vacancies

3.10.1 Except as provided in Section 3.4.2, if the seat of an Elected Director becomes vacant, the Board may:

(a) leave the seat vacant until the next election, subject to Section 3.10.2;

(b) appoint as an Elected Director the nominee (if any) who had the most votes of all the unsuccessful nominees in the last election of Directors, subject to such nominee satisfying the eligibility criteria prescribed in Section 2.2 and consenting to act as an Elected Director. Should consent not be provided or the eligibility criteria not be satisfied, then the Board may appoint the nominee with the next highest number of votes subject to such nominee satisfying the eligibility criteria prescribed in Section 2.2 and such nominee's consent; or

(c) direct the Registrar to hold a by-election.

3.10.2 If the number of remaining Elected Directors is less than the minimum number required by law, the Board shall take action under Section 3.10.1(b) or Section 3.10.1(c) to fill the number of vacant seats needed so that the number of Elected Directors is not less than the minimum number required by law.

3.10.3 The term of office of an Elected Director appointed under Section 3.10.1(b) or elected in a by-election expires when the term of the former Elected Director, whose vacancy has been filled, would have expired and shall count towards calculation of the new Elected Director's maximum years as a Director as set out in Section 3.2.

3.10.4 By-elections, including the review and approval of candidates to stand for election to the Board in the by-election, shall be held in a manner consistent with, and be subject to the same criteria as, regular elections held under the By-laws, subject to changes to time limits and deadlines and any other necessary modifications, as determined by the Registrar.

ARTICLE 4 ACADEMIC DIRECTORS

4.1 Selection of Academic Directors

4.1.1 Subject to the eligibility criteria prescribed in Section 2.2, the Academic Directors shall be selected in accordance with Section 4.1.

4.1.2 In addition to the review contemplated under Section 3.3.1, the Governance and Nominating Committee shall identify the skills, expertise and diversity that are needed or desired when filling upcoming positions for Academic Directors.

4.1.3 At the direction of the Governance and Nominating Committee, the Registrar shall invite the dean of each faculty of medicine of a university in Ontario to propose one or more Physician Registrants who are members of the faculty to be considered as candidates for selection and appointment as an Academic Director. All candidates shall complete and submit an application in the form required by the Governance and Nominating Committee no later than the deadline specified by the Registrar.

4.1.4 The Registrar shall forward all applications received by the deadline to the chair of the Governance and Nominating Committee for consideration.

4.1.5 The Governance and Nominating Committee shall review all applications received by the deadline to verify that each candidate satisfies the eligibility criteria prescribed in Section 2.2.

4.1.6 The Governance and Nominating Committee shall review all applications received by the deadline to assess whether each candidate has skills, expertise and diversity that are within the Board Profile and identified by the Governance and Nominating Committee as needed or desired for the Board pursuant to Section 4.1.2. If an incumbent Academic Director is seeking re-appointment, the Governance and Nominating Committee shall also take into consideration the incumbent Director's performance as a Director in determining if the incumbent Director is qualified to be re-appointed as an Academic Director. To support the Governance and Nominating Committee in its deliberations, the Governance and Nominating Committee may interview short-listed candidates.

4.1.7 The Governance and Nominating Committee shall propose nominees for appointment as Academic Directors for the number of Academic Directors whose terms are to expire at the close of the Annual Organizational Meeting that year plus the number of vacancies (if any) in Academic Director positions at the time of proposing the nominees. The Governance and Nominating Committee shall only propose nominees who (a) satisfy the eligibility criteria prescribed in Section 2.2, and (b) have skills, expertise and diversity that were identified by the Governance and Nominating Committee as needed or desired for the Board pursuant to Section 4.1.2.

4.1.8 At a meeting of the Board prior to the Annual Organizational Meeting for that year, the Board shall consider a motion to select and appoint the nominees proposed by the Governance and Nominating Committee as Academic Directors, starting upon the close of the Annual Organizational Meeting for the year until the close of the third Annual Organizational Meeting thereafter or until such earlier time as specified in the appointment.

4.2 Term of Office of Academic Directors

4.2.1 Academic Directors shall hold office for a term of three years or such shorter period of time as specified in the appointment.

4.3 Disqualification of Academic Directors

4.3.1 If an Academic Director is disqualified from sitting on the Board under Section 2.4, a Physician Registrant who is a member of a faculty of medicine of a university in Ontario shall be selected to fill the vacancy in accordance with Section 4.1.

ARTICLE 5 OFFICERS

5.1 Officers

5.1.1 The Board shall annually elect a Board Chair and Board Vice-Chair to hold office starting upon the close of the next Annual Organizational Meeting (or if elected at an Annual Organizational Meeting, starting upon the close of such meeting) until the next Annual Organizational Meeting and, if an election is not so held, the Board

Chair and Board Vice-Chair shall continue in office until their successors are elected. The procedure for election of the Board Chair and Board Vice-Chair shall be in accordance with Section 6.2.10.

5.1.2 The candidates for Board Chair and Board Vice-Chair positions shall be determined as follows:

(a) at the direction of the Governance and Nominating Committee, the Registrar shall invite all Directors to submit an expression of interest if interested to serve as the Board Vice-Chair or Board Chair;

(b) the Governance and Nominating Committee may also identify and solicit candidates to submit expressions of interest for election to be Board Vice-Chair and Board Chair;

(c) the Registrar shall specify the deadline by which expressions of interest must be received by the Registrar. The Registrar shall forward all expressions of interest received by the deadline to the chair of the Governance and Nominating Committee for consideration;

(d) the Governance and Nominating Committee shall identify the skills, expertise and diversity based on the Board Profile that are needed or desired when filling upcoming positions for Board Chair and Board Vice-Chair positions;

(e) the Governance and Nominating Committee shall review all expressions of interest received by the deadline to assess whether each candidate has skills, expertise and diversity identified by the Governance and Nominating Committee as needed or desired for Board Chair and Board Vice-Chair positions pursuant to Section 5.1.2(d). To support the Governance and Nominating Committee in its deliberations, the Governance and Nominating Committee may interview short-listed candidates; and

(f) the Governance and Nominating Committee shall propose nominees for each of the Board Chair and Board Vice-Chair positions who have skills, expertise and diversity that were identified by the Governance and Nominating Committee as needed or desired for the Board Chair and Board Vice-Chair positions pursuant to Section 5.1.2(d), and submit the proposed nominees to the Board for election.

5.2 Board Officers

5.2.1 The Board Chair is the chief officer of the College, and the other members of the Executive Committee shall assist the Board Chair in the discharge of the Board Chair's duties as may be requested by the Board Chair from time to time.

5.2.2 The Board Vice-Chair is the deputy chief officer of the College and shall discharge the duties of the Board Chair if the Board Chair is unavailable or unable to act. The Board Vice-Chair shall also perform the other duties requested from time to time by the Board Chair.

5.3 Vacancies in Board Officer Positions

5.3.1 The office of the Board Chair or Board Vice-Chair becomes vacant if the holder of the office dies, resigns, is disqualified from the Board or a committee, otherwise stops being a Director, is removed from office by a vote of the Board at a special meeting called for that purpose or, in the case of the Board Vice-Chair, in accordance with Section 5.3.2(b). A vacancy in the office of the Board Chair shall be filled in accordance with Section 5.3.2 or Section 5.3.4, as the case may be. A vacancy in the office of the Board Vice-Chair shall be filled in accordance with Section 5.3.3 or Section 5.3.4, as the case may be.

5.3.2 If the office of the Board Chair becomes vacant:

(a) the Board Vice-Chair becomes the Board Chair for the unexpired term of the office; and

(b) the office of the Board Vice-Chair thereby becomes vacant.

5.3.3 If the office of the Board Vice-Chair becomes vacant, the Board shall fill any vacancy in the office of the Board Vice-Chair at a special meeting which the Board Chair shall call for that purpose as soon as practicable after the vacancy occurs.

5.3.4 If the offices of the Board Chair and the Board Vice-Chair become vacant concurrently:

(a) the longest-serving member of the Executive Committee who is:

(i) a Registrant if the Board Chair was a Registrant; or

(ii) a Public Director if the Board Chair was a Public Director, becomes the Board Chair *pro tempore* until the Board fills the vacancies; and

(b) the Board shall fill both vacancies at a special meeting which the Board Chair *pro tempore* shall call for that purpose as soon as practicable after the vacancies occur.

ARTICLE 6 MEETINGS OF THE BOARD

6.1 Board Meetings

6.1.1 The Board shall hold:

(a) an annual organizational meeting, which shall be called by the Board Chair between November 1st and December 14th of each year (the "**Annual Organizational Meeting**");

(b) an annual financial meeting, which shall be called by the Board Chair between March 1st and June 30th of each year (the "**Annual Financial Meeting**");

(c) regular meetings other than the Annual Organizational Meeting and the Annual Financial Meeting, which shall be called by the Board Chair from time to time; and

(d) special meetings, which may be called by the Board Chair, any four members of the Executive Committee or by any 12 Directors, in each case by depositing with the Registrar a written requisition for the meeting containing the matter or matters for decision at the meeting. On receipt of a requisition, the meeting shall be called in accordance with Section 6.2.1.

6.1.2 A regular meeting of the Board includes an Annual Organizational Meeting and an Annual Financial Meeting.

6.1.3 The Board shall, at the Annual Organizational Meeting, approve a budget authorizing expenditures for the benefit of the College during the following fiscal year.

6.1.4 At each Annual Financial Meeting, the Board shall do the following:

(a) consider and, if thought fit, approve the financial statements for the preceding fiscal year and the Auditor's report; and

(b) appoint one or more auditors who are duly licensed under the *Public Accounting Act, 2004*, S.O. 2004, c. 8 to hold office until the next Annual Financial Meeting (the "**Auditor(s)**") and, if an appointment is not so made, the Auditor in office shall continue until a successor is appointed.

6.1.5 The Board shall fill any temporary vacancy in the office of the Auditor but, while such vacancy continues, the surviving or continuing Auditor, if any, shall continue as the Auditor.

6.1.6 The Registrar shall give notice of every appointment and reappointment of an Auditor to the Auditor in writing promptly after the appointment or reappointment is made, together with a copy of the By-laws.

6.2 Meeting Process

6.2.1 Meetings of the Board shall take place in Ontario at a place, date and time designated by the Board Chair, the four members of the Executive Committee or the 12 Directors calling the meeting but, if a place, date or time is not designated or is incompatible with the By-laws, the Registrar shall select a place, date and time compatible with the By-laws which is as close as the Registrar can reasonably select to the place, date and time designated by the person(s) calling the meeting.

6.2.2 The Registrar shall cause each Director to be notified in writing of the place, date and time of a Board meeting, by sending such notification at least:

(a) 14 days before a regular meeting; and

(b) five days before a special meeting.

The Registrar is responsible for including in or with the notification of a special meeting the matter or matters for decision contained in the requisition of the meeting deposited with the Registrar.

6.2.3 The Board 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 Director at the preceding Board meeting; or

(iv) if a vote is held at the meeting and at least a two-thirds majority of the votes cast by the Directors in attendance at the meeting agree to consider such motion; and

(c) at any meeting, routine and procedural motions in accordance with the rules of order.

6.2.4 The Board Chair is responsible for the organization of an agenda for each Board meeting, which shall be distributed to the Directors as long a time before the meeting as is practical. Each agenda for a Board meeting shall include an anticipated time for the consideration of each item on the agenda.

6.2.5 If a Director wishes to ask questions of the Executive Committee, or raise topics for informal discussion, that are relevant to the affairs of the College at the Board meeting, the Director shall submit such questions or topics to the Board Chair as far in advance of the Board meeting as is practical, and where possible, prior to the Board Chair distributing an agenda for such Board meeting.

6.2.6 The Board Chair or the Board Chair’s appointee for the purpose shall be the presiding officer for meetings of the Board. Unless otherwise required by law or in the By-laws, the presiding officer may vote on any motion or in any election which properly comes before the Board unless the presiding officer has a Conflict of Interest in connection with such motion or election.

6.2.7 Unless otherwise required by law or in the By-laws, a majority of Directors constitutes a quorum.

6.2.8 Unless otherwise required by law or in the By-laws, every motion which properly comes before the Board shall be decided by a simple majority of the votes cast at the meeting by the Directors in attendance, and if there is an equality of votes on a motion, the motion shall be deemed to have been defeated.

6.2.9 Unless otherwise required or permitted by the By-laws, every vote at a Board meeting shall be by a show of hands. The presiding officer shall declare the result of every vote, and the presiding officer's declaration is final.

6.2.10 The procedure for election of the Board Chair, Board Vice-Chair and members of the Governance and Nominating Committee shall be as follows:

(a) if there is only one nominee for an office or position, the presiding officer shall declare the nominee elected by acclamation; or

(b) if there are two or more nominees for an office or position:

(i) prior to the first vote, each of these nominees shall be given an opportunity to speak to the Board for a maximum of two minutes about the nominee's candidacy for the office or position;

(ii) such office or position shall be selected by voting by secret ballot, using generally accepted democratic procedures;

(iii) the nominee who receives a majority of the votes cast for such office or position shall be declared the successful nominee;

(iv) if no nominee receives a majority of the votes cast, the nominee who receives the lowest number of votes shall be deleted from the nomination (subject to Section 6.2.10(b)(v)), and another vote by secret ballot shall be taken. This procedure shall be followed until one nominee receives a majority of the votes cast;

(v) if a tie vote occurs between two or more nominees having the lowest number of votes, there are nominees other than the tied nominees, and no nominee receives a majority of the votes cast:

(A) if there is only one nominee other than the tied nominees, a vote by secret ballot shall be taken to determine which of the tied nominees shall be deleted from the nomination. If the nominees again receive an equal number of votes, the presiding officer shall break the tie by lot; or

(B) if there are two or more nominees other than the tied nominees, all of the tied nominees shall be deleted from the nomination; and

(vi) if, at any point during the election process, all the nominees that remain have an equal number of votes, each of these nominees shall be given an opportunity to speak to the Board for a maximum of two minutes about the nominee's candidacy for the office or position, and then another vote by secret ballot shall be taken. If the nominees again receive an equal number of votes, the presiding officer shall break the tie by lot.

6.2.11 The Board may, at the discretion of the presiding officer, use an electronic voting system for votes to be held by ballot (including secret ballot) or by a show of hands.

If an electronic voting system is used for a vote by ballot, references in the By-laws shall be deemed to be references to an electronic ballot.

6.2.12 The Registrar is responsible for the recording of the proceedings of each Board meeting. The written record of the proceedings of a Board meeting when accepted at a subsequent Board meeting, subject to any corrections made at such subsequent meeting, is conclusive proof that the written record accurately reflects the proceedings of the Board meeting. A Director's absence from the meeting for which the record of proceedings are being approved does not prevent the Director from participating in the correction or approval of the record.

6.2.13 Whether or not a quorum is present, the presiding officer may adjourn any properly called Board meeting and reconvene the meeting at any time and from time to time. If a quorum is present at any reconvened meeting, any matter may be considered and transacted at the reconvened meeting which could have been transacted at the original meeting which was adjourned.

6.2.14 A meeting of the Board may, in the discretion of the presiding officer, be held in any manner, including by telephonic or electronic means, that allows all the persons participating to communicate with each other simultaneously and instantaneously. The meeting may only be held by telephonic or electronic means if the presiding officer is satisfied that the proceedings may proceed with adequate security and if applicable, confidentiality.

6.2.15 The rules of order prescribed in Schedule 1 to this By-law are the rules of order for meetings of the Board.

PART 3. COMMITTEES

ARTICLE 7 APPOINTMENTS AND PROCEDURE

7.1 Committee Composition

7.1.1 Unless otherwise required by law or in the By-laws:

(a) the Board shall appoint the members of each committee and a chair and if desired, a vice-chair of each committee;

(b) the Board shall establish the powers and duties of each committee; and

(c) each committee shall be composed of such Registrants and others as the Board may appoint.

7.1.2 The Board and the Executive Committee may establish special committees, and may appoint the members and a chair and vice-chair to, and establish the powers and duties of, any such special committee. The members of a special committee shall be composed of such Registrants and others as the Board may appoint.

7.2 Appointment to Committees

7.2.1 The chair and vice-chair (if any) of each committee shall identify the skills, expertise and diversity that are needed or desired for the committee when filling upcoming positions on the committee.

7.2.2 For each committee, the chair and vice-chair (if any) of the committee shall review expressions of interest received from Registrants or other persons interested in serving as a committee member, chair or vice-chair of the committee and any other candidates identified by the chair or vice-chair (if any) of the committee to (a) verify that each candidate satisfies the eligibility criteria prescribed in Section 7.3, and (b) assess whether each candidate has skills, expertise and diversity that will meet the needs of the committee as identified pursuant to Section 7.2.1. The chair and vice-chair (if any) of the committee may interview short-listed candidates for the committee.

7.2.3 For each committee, the chair and vice-chair (if any) of the committee shall consider, no less than annually, the upcoming needs for positions on the committee, and shall propose nominees for committee members, chairs and vice-chairs to be submitted to the Board for appointment as needed for the committee. The chair and vice-chair (if any) of the committee shall only propose nominees who (a) satisfy the eligibility criteria prescribed in Section 7.3, and (b) have skills, expertise and diversity that will meet the needs of the committee as identified pursuant to Section 7.2.1.

7.2.4 Sections 7.2.1, 7.2.2, and 7.2.3 do not apply to filling positions on the Finance and Audit Committee, Governance and Nominating Committee or the Executive Committee.

7.2.5 The Board may appoint to a committee a person who is not a Registrant or a Director.

7.3 Eligibility of Committee Members

7.3.1 To be eligible to be appointed to a committee, a Registrant or other person (other than a Public Director), on the date of the appointment:

(a) in the case of a Registrant, has their Business Address (if any) in Ontario and resides in Ontario;

(b) in the case of a Registrant, is not in default of payment of any fees payable to the College;

(c) in the case of a Registrant, is not 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, the Ontario Specialists Association, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

(d) is not a Relative of an employee of the College;

(e) is not, and has never been, a party to civil litigation or arbitration adverse in interest against the College, the Board, a committee, a Director or a College officer, employee or agent, provided that the litigation or arbitration against a College employee or agent relates to the College or their role as an employee or agent of the College;

(f) in the case of a Registrant, holds a certificate of registration that has never been revoked or suspended, other than an Administrative Suspension more than six years before the date of the appointment;

(g) in the case of a Registrant, holds a certificate of registration that is not subject to a term, condition or limitation other than one prescribed by a regulation made under the Act or the Medicine Act or imposed by the Registration Committee pursuant to a College registration policy;

(h) in the case of a Registrant, has not been found to have committed an act of professional misconduct or to be incompetent by a panel of the Ontario Physicians and Surgeons Discipline Tribunal or found to be incapacitated by a panel of the Fitness to Practise Committee, unless the notation of such finding has been removed from the Register pursuant to section 23(11) of the Code;

(i) in the case of a Registrant, is not the subject of any disciplinary or incapacity proceeding;

(j) in the case of a Registrant, is not subject to an outstanding interim order by the ICRC under the Code;

(k) in the case of a Registrant, has not been required by the ICRC to complete a SCERP within five years before the date of the appointment;

(l) in the case of a Registrant, has not been required to appear before a panel of the ICRC to be cautioned within five years before the date of the appointment;

(m) has no findings of guilt (unless a pardon was granted or a record suspension was ordered in respect of the findings) or outstanding charges made against the Registrant under the Health Insurance Act, the Criminal Code or the Controlled Drugs and Substances Act or under any comparable legislation or criminal laws of another jurisdiction;

(n) in the case of a Registrant, is in compliance with all continuing professional development required by the Medicine Act;

(o) is not an undischarged bankrupt;

(p) is not a person who has been found to be incapable of managing property under the Substitute Decisions Act or under the Mental Health Act;

(q) is not a person who has been declared incapable by any court in Canada or elsewhere; and

(r) is not ineligible for such appointment under Section 7.6.6 or Section 7.6.7.

7.4 Rescission of Committee Appointment

7.4.1 The Board may rescind the appointment of a committee member prior to the expiry of the appointment at any time upon recommendation from the chair or vice-chair (if any) of the committee. This Section 7.4.1 does not apply to members of the Governance and Nominating Committee, the Executive Committee, or individuals who are committee members by virtue of the office they hold.

7.5 Disqualification of Members from Committees

7.5.1 A committee member (other than a Public Director) is automatically disqualified from sitting on the committee if the committee member:

(a) in the case of a Registrant, ceases to have their Business Address (if any) in Ontario or ceases to reside in Ontario;

(b) 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, the Ontario Specialists Association, the Canadian Association of Physician Assistants or the Ontario Physician Assistants Association;

(c) becomes a Relative of an employee of the College;

(d) becomes a party to civil litigation or arbitration adverse in interest against the College, the Board, a committee, a Director or a College officer, employee or agent, provided that the litigation or arbitration against a College employee or agent relates to the College or their role as an employee or agent of the College;

(e) in the case of a Registrant, has had their certificate of registration revoked or suspended, including an Administrative Suspension;

(f) in the case of a Registrant, has one or more terms, conditions and limitations imposed on their certificate of registration other than one prescribed in any regulation made under the Act or the Medicine Act or imposed by the Registration Committee pursuant to a College registration policy;

(g) in the case of a Registrant, is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the Ontario Physicians and Surgeons Discipline Tribunal;

(h) in the case of a Registrant, is found to be incapacitated by a panel of the Fitness to Practise Committee;

(i) in the case of a Registrant, becomes the subject of any disciplinary or incapacity proceeding;

(j) in the case of a Registrant, becomes subject to an interim order by the ICRC under the Code;

(k) in the case of a Registrant, is required by the ICRC to complete a SCERP;

(l) in the case of a Registrant, is required to appear before a panel of the ICRC to be cautioned;

(m) is charged with an offence under the Health Insurance Act, the Criminal Code or the Controlled Drugs and Substances Act or under any comparable legislation or criminal laws of another jurisdiction;

(n) is found guilty of an offence under the Health Insurance Act, the Criminal Code or the Controlled Drugs and Substances Act or under any comparable legislation or criminal laws of another jurisdiction;

(o) in the case of a Registrant, is not in compliance with all continuing professional development required by the Medicine Act;

(p) becomes an undischarged bankrupt;

(q) is found to be incapable of managing property under the Substitute Decisions Act or under the Mental Health Act; or

(r) is declared incapable by any court in Canada or elsewhere.

7.5.2 A committee member (other than a Public Director) may be disqualified from sitting on the committee if the committee member:

(a) fails to attend three consecutive meetings of the committee;

(b) fails to attend all or part of a hearing for which the committee member has been selected;

(c) in the case of a Registrant, is in default of payment of any fee payable to the College for more than 30 days;

(d) fails, in the opinion of the Board, to discharge the committee member's duties to the College, including having acted in a Conflict of Interest or otherwise in breach of a College By-law, the Act, or the College's governance policies; or

(e) did not satisfy one or more of the criteria for eligibility prescribed in Section 7.3 at the date of appointment to the committee, and the committee member did not disclose same to the College or the committee member was untruthful or misled the College about same.

7.5.3 A committee member (including a Public Director) shall immediately notify the Registrar in writing if any of the criteria for disqualification prescribed in Section 7.5.1 or Section 7.5.2 arise regarding that committee member.

7.5.4 The chair or vice-chair of a committee shall advise the Registrar in writing if they believe that a committee member (including a Public Director) meets one or more of the criteria for disqualification prescribed in Section 7.5.1 or Section 7.5.2.

7.5.5 If the Registrar receives information in writing that suggests a committee member (other than a Public Director) meets any of the criteria for disqualification prescribed in Section 7.5.1 or Section 7.5.2, the Registrar shall report the matter to the Executive Committee.

7.5.6 If the Executive Committee receives information pursuant to Section 7.5.5 that suggests a committee member (other than a Public Director) meets any of the criteria for disqualification prescribed in Section 7.5.1, the Executive Committee shall notify such committee member and the chair of the applicable committee that such committee member has been disqualified from the committee.

7.5.7 If the Executive Committee believes that a committee member (other than a Public Director) meets any of the criteria for disqualification prescribed in Section 7.5.2, the Executive Committee shall notify such committee member (the **"Subject Committee Member"**) of the nature of the concern and provide the Subject Committee Member a reasonable opportunity to respond to the concern before making a decision to refer the matter to the Board.

7.5.8 If the Executive Committee decides that the matter warrants the Board's consideration, the Executive Committee shall place the matter on the agenda of the Board's next meeting, or the Board Chair shall call a special Board meeting for the purpose of determining whether the Subject Committee Member meets any of the criteria for disqualification prescribed in Section 7.5.2. The Registrar shall advise the Subject Committee Member of the date of the meeting and that the Subject Committee Member may make written or oral submissions to the Board at the meeting.

7.5.9 Disqualification of a committee member (other than a Public Director) pursuant to the disqualification criteria prescribed in Section 7.5.2 shall be decided by a simple majority of the votes cast at the meeting by the Directors in attendance.

7.5.10 A committee member who is disqualified ceases to be a member of the committee.

7.5.11 A Director who is disqualified from sitting on the Board is thereby disqualified from sitting on each committee of which the Director is a member.

7.5.12 If any of the criteria for disqualification prescribed in Section 7.5.1 or Section 7.5.2 occur with respect to a member of a committee who is a Public Director, the College may report this to the Ministry of Health and may request that the Public Director's appointment to the Board be revoked.

7.6 Committee Member Terms

7.6.1 The term of office of a committee member starts when the committee member is appointed or at such later time as the Board specifies in the appointment.

7.6.2 Except as provided in Section 7.6.3, the term of office of a committee member automatically expires at the close of the third Annual Organizational Meeting of the Board which occurs after the appointment or at such earlier time as the Board specifies in the appointment.

7.6.3 The term of office of each member of the Governance and Nominating Committee and the Executive Committee automatically expires at the close of the Annual Organizational Meeting of the Board which occurs next after the appointment.

7.6.4 If one or more vacancies occur in the membership of a committee, the committee members remaining in office constitute the committee so long as their number is not fewer than the quorum prescribed by law or in the By-laws.

7.6.5 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.

7.6.6 Subject to Section 7.6.8, a person is not eligible for appointment to a committee if a person has been a member of such committee for a total of nine years or more, whether consecutively or non-consecutively.

7.6.7 Subject to Section 7.6.8:

(a) a Registrant is not eligible for appointment to a committee if the Registrant has been a Director or a member of any one or more committees for a total of 18 years or more, whether consecutively or non-consecutively; and

(b) a person who is not a Registrant is not eligible for appointment to a committee if the person has been a member of any one or more committees for a total of 18 years or more, whether consecutively or non-consecutively.

For greater certainty, for purposes of calculating the 18-year total in Section 7.6.7, any period of time spent on the Board and/or one or more committees concurrently counts as one period of time, and is not counted separately for the Board and each committee.

7.6.8 Despite Sections 7.3.1(r), 7.6.6 and 7.6.7, the Board, if it determines it is necessary to do so due to exceptional circumstances, may appoint a person to a committee for additional one-year terms, but not to exceed two years in total.

7.7 Committee Meetings

7.7.1 Section 7.7 does not apply to a proceeding of a committee or a panel of a committee that is held for the purpose of conducting a hearing.

7.7.2 All committee meetings shall be conducted in accordance with the By-laws and the terms of reference, if any, established by the applicable committee, and the Code as may be applicable.

7.7.3 Each committee shall meet from time to time at the direction of the Board or the Executive Committee or the call of the chair of the committee at a place in Ontario, and the date and time are to be designated by the chair of the committee.

7.7.4 Committee members shall be provided with notice of all regular meetings through a periodic committee meeting schedule provided to each committee member. Notice shall be provided to committee members for any additional committee meetings as far in advance of the meeting as is practical.

7.7.5 Unless otherwise required by law or in the By-laws, a majority of the members of a committee constitutes a quorum.

7.7.6 The chair of a committee or the chair's appointee for the purpose shall be the presiding officer for meetings of the committee or panel as appropriate.

7.7.7 Every question or motion which comes before a committee may be decided by a majority of the votes cast at the meeting and, if there is an equality of votes on a question or motion, the question or motion shall be deemed to have been defeated.

7.7.8 A meeting of a committee or of a panel of a committee that is held for any purpose other than conducting a hearing may, in the discretion of the chair of the committee, be held in any manner, including by telephonic or electronic means, that allows all the persons participating to communicate with each other simultaneously and instantaneously. The meeting may only be held by telephonic or electronic means if the presiding officer is satisfied that the proceedings may proceed with adequate security and confidentiality.

7.7.9 The presiding officer is responsible for the recording of the proceedings and deliberations at every meeting of a committee and meeting of a panel of a committee. The presiding officer may vote on any question or motion which comes before the committee unless the presiding officer has a Conflict of Interest in connection with such question or motion.

7.7.10 The written record of the proceedings and deliberations at a committee meeting (other than a meeting of a panel of a committee) when accepted at a subsequent committee meeting, subject to any corrections made at such subsequent meeting, is conclusive proof that the written record accurately reflects the proceedings and deliberations at the committee meeting. A committee member's absence from the meeting for which the record of proceedings are being approved does not prevent the committee member from participating in their correction or approval.

7.7.11 The written record of the proceedings and deliberations of a meeting of a panel of a committee for any purposes other than conducting a hearing, when signed by the persons purporting to be the presiding and recording officers thereof, is conclusive proof that the written record accurately reflects the proceedings and deliberations of the panel of the committee.

ARTICLE 8 COMMITTEES

8.1 Statutory and Standing Committees

8.1.1 The Code provides that the College shall have the following committees:

(a) Executive Committee;

(b) Registration Committee;

(c) Inquiries, Complaints and Reports Committee;

(d) Discipline Committee;

(e) Fitness to Practise Committee;

(f) Quality Assurance Committee; and

(g) Patient Relations Committee.

8.1.2 The following committees are the standing committees established pursuant to By-laws:

(a) Finance and Audit Committee;

(b) Governance and Nominating Committee; and

(c) Premises Inspection Committee.

8.1.3 Subject to the Code and the By-laws, statutory committees, standing committees and any special committees may establish their own terms of reference and rules of procedures.

8.2 Registration Committee

8.2.1 The Registration Committee shall be composed of Registrants and Public Directors. The number of members on the Registration Committee shall be determined by the Board annually to meet the needs of the Registration Committee.

8.3 Inquiries, Complaints and Reports Committee

8.3.1 The Inquiries, Complaints and Reports Committee (**"ICRC"**) shall be composed of Registrants and Public Directors. The number of members on the ICRC shall be determined by the Board annually to meet the needs of the ICRC.

8.4 Fitness to Practise Committee

8.4.1 The Fitness to Practise Committee shall be composed of Registrants, Public Directors and individuals with previous experience as adjudicators. The number

of members on the Fitness to Practise Committee shall be determined by the Board annually to meet the needs of the Fitness to Practise Committee.

8.5 Patient Relations Committee

8.5.1 The Patient Relations Committee shall be composed of the following:

(a) no fewer than two and no more than four Registrants who are not currently Directors or current members of other committees; and

(b) one or two members of the public who are not Registrants and who are not currently Public Directors.

8.6 Quality Assurance Committee

8.6.1 The Quality Assurance Committee shall be composed of Registrants and may, but need not, include Public Directors. The number of members on the Quality Assurance Committee shall be determined by the Board annually to meet the needs of the Quality Assurance Committee.

8.6.2 A panel of three members of the Quality Assurance Committee appointed by the chair of the Quality Assurance Committee is a quorum and may discharge the duties and exercise the authority of the Quality Assurance Committee.

8.7 Discipline Committee (Tribunal)

8.7.1 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 the College as specified in the Code and the Medicine Act*,* and any other legislation or policy where the context requires. For ease of reference, the Ontario Physicians and Surgeons Discipline Tribunal is referred to in the By-laws by its English name or acronym, and all references to the English name or acronym shall be deemed to equally refer to or apply to its French name or acronym, respectively.

8.7.2 The Ontario Physicians and Surgeons Discipline Tribunal shall be composed of Registrant Directors, Public Directors and individuals with previous experience as adjudicators, and may, but need not include, Registrants who are not Directors. The number of members on the Ontario Physicians and Surgeons Discipline Tribunal shall be determined by the Board annually to meet the needs of the Ontario Physicians and Surgeons Discipline Tribunal.

8.8 Premises Inspection Committee

8.8.1 The Premises Inspection Committee shall be composed of Registrants and may, but need not, include Public Directors. The number of members on the Premises Inspection Committee shall be determined by the Board annually to meet the needs of the Out-of-Hospital Premises Inspection Program.

8.8.2 The Premises Inspection Committee shall administer and govern the College's premises inspection program in accordance with Part XI of Ontario Regulation 114/94 under the Medicine Act, and its duties shall include the following:

(a) ensuring appropriate individuals are appointed to perform inspections or re-inspections as authorized by Ontario Regulation 114/94 under the Medicine Act;

(b) ensuring adequate inspections and re-inspections are undertaken and completed in a timely way using appropriate tools and mechanisms;

(c) reviewing premises inspection reports and other material referred to in Ontario Regulation 114/94 under the Medicine Act and determining whether premises pass, pass with conditions or fail an inspection;

(d) specifying the conditions that shall attach to each "pass with conditions";

(e) delivering written reports as prescribed under Ontario Regulation 114/94 under the Medicine Act; and

(f) establishing or approving costs of inspections and re-inspections and ensuring the Registrant or Registrants performing the procedures on the premises are invoiced for those costs.

8.8.3 A panel of three members of the Premises Inspection Committee appointed by the chair of the Premises Inspection Committee is a quorum, and may discharge the duties and exercise the authority of the Premises Inspection Committee.

8.9 Summonses

8.9.1 Any member of the OPSDT or Fitness to Practise Committee may sign summonses issued under subsection 12(1) of the *Statutory Powers Procedure Act*.

ARTICLE 9 BOARD COMMITTEES

9.1 Executive Committee

9.1.1 The Executive Committee shall be composed of the following six members:

(a) the Board Chair;

(b) the Board Vice-Chair; and

(c) four Directors (each, an "**Executive Member Representative**").

A minimum of three members of the Executive Committee (regardless of their position on the Executive Committee) shall be Registrant Directors. A minimum of two members of the Executive Committee (regardless of their position on the Executive Committee) shall be Public Directors.

9.1.2 The Board shall annually appoint the Executive Member Representatives to the Executive Committee starting upon the close of the next Annual Organizational Meeting (or if appointed at an Annual Organizational Meeting, starting upon the close of such meeting) until the close of the following Annual Organizational Meeting. The nominees for the Executive Member Representatives shall be determined by the Governance and Nominating Committee in accordance with the following:

(a) at the direction of the Governance and Nominating Committee, the Registrar shall invite all Directors to submit an expression of interest if interested to serve as an Executive Member Representative;

(b) the Governance and Nominating Committee may also identify and solicit Directors to submit expressions of interest to serve as an Executive Member Representative;

(c) the Registrar shall specify the deadline by which expressions of interest must be received by the Registrar. The Registrar shall forward all expressions of interest received by the deadline to the chair of the Governance and Nominating Committee for consideration;

(d) the Governance and Nominating Committee shall identify the skills, expertise and diversity based on the Board Profile that are needed or desired when filling upcoming Executive Member Representative positions;

(e) the Governance and Nominating Committee shall review all expressions of interest received by the deadline to assess whether each candidate has skills, expertise and diversity identified by the Governance and Nominating Committee as needed or desired for the Executive Committee pursuant to Section 9.1.2(d). To support the Governance and Nominating Committee in its deliberations, the Governance and Nominating Committee may interview short-listed candidates; and

(f) the Governance and Nominating Committee shall propose nominees for each Executive Member Representative position who have skills, expertise and diversity that were identified by the Governance and Nominating Committee as needed or desired for the Executive Committee pursuant to Section 9.1.2(d), and submit the proposed nominees to the Board for appointment.

9.1.3 The Board Chair is the chair of the Executive Committee. The Board Vice-Chair is the vice-chair of the Executive Committee.

9.1.4 In addition to the duties of the Executive Committee set out in section 12(1) of the Code and Section 8.3.1, the Executive Committee shall:

(a) review the performance of the Registrar and shall set the compensation of the Registrar; and

(b) oversee and assist College staff with the development and delivery of major communications, government relations, and outreach initiatives to the

profession, the public and other stakeholders, consistent with the College's strategic plan.

9.1.5 In order to fulfill its duties under Section 8.2.4(a), the Executive Committee shall:

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

(b) ensure that the appointment and re-appointment of the Registrar are approved by the Board; and

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

9.2 Executive Delegation

9.2.1 Unless otherwise required by law or in the By-laws, the Executive Committee may exercise all the powers and duties of the Board with respect to any matter that, in the opinion of the Executive Committee, requires attention between meetings of the Board.

9.2.2 The Executive Committee shall not exercise the powers or duties of the Board under Sections 6.1.4(b), 6.1.5 and 14.5.1.

9.3 Finance and Audit Committee

9.3.1 The Finance and Audit Committee shall be composed of a minimum of five members, including the following:

(a) the Board Chair; and

(b) four Directors.

A minimum of two members of the Finance and Audit Committee (regardless of their position on the Finance and Audit Committee) shall be Registrant Directors. A minimum of two members of the Finance and Audit Committee (regardless of their position on the Finance and Audit Committee) shall be Public Directors. The number of members on the Finance and Audit Committee shall be determined by the Board annually to meet the needs of the Finance and Audit Committee.

9.3.2 The Finance and Audit Committee shall review and report to the Board regarding the financial affairs and position of the College.

9.3.3 In order to fulfil its duty under Section 9.3.2, the Finance and Audit Committee shall:

(a) meet with the Auditor each year:

(i) before the audit to review the timing and extent of the audit and to bring to the attention of the Auditor any matters to which it considers the Auditor should pay attention; and

(ii) as shortly before the Annual Financial Meeting as practical in order to review and discuss with the Auditor the financial statements, the Auditor's report and the management letter;

(b) review the draft budget before it is presented to the Executive Committee, and report to the Executive Committee and the Board arising from its review of:

(i) the assumptions in the draft budget;

(ii) the steps taken to maximize efficiency and minimize cost in relation to the quality of goods and level of service; and

(iii) any other issue which the Finance and Audit Committee considers may affect the financial affairs and position of the College; and

(c) review from time to time:

(i) the expenditures of the College in relation to the budget;

(ii) the performance and administration of the College's pension plans;

(iii) the investment strategies and performance of the College's non-pension investments; and

(iv) the security of the College's assets generally.

9.4 Governance and Nominating Committee

9.4.1 The Governance and Nominating Committee shall be composed of a minimum of five persons, including the following:

(a) the Board Vice-Chair;

(b) two Registrant Directors who are not members of the Executive Committee; and

(c) two Public Directors who are not members of the Executive Committee.

9.4.2 The Governance and Nominating Committee may use consultants with expertise relating to corporate governance, professional regulation or any other area of expertise as the Governance and Nominating Committee deems appropriate to advise the Governance and Nominating Committee with performing its mandate.

9.4.3 The nominees for the positions (other than the Board Vice-Chair) on the Governance and Nominating Committee shall be determined in accordance with the following:

(a) at the direction of the Executive Committee, the Registrar shall invite all Directors to submit an expression of interest by the deadline specified by the

Registrar if interested to serve on the Governance and Nominating Committee; and

(b) the Executive Committee shall forward the names of the Directors who have submitted an expression of interest to serve on the Governance and Nominating Committee as nominees to the Board for election.

9.4.4 The procedure for election of the members of the Governance and Nominating Committee shall be in accordance with Section 6.2.10.

9.4.5 The Board shall annually appoint to the Governance and Nominating Committee the Board Vice-Chair and the members elected by the Board starting upon the close of the next Annual Organizational Meeting (or if appointed at an Annual Organizational Meeting, starting upon the close of such meeting) until the following Annual Organizational Meeting.

9.4.6 The Board Vice-Chair shall chair the Governance and Nominating Committee.

9.4.7 The Governance and Nominating Committee shall:

(a) monitor the governance process adopted by the Board and report annually to the Board on the extent to which the governance process is being followed;

(b) consider and, if considered advisable, recommend to the Board changes to the governance process;

(c) annually assess the Board profile of skills, expertise and diversity of incumbent Directors and identify the skills, expertise and diversity that are desired when filling vacancies on the Board, in the offices of the Board Chair and Board Vice-Chair and in the Executive Member Representative positions;

(d) engage in a process, in accordance with Section 3.3, to approve a slate of nominees for election to the Board as Elected Directors;

(e) engage in a process, in accordance with Section 4.1, to propose nominees for Academic Directors and submit the nominations to the Board for appointment;

(f) engage in a process, in accordance with Section 5.1.2, to propose nominees for each of the Board Chair and Board Vice-Chair positions and submit the nominations to the Board for election;

(g) engage in a process, in accordance with Section 9.1.2, to propose nominees for the Executive Member Representative positions and submit the nominations to the Board for appointment; and

(h) make recommendations to the Board regarding any other officers, officials or other people acting on behalf of the College.

PART 4. CONFLICT OF INTEREST

ARTICLE 10 CONFLICT OF INTEREST

10.1 Definition of Conflict of Interest

10.1.1 A Conflict of Interest means any real or perceived, actual or potential, direct or indirect situation in which a Director or committee member has a personal or financial interest, a relationship or affiliation that affects, or a reasonable person would conclude that such interest, relationship or affiliation may affect, the Director's or committee member's judgment or ability to discharge their duties and responsibilities to the College, the Board or a committee, as the case may be.

10.2 Process for Resolution of Conflicts

10.2.1 If a Director or committee member has a Conflict of Interest, the Director or committee member shall:

(a) disclose the conflict;

(b) not participate in the discussion of the matter;

(c) absent themselves from that portion of the meeting when the Board or committee, as the case may be, is discussing the matter; and

(d) not vote on the matter, attempt to influence the vote or decision on the matter, or do anything that might reasonably be perceived as an attempt to influence other Directors or committee members, as the case may be, or the vote or the decision relating to the matter.

10.2.2 Without limiting the generality of Section 10.2.1, a Director who has or may have a Conflict of Interest in connection with Board business shall consult with the Registrar and disclose the Conflict of Interest at the earliest opportunity, and in any case before the Board considers the matter to which the Conflict of Interest relates. If there is any doubt as to whether a Conflict of Interest exists, the Director shall declare it to the Board and accept the Board's decision as to whether a Conflict of Interest exists.

10.2.3 Without limiting the generality of Section 10.2.1, a committee member who has or may have a Conflict of Interest in connection with a matter before the committee shall consult with the appropriate committee support representative, or in the case of an adjudicative committee (including, for greater certainty, OPSDT and the Fitness to Practise Committee), with the OPSDT Office. The committee member shall disclose the Conflict of Interest at the earliest opportunity, and in any case before the committee considers the matter to which the Conflict of Interest relates. The committee member shall accept the direction of the chair of the committee as to whether there is a Conflict of Interest and any steps the chair takes or requires to resolve the Conflict of Interest. If the chair of a committee has or may have a Conflict of Interest, the chair shall accept the direction of the Executive Committee as to whether there is a Conflict of Interest and any steps the Executive Committee takes or requires to resolve the Conflict of Interest.

10.3 Record of Declarations and Compliance

10.3.1 Declarations of Conflict of Interest shall be recorded in the written record of proceedings of the applicable meeting.

10.3.2 All Directors and committee members shall comply with the Conflicts of Interest Policy of the College and the Impartiality in Decision Making Policy of the College.

PART 5. DECLARED EMERGENCY

ARTICLE 11 EMERGENCIES

11.1 Declaring an Emergency

11.1.1 A declared emergency shall occur in any of the following circumstances:

(a) the Executive Committee has, by a motion decided by a simple majority vote of the votes cast at the meeting by the members of the Executive Committee in attendance, declared there to be an emergency; or

(b) the Registrar has declared there to be an emergency provided that the Registrar may only do so if there has been a declared emergency under the *Emergency Management and Civil Protection Act*, R.S.O. 1990, c. E.9 anywhere in the Province of Ontario and the Executive Committee is unable to meet within 24 hours of such declaration.

11.1.2 For greater certainty, a declared emergency under this Article 11 does not constitute emergency circumstances for purposes of initiating registrations under the Emergency Circumstances Practice class of certificates of registration contemplated in Ontario Regulation 865/93 under the Medicine Act. For further certainty, a determination by the Board or the Minister of Health that emergency circumstances exist for purposes of initiating registrations under the Emergency Circumstances Practice class of certificates of registration contemplated in Ontario Regulation 865/93 under the Medicine Act does not constitute a declared emergency under this Article 11.

11.2 Emergency Measures and Limitations

11.2.1 The following provisions shall apply only in the event of a declared emergency under this Article 11:

(a) the Registrar or the Executive Committee shall give immediate notice to every Director that a declared emergency exists;

(b) three members of the Executive Committee, at least one of which shall be a Registrant Director and at least one of which shall be a Public Director, shall constitute a quorum, and this Section 11.2.1(b) also applies for the purpose of the Executive Committee declaring an emergency;

(c) in the event that during the declared emergency there shall be one or more vacancies on the Executive Committee, each such vacancy shall be deemed to be filled by a Director in the following order:

(i) if the vacancy is the Board Chair position, the Board Vice-Chair shall become the Board Chair;

(ii) if the vacancy is the Board Vice-Chair position, the member of the Executive Committee (other than the Board Chair or past Board Chair, if on the Executive Committee) who has been on the Board the longest shall become the Board Vice-Chair;

(iii) except as set out in Sections 11.2.1(c)(i) and (ii), fill each Public Director vacancy with a Public Director (other than a Public Director who is appointed to the Governance and Nominating Committee) based on their seniority on the Board (for greater certainty, length of term);

(iv) except as set out in Sections 11.2.1(c)(i) and (ii), fill each Registrant Director vacancy with a Registrant Director (other than a Registrant Director who is appointed to the Governance and Nominating Committee) based on their seniority on the Board (for greater certainty, length of term); and

(v) subject to the quorum requirements in Section 11.2.1(b), if a vacancy on the Executive Committee is not able to be filled in accordance with Sections 11.2.1(c)(iii) or (iv), such vacancy may be filled by either a Public Director or a Registrant Director, despite Section 8.2.1;

(d) a position on the Executive Committee may be declared vacant by the other members of the Executive Committee if the Director holding that position on the Executive Committee is considered by the other members of the Executive Committee to be unable to participate in Executive Committee meetings due to a circumstance connected to the declared emergency;

(e) in the event that an election of Directors is not able to be held, the term of office of the Elected Directors shall continue despite Section 3.2 until the first regular meeting of the Board held after the election;

(f) despite Section 6.2.2 and Section 6.2.3, a Board meeting may be called by the Board Chair or Registrar at any time on such notice as is sufficient for a quorum to be present, and such meeting may consider and deal with any matter that the Board agrees to consider by a simple majority of votes cast by the Directors in attendance at the meeting; and

(g) the Executive Committee may vary the application of any provision(s) of the By-laws as it determines is necessary to facilitate the proper functioning or operation of the College, the Executive Committee or the Board, or their ability to fulfill their mandate, without the need to amend the By-laws, provided that such variation is not contrary to law and the affected By-laws shall be applied as enacted once the declared emergency is over.

11.2.2 The Executive Committee and the Registrar shall exercise the powers granted to them under this Article 11 only when, and to the extent, necessary in the circumstances.

11.2.3 In the event of a conflict between this Article 11 and any other provisions of the By-laws, the provisions of this Article 11 shall prevail.

11.3 Ceasing Emergency

11.3.1 The declared emergency is not intended to continue indefinitely and should be declared over, as provided in Section 11.3.2, when there is no longer a reasonable basis or rationale for keeping the declared emergency in place. Without limiting the generality of the foregoing, the Executive Committee or the Board should consider ceasing the declared emergency if one or more of the following applies:

(a) if the emergency declared under the By-laws is related to, or affected by, an emergency declared under the *Emergency Management and Civil Protection Act*, R.S.O. 1990, c. E.9 anywhere in the Province of Ontario, the emergency declared under such Act is terminated; or

(b) the circumstances leading to the declaration of emergency under the By-laws no longer exist or apply, or are not significantly impeding or negatively affecting, and are not expected to significantly impede or negatively affect, the proper functioning or operation of the College, the Executive Committee or the Board, or their ability to fulfill their mandates.

11.3.2 A declared emergency shall cease when the Executive Committee or the Board declares, by a motion decided by a simple majority vote of the votes cast at the meeting by the members of the Executive Committee or the Directors of the Board, as the case may be, in attendance (including the presiding officer of the meeting), that the emergency is over or the powers set out in this Article 11 are no longer needed.

PART 6. – REMUNERATION AND INDEMNIFICATION

ARTICLE 12 REMUNERATION

12.1 Board and Committee Remuneration

12.1.1 In Article 12, **"committee"** includes, in addition to committees (as defined in Section 1.1.1), a special committee, task force or other similar body established by the Board or the Executive Committee by resolution.

12.1.2 Nothing in Article 12 applies to a Public Director or to an employee of the College.

12.1.3 Except as provided in Section 12.2, Registrant Directors and committee members shall be remunerated for conducting College business, including attendance at, and preparation for, meetings of the Board or committees, at the hourly rate authorized in the budget approved by the Board for the fiscal year for which such remuneration is payable (the **"Hourly Rate"**) in accordance with, and subject to, such limits, rules and processes established by the College from time to time.

12.1.4 Registrant Directors and committee members shall be remunerated for time spent travelling to or from College locations, in connection with the conduct of College business at the Hourly Rate.

12.1.5 Registrant Directors and committee members shall be reimbursed for eligible expenses for transportation, accommodations and meals they incur in the conduct of College business in accordance with, and subject to, such limits, rules and processes established by the College from time to time.

12.1.6 No person shall be paid under Section 12.1 or Section 12.2 except in accordance with properly submitted receipts or other supporting documents, in accordance with rules and processes established by the College from time to time.

12.2 Board Chair Remuneration

12.2.1 For all College business conducted by the Board Chair that is part of or related to the role of the Board Chair (for greater certainty, including external stakeholder meetings coordinated by the College), Section 12.1.3 does not apply and the College shall pay the Board Chair a stipend in the annual amount authorized in the budget approved by the Board for the fiscal year for which such stipend is payable, or if the Board Chair is unable or unwilling to serve any part of the term as Board Chair, a pro rata amount for the time served.

12.2.2 The Board Chair shall be remunerated at the Hourly Rate for College business conducted by the Board Chair that is not part of or related to the role of the Board Chair, including the following:

(a) attendance at and preparation for meetings of, and work resulting from, College advisory or working groups or committees other than the Executive Committee, the Governance and Nominating Committee and the Finance and Audit Committee; and

(b) authorized optional activities.

12.2.3 For greater certainty, Section 12.1.4 applies to the Board Chair, and amounts payable under Section 12.1.4 are not included in the stipend contemplated in Section 12.2.1 or in the remuneration payable to the Board Chair under Section 12.2.2.

ARTICLE 13 INDEMNIFICATION

13.1 Indemnification

13.1.1 Every Director, committee member, employee of the College and their heirs, executors and administrators (each, an "**Indemnified Party**"), and estate and effects, shall from time to time and at all times be indemnified and saved harmless by the College from and against:

(a) all liabilities, costs, charges and expenses whatsoever that an Indemnified Party sustains or incurs in or about any action, suit or proceeding that is brought, commenced or prosecuted against the Indemnified Party for or in

respect of any act, omission, deed, matter or thing whatsoever made, done or permitted by the Indemnified Party in or about the execution or intended execution of the duties of the Indemnified Party's office with the College; and

(b) all other liabilities, costs, charges and expenses that the Indemnified Party sustains or incurs in or about or in relation to the Indemnified Party's office with the College or the affairs of the College,

except such liabilities, costs, charges or expenses as are occasioned by the Indemnified Party's intentional default, or dishonest, fraudulent, criminal or malicious acts or deeds.

13.1.2 Without limiting the generality of Section 13.1.1, if an employee (including a lawyer who is an employee) of the College is named in civil litigation or, in the case of a lawyer, in a law society proceeding, and the subject matter relates to the employee's employment by the College, the College shall pay for the employee's legal representation in the proceedings and any appeal, and shall pay any sum of money the employee or the employee's estate becomes liable to pay in connection with the matter but, if the court finds that the employee has been dishonest, fraudulent, malicious or committed a criminal offence, the College shall not be liable for such payment.

PART 7 – BUSINESS AND ORGANIZATIONAL MATTERS

ARTICLE 14 BUSINESS PRACTICES

14.1 Delegation

14.1.1 The Registrar may delegate any of the Registrar's powers or duties to other officers, agents, or employees of the College, subject to Section 14.6.2.

14.2 Fiscal Year

14.2.1 The fiscal year of the College shall be the calendar year, 01 January to 31 December inclusive.

14.3 Banking

14.3.1 The Executive Committee shall appoint one or more banks chartered under the *Bank Act*, S.C. 1991, c. 46 for the use of the College.

14.3.2 All money belonging to the College shall be deposited in the name of the College with one or more of the banks appointed in accordance with Section 14.3.1.

14.4 Investment

14.4.1 Funds of the College that are not immediately required may be invested by an investment dealer selected by, and acting in accordance with criteria or parameters given by, the Finance and Audit Committee, only in the following:

(a) bonds, debentures or other evidences of indebtedness of, or guaranteed by, the Government of Canada;

(b) deposit receipts, deposit notes, certificates of deposit, acceptances and other similar instruments issued or endorsed by a bank listed in Schedule I to the *Bank Act*, S.C. 1991, c. 46; or

(c) investment-grade money market funds previously approved for the purpose by the Finance and Audit Committee.

14.4.2 The Executive Committee may by resolution approve the investment or reinvestment of funds of the College that are not immediately required in any investment which the Executive Committee considers advisable, and two Signing Officers shall implement the decision.

14.5 Borrowing

14.5.1 The Board may by resolution:

(a) borrow money on the credit of the College, except that a Board resolution is not required for the College to borrow amounts not exceeding $250,000 in total;

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

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

14.5.2 The Board or the Executive Committee may by resolution borrow money on behalf of the College for periods of six months or less secured only by investments of the College of the type set out in Section 14.4.1.

14.5.3 Two Signing Officers shall sign documents to implement a decision made under Section 14.5.1 or Section 14.5.2.

14.6 Signing of Contracts and Other Documents and Approval of Expenditures

14.6.1 The signing officers of the College shall be any of the following (the **"Signing Officers"**): the Registrar, the Chief Operating Officer, the Corporate Controller and the Corporate Accountant.

14.6.2 If Signing Officers are not reasonably available, the Registrar or the Chief Operating Officer may delegate signing authority for one or more contracts, agreements, instruments and other similar or related documents, and for authorizations for Obligations, to a College staff person who is an officer (including a deputy or associate Registrar) or director (each, a **"Delegated Signatory"**), such delegation to be in writing and saved in College systems. Despite the foregoing, the Registrar and the Chief Operating Officer may not delegate signing authority for any documents or authorizations contemplated in Section 14.5.3, Section 14.6.7, Section 14.6.10.

14.6.3 Contracts, agreements, instruments and other similar or related documents are subject to review by the College Legal Office in accordance with the internal College Agreement and Contract Management Policy.

14.6.4 Except as otherwise provided in the By-laws, contracts, agreements, instruments and any other documents requiring signature by the College shall be signed by a Signing Officer or a Delegated Signatory.

14.6.5 Goods may be purchased or leased, and services may be obtained, for the benefit of the College in accordance with the By-laws.

14.6.6 Budgeted Expenses: Contracts, agreements, instruments and any other documents requiring signature by the College, and any other authorization, for expenditures or expenses (for greater certainty, whether for procurement of goods and services or for a non-procurement purpose) (collectively, **"Obligations"**) included or authorized in a budget approved by the Board shall be signed or authorized by a Signing Officer or Delegated Signatory.

14.6.7 Non-Budgeted Expenses: Contracts, agreements, instruments and any other documents requiring signature by the College, and any other authorization, for Obligations not included or authorized in a budget approved by the Board shall be signed or authorized by:

(a) a Signing Officer if the total Obligations are equal to or less than $100,000;

(b) two of the Registrar, the Chief Operating Officer or the Corporate Controller if the total Obligations are greater than $100,000 but not greater than $250,000;

(c) subject to Section 14.6.8, one of the Registrar, the Chief Operating Officer or the Corporate Controller and one of the Board Chair or Board Vice-Chair if the total Obligations are greater than $250,000;

(d) in the case of Obligations that are for legal services, legal advice or representation for the benefit of the College, the Chief Legal Officer (or their delegate) with the concurrence of the Registrar and one of the Board Chair or Board Vice-Chair after conferral with the Finance and Audit Committee; or

(e) the Executive Committee or the Board, by resolution.

14.6.8 Unless the Board or the Executive Committee directs otherwise by resolution, no Obligation greater than $250,000 that is not authorized in a budget approved by the Board may be made or committed to, and no contract, agreement, instrument or other document relating to such an Obligation may be entered into, without providing an opportunity for the Finance and Audit Committee to consider the implications of the unbudgeted expenditure and provide a revised budget to the Executive Committee.

14.6.9 The Board may appoint any persons on behalf of the College to sign documents generally or to sign specific documents.

14.6.10 Two Signing Officers shall sign each cheque or authorize each electronic transfer of funds. A Signing Officer shall not sign a cheque or authorize an electronic transfer of funds payable to such Signing Officer.

14.6.11 Despite Section 14.6.4:

(a) an offer of employment or an agreement for employment with the College (other than for the Registrar), which employment position is authorized by the College budget, shall be signed by the director of the department in which the employee is to be working, the manager responsible for hiring the employee, the director or manager of Human Resources, the Chief Operating Officer or the Registrar; and

(b) an offer of employment to or an agreement for employment with the College for the Registrar shall be signed on behalf of the College by one of the Board Chair or the Board Vice-Chair.

14.7 Audit

14.7.1 The Auditor shall make such examinations as will enable the Auditor to report to the Board as required by law and under this Section 14.7.

14.7.2 The Auditor has a right of access at all reasonable times to all records, documents, books and accounts of the College and is entitled to require from Directors, officers and employees of the College such information as in the Auditor's opinion is necessary to enable the Auditor to report as required by law or under this Section 14.7.

14.7.3 The Auditor is entitled to attend any meeting of the Board and to be heard at any such meeting that the Auditor attends on any part of the business of the meeting that concerns the Auditor as Auditor.

14.7.4 The Auditor shall report:

(a) in person to the Finance and Audit Committee on the financial statements and related matters as soon as possible after the financial statements are prepared and as far in advance of the Annual Financial Meeting as possible; and

(b) to the Board at each Annual Financial Meeting on the financial statements, which shall be submitted to each Annual Financial Meeting, and the Auditor shall state in the report whether, in the Auditor's opinion, the financial statements present fairly, in all material respects, the financial position of the College and the results of its operations for the period under audit in accordance with generally accepted accounting principles.

14.7.5 As soon as practical after each Annual Financial Meeting, the College shall, in a publication sent to the Registrants of the College generally, publish the financial statements submitted to such meeting, together with a report from the Auditor on those financial statements indicating whether, in the Auditor's opinion, the financial statements present fairly, in all material respects, the financial position of the

College and the results of its operations for the period under audit in accordance with generally accepted accounting principles, and comparing the information in the statement with that of the preceding fiscal year.

14.7.6 For the purposes of Sections 14.7.3 and 14.7.4, the Registrar is responsible to send notices of every meeting of the Board to the Auditor.

ARTICLE 15 BY-LAWS

15.1 Making and Amending By-laws

15.1.1 By-laws of the College may be made, revoked or amended in the manner contemplated in, and subject to the provisions of, the Code and this By-law.

15.1.2 A By-law may be made, revoked or amended by a simple majority of the votes cast at the meeting by the Directors in attendance, except that a By-law may not be made, revoked or amended pursuant to a motion at a regular meeting of the Board pursuant to Section 6.2.3(b)(iv).

15.1.3 Subject to the Code, a By-law or an amendment to or a revocation of a By-law passed by the Board has full force and effect from the time the motion was passed, or from such future time as may be specified in the motion.

15.1.4 All By-laws, including every amendment and revocation of a By-law, shall be maintained in the College records in the order in which they were passed.

ARTICLE 16 NOT-FOR-PROFIT STATUS

16.1 Not for Profit Status

16.1.1 No part of the College's income shall be payable to, or otherwise available for the personal benefit of, any Registrant, provided that this restriction shall not prevent a Registrant from receiving reasonable remuneration, including fees, wages, honoraria and expense reimbursement, for any services provided by such Registrant to or for the benefit of the College.

16.1.2 It is further specifically provided that in the event of dissolution or winding up of the College, all of the College's remaining assets after payment of the College's liabilities shall be distributed or disposed of to other not-for-profit or charitable organizations in the province of Ontario which carry on work and activities similar to those of the College and approved by the College.

PART 8 – FEES AND CHARGES

ARTICLE 17 APPLICATION FEES

17.1 Application Fees

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

(a) for a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in Section 18.1.2(a);

(b) for a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 18.1.2(a);

(c) for a certificate of registration authorizing temporary independent practice, 25% of the annual fee specified in Section 18.1.2(a);

(d) for a certificate of registration authorizing practice as a physician assistant, $300;

(e) for any other certificate of registration, 60% of the annual fee specified in Section 18.1.2(a);

(f) for an application for reinstatement of a certificate of registration, 60% of the annual fee specified in Section 18.1.2(a);

(g) for a certificate of authorization, $400;

(h) for an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the Registrant's certificate of registration by the Registration Committee, 25% of the annual fee specified in Section 18.1.2(a); and

(i) if the person:

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

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

an additional fee equal to 50% of the application fee applicable to such person under Section 17.1.1(a), (b), (c), (d) or (e).

17.1.2 Application fees are due at the time the application is submitted. Application fees are not refundable, either in whole or in part.

ARTICLE 18 ANNUAL FEES

18.1 Annual Fees

18.1.1 Every holder of a certificate of registration or authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing temporary independent practice, shall pay an annual fee.

18.1.2 Annual fees as of June 1, 2018, are as follows:

(a) $1,725 for a holder of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, a certificate of registration authorizing temporary independent practice, or a certificate of registration authorizing practice as a physician assistant;

(b) for a holder of a certificate of registration authorizing postgraduate education applying to renew the holder's certificate of registration, 20% of the annual fee set out in Section 18.1.2(a);

(c) for a holder of a certificate of registration authorizing practice as a physician assistant, $425; and

(d) despite Sections 18.1.2(a), (b) and (c), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is 50% of the annual fee applicable to the holder of the certificate of registration as set out in Sections 18.1.2(a), (b) and (c), so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. If an application for the parental leave reduced annual fee is received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration. This Section 18.1.2(d) only applies to annual fees for membership years commencing on or after June 1, 2020.

18.1.3 The annual fee for a holder of a certificate of authorization, as of January 1, 2017, is $175.

18.1.4 In addition to the amounts set out in Section 18.1.2, any outstanding balance owing to the College in respect of any decision made by a committee, and any fees payable under this By-law will be added to and included in the annual fees.

18.1.5 The due dates for the payment of annual fees are as follows:

(a) if the College is issuing a certificate of registration or authorization, before the College issues the certificate;

(b) if the College is renewing a certificate of registration, other than a certificate of registration authorizing postgraduate education, on June 1 of each year;

(c) if the College is renewing a certificate of registration authorizing postgraduate education on an application for renewal, before the expiry of the previous certificate; and

(d) if the College is renewing a certificate of authorization, on the anniversary of the certificate's date of issue.

ARTICLE 19 COMMITTEE AND PROGRAM FEES

19.1 Committee and Program Fees

19.1.1 The College may charge a Registrant, a health profession corporation or other person a fee in connection with decisions or activities that the College or a College committee are required or authorized to make or do with respect to a Registrant, health profession corporation or other person. Such fees may include an administrative component relating to the decision or activity.

19.1.2 Committee and program fees include the following:

(a) costs of a hearing or other items ordered by the Ontario Physicians and Surgeons Discipline Tribunal;

(b) for the College's quality assurance program, the costs to the College of completing an assessment and re-assessment authorized by Ontario Regulation 114/94 under the Medicine Act, including costs relating to assessors, the review of assessment reports, preparation of written reports, monitoring compliance with conditions, and any administration fee charged by the College;

(c) for physician education and remediation programs:

(i) for individual education or remediation programs, the fee charged by the supervisor, monitor, preceptor or trainer, in addition to any administration fee charged by the College; and

(ii) for programs given by a university or other education institution, the fee charged by the institution;

(d) for monitoring, supervision or assessment pursuant to a decision of the Registration Committee, the fee charged by the monitor, supervisor or assessor in addition to any administration fee charged by the College;

(e) for the College's premises inspection program, the costs to the College of completing an inspection as authorized by Ontario Regulation 114/94 under the Medicine Act, including costs relating to inspectors, the review of premises inspection reports, preparation of written reports, monitoring compliance with conditions, and any administration fee charged by the College;

(f) fees relating to activities, including programs and assessments, referred to in undertakings entered into by a Registrant with the College;

(g) fees relating to orders and directions of committees; and

(h) costs to the College of completing an inspection or assessment as authorized by the *Independent Health Facilities Act*, including costs relating to inspectors and assessors, Facility Review Panels, preparation of assessments and

written reports, monitoring compliance with conditions, and any administration fee charged by the College.

19.1.3 The College may require a Registrant, applicant, health profession corporation or other person to pay a committee or program fee, including an annual fee, that is not set out in Section 19.1.2, in which case the College shall provide the Registrant, applicant, health profession corporation or other person with an invoice setting out the fee.

ARTICLE 20 PENALTY FEES AND INTEREST ON UNPAID FEES

20.1 Penalty Fees and Interest on Unpaid Fees

20.1.1 A Registrant who fails to pay an annual fee on or before the day on which the fee is due, other than a fee for a certificate of registration authorizing postgraduate education or a fee for a certificate of authorization, shall pay the College, in addition to the annual fee, a penalty fee of 25% of the applicable annual fee set out in Section 18.1.2.

20.1.2 A Registrant, health profession corporation or other person who fails to pay a committee or program fee on or before the day on which the fee is due shall pay the College, in addition to the applicable committee or program fee, a penalty fee of 25% of the applicable committee or program fee.

20.1.3 The College may charge interest at a rate of 18% per annum on any fee, including a penalty fee, that is unpaid as of the applicable due date, and the College shall consider the accrued interest on any unpaid fee as part of the fee itself.

20.2 Fees for Non-negotiable Payment

20.2.1 A Registrant shall pay the College a fee of $50 where a financial institution returns a Registrant's cheque as non-negotiable, or the Registrant's payment by credit card to the College is not accepted by the Registrant's credit card provider.

20.3 Failure to Provide Information

20.3.1 The College may charge a Registrant a fee of $50 for each notice it sends to the Registrant for the Registrant's failure to provide by the due date or, where there is no due date specified, within 30 days of a College written or electronic request in a form approved by the Registrar, any information that the College is required or authorized to request and receive from the Registrant.

20.4 Other Fees and Miscellaneous Provisions

20.4.1 A person who requests the Registrar to do anything that the Registrar is required or authorized to do by statute, regulation or by-law shall pay either:

(a) the prescribed fee; or

(b) if there is no prescribed fee, the fee set by the Registrar.

20.4.2 The obligation of a Registrant or health profession corporation to pay a fee continues, despite any failure of the College to provide notice of the fee or provide notice of the fee by a certain date, or despite a failure of the Registrant or health profession corporation to receive notice of the fee.

20.4.3 The fees set out in the By-laws are exclusive of any applicable taxes.

PART 9 – REGISTER AND REGISTRANT MATTERS

ARTICLE 21 REGISTER

21.1 Registrant Names and Addresses

21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, as supported by documentary evidence satisfactory to the College.

21.1.2 The Registrar may direct that a Registrant's name, other than as provided in Section 21.1.1, be entered in the Register if the Registrant satisfies the Registrar that the Registrant has validly changed the Registrant's name and that the use of the newer name is not for an improper purpose.

21.1.3 The Registrar may give a direction under Section 21.1.2 before or after the initial entry of the Registrant's name in the Register.

21.1.4 A Registrant's business address in the Register shall be the Registrant's principal place of practice reported by the Registrant to the College.

21.2 Additional Register Content

21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant:

(a) any changes in the Registrant's name that have been made in the Register since the College first issued a certificate of registration to the Registrant, the date of such change, if known to the College, and each former name of the Registrant that was listed in the Register as the Registrant's name;

(b) the Registrant's registration number;

(c) the Registrant's gender;

(d) the facsimile number or the business e-mail address that the Registrant makes available to the public and uses for practice purposes;

(e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine reported by the Registrant to the College;

(f) if the Registrant is no longer practising in Ontario, contact information regarding the transfer or provisional custody of medical records, if applicable and if that information has been provided to the College;

(g) the language(s) in which the Registrant is competent to conduct practice, as reported by the Registrant to the College;

(h) the name of the medical school from which the Registrant received the Registrant's degree in medicine and the year in which the Registrant obtained the degree;

(i) a description of the postgraduate training in Ontario for each Registrant who holds a certificate of registration authorizing postgraduate education;

(j) the date the Registrant received specialty certification or recognition (if any);

(k) the name of each hospital in Ontario where the Registrant holds privileges and appointment to the professional staff of the hospital;

(l) all revocations of the Registrant's hospital privileges at hospitals in Ontario reported to the College by hospitals under section 85.5 of the Code or section 33 of the *Public Hospitals Act*, R.S.O. 1990, c. P.40, as amended from time to time;

(m) the classes of certificate of registration held by the Registrant and the date on which each certificate was issued;

(n) if the Registrant's certificate of registration is revoked or suspended:

(i) the effective date of the suspension or revocation of the Registrant's certificate of registration;

(ii) the committee that ordered the suspension or revocation of the Registrant's certificate of registration, if applicable; and

(iii) the date of removal of a suspension, if applicable;

(o) if the Registrant's certificate of registration is expired, the expiration date and the reason for the expiry;

(p) in respect of a decision of the ICRC that includes a disposition of a caution, if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file, is dated on or after January 1, 2015:

(i) a summary of that decision; and

(ii) if applicable, a notation that the decision has been appealed or reviewed.

If that decision is overturned on appeal or review, the summary of that decision shall be removed from the Register;

(q) in respect of a decision of the ICRC that includes a disposition of a SCERP, if the complaint that led to the decision, or, in a case where there is no

complaint, the first appointment of investigators in the file is dated on or after January 1, 2015:

(i) a summary of that decision, including the elements of the SCERP;

(ii) if applicable, a notation that the decision has been appealed or reviewed; and

(iii) a notation that all of the elements of the SCERP have been completed, when so done.

If that decision is overturned on appeal or review, the summary of that decision shall be removed from the Register;

(r) if terms, conditions and limitations (other than those prescribed by a regulation made under the Act or the Medicine Act) are imposed on the Registrant's certificate of registration or if terms, conditions and limitations in effect on the Registrant's certificate of registration are amended:

(i) the effective date of the terms, conditions and limitations imposed or of the amendments; and

(ii) a notation as to whether the Registrant or a committee imposed or amended the terms, conditions and limitations on the Registrant's certificate of registration, and if a committee, the name of the committee;

(s) if the Registrant's certificate of registration is subject to an interim order of the ICRC made on or after October 16, 2024, a notation of that fact, the nature of that order and the effective date of that order, until such interim order is no longer in effect;

(t) if an allegation of professional misconduct or incompetence against the Registrant has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided:

(i) a summary of the allegation and/or notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to October 16, 2024;

(ii) the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal on or after October 16, 2024;

(iii) the anticipated date of the hearing, if the date has been set;

(iv) if the hearing has been adjourned and no future date has been set, the fact of the adjournment; and

(v) if the decision is under reserve, that fact;

(u) if the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the Registrant is in the Register:

(i) the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding;

(ii) the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty; and

(iii) if the finding is appealed, the status of the appeal and the disposition of the appeal;

(v) if an allegation of the Registrant's incapacity has been referred to the Fitness to Practise Committee and not yet decided:

(i) a notation of that fact; and

(ii) the date of the referral;

(w) if the result of an incapacity proceeding in which a finding was made by the Fitness to Practise Committee in respect of the Registrant is in the Register:

(i) the date on which the Fitness to Practise Committee made the finding;

(ii) the effective date of any order of the Fitness to Practise Committee;

(iii) if the finding is under appeal, a notation to that effect; and

(iv) when an appeal of a finding of incapacity is finally disposed of, the notation added under Section 21.2.1(w)(iii) shall be removed;

(x) if an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal:

(i) that fact; and

(ii) if the application has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal;

(y) if an application for reinstatement has been made to the Board or the Executive Committee under section 74 of the Code:

(i) that fact;

(ii) the date on which the Board or the Executive Committee will consider the application;

(iii) in the case of an application with respect to a person whose certificate of registration has been revoked or suspended as a result of

disciplinary proceedings, if the application has been decided, the decision of the Board or Executive Committee; and

(iv) in the case of an application with respect to a person whose certificate of registration has been revoked or suspended as a result of incapacity proceedings, if the application has been decided, a summary of the decision of the Board or Executive Committee or if the Registrar determines that it is in the public interest that the decision be disclosed, the decision of the Board or Executive Committee;

(z) if an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed on or after June 16, 2022:

(i) that fact; and

(ii) if the application has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal;

(aa) if the Registrant has been charged with an offence under the Health Insurance Act, and the charge is outstanding and is known to the College:

(i) the fact and content of the charge; and

(ii) the date and place of the charge;

(bb) any currently existing conditions of release following a charge against the Registrant for a Health Insurance Act offence, or subsequent to a finding of guilt under the Health Insurance Act and pending appeal, or any variations to those conditions, in each case if known to the College;

(cc) if there has been a finding of guilt made against the Registrant under the Health Insurance Act on or after June 1, 2015, under any criminal laws of another jurisdiction on or after September 20, 2019, or under laws of another jurisdiction comparable to the Health Insurance Act or the Controlled Drugs and Substances Act on or after September 20, 2019, in each case if known to the College:

(i) a brief summary of the finding;

(ii) a brief summary of the sentence;

(iii) if the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

(iv) the dates of the information under Sections 21.2.1(cc)(i-iii);

(dd) if a notation of a finding of professional negligence or malpractice in respect of the Registrant is in the Register:

(i) the date of the finding; and

(ii) the name and location of the court that made the finding against the Registrant, if known to the College; and

(ee) the date on which the College issued a certificate of authorization in respect of the Registrant, and the effective date of any revocation or suspension of the Registrant's certificate of authorization.

21.2.2 The Register shall contain the most current outcome or status of inspections of all premises (including conditions and/or reasons for fail results) carried out under Part XI of Ontario Regulation 114/94 under the Medicine Act, including the relevant date.

21.3 Public Information

21.3.1 All information required by the By-laws to be contained in the Register is designated as public, other than:

(a) any information that, if made public, would violate a publication ban if known to the College; and

(b) information that the Registrar refuses or has refused to post on the College's website pursuant to subsection 23(6), (7), (8), (9) or (11) of the Code.

21.3.2 Notwithstanding Section 21.3.1, the content of terms, conditions or limitations are no longer public information if:

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

(b) the terms, conditions or limitations have been removed from the Register.

21.3.3 The Registrar may give any information contained in the Register which is designated as public to any person in printed, electronic or oral form.

ARTICLE 22 LIABILITY PROTECTION

22.1 Liability Protection

22.1.1 Each Registrant shall obtain and maintain professional liability protection that extends to all areas of the Registrant's practice, through one or more of:

(a) membership in the Canadian Medical Protective Association;

(b) a policy of professional liability insurance issued by a company licensed to carry on business in Ontario, that provides coverage of at least $10,000,000; or

(c) coverage under the Treasury Board Policy on Legal Assistance and Indemnification.

ARTICLE 23 REGISTRANT INFORMATION

23.1 Notification Required by Registrants

23.1.1 A Registrant shall notify the College in writing or electronically as specified by the College of:

(a) the Registrant's preferred mailing address and e-mail address for communications from the College;

(b) the address and telephone number of the Registrant's business address that is the Registrant's principal place of practice;

(c) the identity of each hospital and health facility in Ontario where the Registrant holds privileges and appointment to the professional staff; and

(d) any changes in the Registrant's name that have been made in the Register since the College first issued a certificate of registration to the Registrant.

23.1.2 If there is a change in the information provided under Section 23.1.1, the Registrant shall notify the College in writing or electronically, as specified by the College, of the change within 30 days of the effective date of the change.

23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following:

(a) the Registrant's home address;

(b) the address of all locations at which the Registrant practises medicine, together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises medicine;

(c) a business e-mail address that the Registrant makes available to the public and uses for practice purposes;

(d) the names, business addresses and telephone numbers of the Registrant's associates and partners;

(e) information required to be maintained on the Register of the College;

(f) the Registrant's date of birth;

(g) information respecting the Registrant's participation in continuing professional development and other professional training, including acceptable documentation confirming completion of continuing professional development programs in which the Registrant has participated during a specified period of time;

(h) the types of privileges held at each hospital at which the Registrant holds privileges and appointment to the professional staff of the hospital;

(i) information that relates to the professional characteristics and activities of the Registrant that may assist the College in carrying out its objects, including:

(i) information that relates to the Registrant's health;

(ii) information about actions taken by other regulatory authorities and hospitals in respect of the Registrant;

(iii) information related to civil lawsuits involving the Registrant;

(iv) information relating to criminal arrest(s) and charge(s); and

(v) information relating to offences; and

(j) information for the purposes of compiling statistical information to assist the College in fulfilling its objects.

23.2 Adverse Event Reports

23.2.1 In this Section 23.2.1, "**premises**" and "**procedure**" have the definitions that are set out in section 44(1) of Ontario Regulation 114/94 made under the Medicine Act 1991.

23.2.2 Every Registrant who performs a procedure in a premises subject to inspection under Part XI of Ontario Regulation 114/94 made under the Medicine Act shall report to the College, in writing or electronically as specified by the College, within 24 hours of learning of any of the following events:

(a) death within the premises;

(b) death within 10 days of a procedure performed at the premises;

(c) any procedure performed on wrong patient, site, or side; or

(d) transfer of a patient from the premises directly to a hospital for care.

23.2.3 In addition to reporting the event, the Registrant shall provide all information underlying the event to the College in writing or electronically as specified by the College and in an adverse events reporting form approved by the College.

23.3 Information for Registration Applications

23.3.1 When applying for a certificate of registration or a renewal of a certificate of registration, an applicant must sign a declaration that the Registrant complies with Section 22.1.1.

23.3.2 A Registrant must have available at the Registrant's Business Address, in written or electronic form, for inspection by the College, evidence that the Registrant complies with Section 22.1.1, or may have the provider of the protection under Section 22.1.1 provide regular updates to the College confirming compliance with Section 22.1.1.

23.3.3 Section 22.1.1 and Section 23.3.1 do not apply to:

(a) a Registrant who provides written evidence, satisfactory to the College, that the Registrant is not providing any medical service in Ontario to any person;

(b) a person who holds emeritus status or who is designated as a life member under section 43 of Ontario Regulation 577/75; or

(c) a Registrant who provides written evidence, satisfactory to the College, from the Registrant's employer that:

(i) the Registrant is only providing medical service to other employees of the employer, and not to any members of the public; and

(ii) any professional liability claim made against the Registrant will be covered by the employer or the employer's insurer.

23.4 Health Profession Corporation Shareholders

23.4.1 Every health profession corporation that holds a certificate of authorization from the College shall provide the Registrar with notice, in writing or electronically as specified by the College, of any change in the shareholders of such corporation who are Registrants within 15 days following the occurrence of such change.

23.4.2 The notice required by Section 23.4.1 shall include the identity of the shareholder who has ceased to be a shareholder, and the identity of any new shareholder(s), and the date upon which such a change occurred. The notice required by Section 23.4.1 shall be signed by a director of the health profession corporation.

23.4.3 The notice required by Section 23.4.1 may be sent (a) electronically as specified by the College, or (b) in printed form by regular mail, courier or personal delivery addressed to the Registrar, in care of the Registration Department of the College, re: Notice of Shareholder Change. The Registrar may from time to time approve one or more standard forms (printed and/or electronic) for the purposes of providing the notice required by Section 23.4.1 and if any such form has been approved, the notice shall be submitted in the applicable approved form.

23.5 Member Portal

23.5.1 If the College specifies, or the By-laws require or permit, that a Registrant or a health profession corporation provide or submit to the College a notice, information, declaration or other documentation electronically, the term **"electronically"** includes (but is not limited to, unless the College specifies otherwise) the College's electronic portal system for Registrants (the **"Member Portal"**).

ARTICLE 24 EMERITUS STATUS

24.1 Emeritus Status

24.1.1 The Registrar may grant emeritus status to a former holder of a certificate of registration of any class who applies therefore and who:

(a) has held a certificate of registration authorizing independent practice, a General licence under Part III of the *Health Disciplines Act* or the equivalent licence under a predecessor of such Act, or some combination of them, continuously for 25 years;

(b) has not been the subject of a finding of professional misconduct or incompetence that has been entered in the Register;

(c) at the time of application, is not:

(i) in default of payment of any fee payable to the College;

(ii) in default of providing to the College any information required by or under an Act or regulation; and

(iii) is not the subject of proceedings for professional misconduct or incompetence; and

(d) is fully retired from the practice of medicine.

24.1.2 The Registration Committee may grant emeritus status to a former holder of a certificate of registration of any class who applies therefore and complies with Sections 24.1.1(c) and 24.1.1(d).

24.1.3 A person with emeritus status may not practise medicine.

24.1.4 A Registrant who was designated as a life member under section 43 of Ontario Regulation 577/75 or a predecessor thereof shall be deemed to continue as a person with emeritus status but a life member who continues to meet the requirements of section 43 of Ontario Regulation 577/75 may elect to maintain their life membership.

24.2 Expiry and Renewal of Emeritus Status

24.2.1 The Registrar shall provide an application for renewal to each person with emeritus status and each life member at the person's last known address or e-mail address before April 15 in each year, together with notification that the person's emeritus status or life membership will expire unless the completed application for renewal is received by the Registrar by the following May 31.

24.2.2 An emeritus status and a life membership expire unless the Registrant's completed application for renewal is received by May 31 of each year.

24.2.3 The Registrar shall, and the Registration Committee may, renew the emeritus status of a person whose emeritus status has expired on the same basis as the Registrar or the Registration Committee may grant emeritus status under Section 24.1.

24.2.4 A life membership which expires may not be renewed, but a life member whose membership has expired is entitled to emeritus status.

SCHEDULE 1
TO BY-LAW NO. 168
RULES OF ORDER OF THE BOARD

General Procedure

1. The presiding officer of the Board meeting shall preserve order and decorum and shall rule on any question of order or procedure. Within their duty to preserve order, the presiding officer may relax these Rules of Order if, in the presiding officer's opinion, strict adherence to the Rules of Order is counterproductive to an orderly meeting of the Board.

2. These Rules of Order shall apply, with necessary modifications, to meetings held by telephonic or electronic means.

3. Each agenda item will be introduced briefly by the presiding officer, or the Director or committee chair affiliated with the motion.

4. The presiding officer may allow discussion of an agenda topic without a motion needing to be made first. A motion may be made after a discussion on the topic. If a motion is made, the rules pertaining to motions shall apply.

5. The Board may decide matters by consensus and may indicate preferences by a straw vote or other informal method but, subject to Section 6.2.3, motions will usually be made if:

   (a) a decision will commit the College to an action or a public position; or

   (b) the presiding officer or the Board is of the opinion that the nature of the matter or of the discussion warrants a motion.

Motions

6. All motions shall be in writing, seconded and given to the presiding officer before being considered except that, if a motion has been printed and distributed to the Board before being made, it does not need to be given to the presiding officer before being considered.

7. When a motion that has not been printed and distributed to the Board is given to the presiding officer, the presiding officer shall then read it aloud, and any Director may require it to be read at any time, but not so as to interrupt a Director while speaking.

8. When the motion contains distinct propositions, any Director may require the vote upon each proposition to be taken separately.

9. The presiding officer shall rule a motion out of order if, in their opinion, a motion is contrary to these Rules of Order or the By-laws.

Amendments and other subordinate motions

10. A substantive motion in writing that has been moved, seconded and given to the presiding officer may be amended by a motion to amend. The presiding officer shall rule a motion to amend out of order if it is irrelevant to the main motion or defeats the basic effect of the main motion.

11. When a motion has been moved, seconded and given to the presiding officer, no other motion may be made except a motion to amend the motion, to refer the motion to a

committee, to postpone the motion, either indefinitely or to a specific meeting, to call the question, to adjourn the debate or to adjourn the meeting.

12. When a motion to refer a motion to a committee has been made, it shall be decided before any amendment is decided and, if it is passed, no further debate or discussion is permitted.

13. A motion to amend the main motion shall be disposed of before the main motion is decided and, if there is more than one motion to amend, they shall be decided in the reverse order to which they were made.

Voting

14. When a matter is being voted on no further debate is permitted.

15. No Director shall vote upon any motion in which the Director has a conflict of interest, and the presiding officer shall disallow the vote of any Director on any motion in which the presiding officer believes the Director has a conflict of interest.

Preserving Order

16. If the presiding officer has ruled on a question of order or procedure, a Director who believes the presiding officer's ruling is wrong may appeal the ruling to the Board.

17. The presiding officer shall call upon Directors to speak as nearly as feasible in the order in which they indicate a wish to speak.

18. When any Director wishes to speak, the Director shall so indicate by raising their hand (or the electronic equivalent) and shall address the presiding officer and confine themselves to the matter under discussion.

19. The presiding officer may permit College staff and consultants with expertise in the matter to make presentations and answer specific questions about a matter being discussed.

20. Observers are not permitted to speak at a meeting of the Board unless invited to do so, but in any event, observers may not speak to a motion prior to the Board voting on the motion.

21. If a Director believes that another Director has behaved improperly or that the Board has broken these Rules of Order or the By-laws, the Director may state a point of order. The presiding officer shall promptly rule on the point of order, which is subject to an appeal to the Board. Directors are not permitted to raise a "point of personal privilege" or a "point of privilege".

22. The presiding officer may limit the number of times a Director may speak, limit the length of speeches and impose other restrictions reasonably necessary to finish the agenda of a meeting.

23. Except where inconsistent with the Act, the Medicine Act, the regulations or the By-laws, any questions of procedure at or for any meetings of the Board shall be determined by the presiding officer of such meeting in accordance with these Rules of Order. When a circumstance arises that is not provided for by these Rules of Order or in the By-laws, the presiding officer shall make a ruling, which is subject to an appeal to the Board.

SCHEDULE 2
TO BY-LAW NO. 168 (CPSO BY-LAWS)
TABLE OF AMENDMENTS

BY-LAW	ACTION	DATE
Declared Emergency By-law (By-law No. 145)	Last revision prior to amalgamation into By-law No. 168	December 10, 2021
General By-law	Last revision prior to amalgamation into By-law No. 168 (other than register and membership information provisions)	December 9, 2022
Fees and Remuneration By-law (By-law No. 2)	Last revision prior to amalgamation into By-law No. 168	December 9, 2022
By-law No. 168	Enacted, as amalgamation of: • General By-law (excerpts) • Fees and Remuneration By-law (By-law No. 2), and • Declared Emergency By-law (By-law No. 145)	December 7, 2023
By-law No. 168	Amendments	February 29, 2024
By-law No. 168	Specific pending amendments put into effect	May 31, 2024
By-law No. 168	Register and Member Information By-laws (By-law No. 158) put into effect and incorporated into By-law No. 168.	October 16, 2024
General By-law	Part 4 of the General By-law is revoked.	October 16, 2024
General By-law	General By-law is revoked.	November 29, 2024
CPSO By-laws	• Pending amendments put into effect • Additional amendments	November 29, 2024 (as of close of Annual Organization Meeting)

CPSO Board Policy

Board and Committee Member Expense Reimbursement Policy

Terms used in this Policy that are defined in the CPSO By-law No. 168 shall have the meanings set out in the CPSO By-law No. 168, unless stated otherwise.

Nothing in this Policy applies to a Public Director or to an employee of the College.

The following are the expenses for which Physician Directors and members of a committee will be reimbursed if they are incurred in the conduct of the Board's or Committee's business:

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

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

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

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

NOVEMBER 2024

Title:	General By-law Revocation (For Decision)
Main Contacts:	Carolyn Silver, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy Officer Tanya Terzis, Manager, Policy & Governance
Attachment:	**Appendix A:** General By-law (Part IV Revoked)
Question for Board:	Does the Board of Directors (Board) agree to revoke the General By-law?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- The CPSO By-laws (By-law No. 168) contain all of the College's By-law provisions. The General By-law is no longer needed and should be formally revoked.

- Revocation of the General By-law streamlines and provides clarity around the College By-laws. This aligns with effective governance processes.

Current Status & Analysis

- The provisions of the General By-law have been revoked over the last year in stages as new or revised By-law provisions were approved by the Board and incorporated into the CPSO By-laws.

- The last part of the General By-law to be revoked was the register and member information provisions. These provisions have been incorporated into the CPSO By-laws and made effective by the Board as of October 16, 2024 (when the new public register was launched).

- The General By-law no longer has any content but is technically still in effect as a shell by-law. It would be best for the Board to now formally revoke the General By-law itself.

- A copy of the General By-law currently in effect is in **Appendix A**.

CPSO

GENERAL BY-LAW

October 16, 2024

Table of Contents

General By-Law

Part 1. Business Practices

[Revoked: December 7, 2023]

Part 2. The Council

[Revoked: December 7, 2023]

Part 3. Committees

[Revoked: December 7, 2023]

Part 4. Registration Matters

[Revoked: October 16, 2024]

Part 5. By-Laws

[Revoked: December 7, 2023]

Part 6. Conflict of Interest

[Revoked: December 7, 2023]

Part 7. Not-For-Profit Status

[Revoked: December 7, 2023]

Schedule 1 to By-Law No. 1

RULES OF ORDER OF THE COUNCIL

[Revoked: December 7, 2023]

Board Motion

Motion Title	For Approval: Revocation of General By-law
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario revokes the General By-law.

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

NOVEMBER 2024

Title:	By-law Amendments for Circulation: PA Register and Fees for Emergency Class Certificate of Registration (For Decision)
Main Contacts:	Marcia Cooper, Senior Corporate Counsel and Privacy Officer Samantha Tulipano, Director, Registration and Membership Tanya Terzis, Manager, Policy & Governance Carolyn Silver, Chief Legal Officer
Attachment:	**Appendix A:** Fees and Register Provisions for PAs
Question for Board:	Does the Board of Directors (Board) approve circulation of the proposed By-law amendments?

Purpose, Public Interest Mandate & Relevance to Strategic Plan

- By-law amendments are proposed relating to certain registration fees and appropriate terminology for physician assistant (PA) information on the public register.
- The proposed By-law amendments facilitate and support the regulation of PAs and transparency, both of which are in the public interest.

Current Status & Analysis

- PAs will start to be regulated as members of the CPSO on April 1, 2025.
- By-law amendments are proposed to capture PA information in the public register as well as information PAs are required to provide to CPSO.
    - Most of these changes relate to references to PA education and degrees.
- By-law amendments are also proposed to add the application and annual renewal fees applicable to certificates of registration authorizing practice in emergency circumstances as PAs.
    - The fees for the emergency circumstances certificates will be $300 for the application and $425 for annual renewal, the same as the application and annual fees for the certificate of registration authorizing practice as PAs.[1]
- These By-law amendments must be circulated to the profession before they can be approved.
- If the Board approves, the proposed By-laws will be circulated to the profession. After circulation, the proposed amendments will be brought back to the Board for final approval.

[1] This is consistent with the approach taken for the physicians emergency circumstances class.

APPENDIX A

PROPOSED AMENDMENTS TO REGISTER AND REGISTRANT INFORMATION BY-LAWS FOR PHYSICIAN ASSISTANTS

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17.1 Application Fees

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

…

(d) for a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $300;

...

18.1 Annual Fees

18.1.2 Annual fees as of June 1, 2018, are as follows:

…

(c) for a holder of a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $425; and

…

ARTICLE 21 REGISTER

21.1 Registrant Names and Addresses

21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, in the case of a Physician Registrant, or the Registrant's physician assistant degree, in the case of a PA Registrant, in each case as supported by documentary evidence satisfactory to the College.

…

21.2 Additional Register Content

21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant:

…

(e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, reported by the Registrant to the College;

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…

(h) in the case of a Physician Registrant, the name of the medical school from which the Registrant received their~~the Registrant's~~ degree in medicine, or in the case of a PA Registrant, the name of the physician assistant training program from which the Registrant received their physician assistant degree, and in each case, ~~and~~ the year in which the Registrant obtained the degree;

…

ARTICLE 23 REGISTRANT INFORMATION

23.1 Notification Required by Registrants

23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following:

…

(b) the address of all locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, in each case together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises ~~medicine~~;

Explanatory Note: This proposed by-law must be circulated to the profession.

Board Motion

Motion Title	For Circulation: By-law Amendments re PA Register and Fees for Emergency Class Certificate of Registration
Date of Meeting	November 29, 2024

It is moved by_____, and seconded by_____, that:

The Board of Directors[1] of the College of Physicians and Surgeons of Ontario proposes to amend By-law No. 168 (the **"CPSO By-laws"**) as set out below, after circulation to stakeholders:

1. Section 17.1.1(d) of the CPSO By-laws is revoked and substituted with the following:

17.1 Application Fees

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

…

(d) for a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $300;

2. Section 18.1.2(c) of the CPSO By-laws is revoked and substituted with the following:

18.1 Annual Fees

18.1.2 Annual fees as of June 1, 2018, are as follows:

…

(c) for a holder of a certificate of registration authorizing practice as a physician assistant or for a certificate of registration authorizing practice in emergency circumstances for physician assistants, $425; and

[1] The Board is deemed to be a reference to the Council of the College as specified in the Health Professions Procedural Code (Schedule 2 to the *Regulation Health Professions Act*) and the *Medicine Act*.

3. Section 21.1.1 of the CPSO By-laws is revoked and substituted with the following:

21.1 Registrant Names and Addresses

21.1.1 A Registrant's name in the Register shall be the Registrant's full name and consistent with the name of the Registrant as it appears on the Registrant's degree of medicine, in the case of a Physician Registrant, or the Registrant's physician assistant degree, in the case of a PA Registrant, in each case as supported by documentary evidence satisfactory to the College.

4. Sections 21.2.1(e) and (h) of the CPSO By-laws are revoked and substituted with the following:

21.2 Additional Register Content

21.2.1 For purposes of paragraph 20 of subsection 23(2) of the Code, the Register shall contain the following additional information with respect to each Registrant:

…

(e) in addition to the Registrant's business address, other locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, reported by the Registrant to the College;

…

(h) in the case of a Physician Registrant, the name of the medical school from which the Registrant received their degree in medicine, or in the case of a PA Registrant, the name of the physician assistant training program from which the Registrant received their physician assistant degree, and in each case, the year in which the Registrant obtained the degree;

5. Section 23.1.3(b) of the CPSO By-laws is revoked and substituted with the following:

23.1 Notification Required by Registrants

23.1.3 The College may at any time and from time to time request information from its Registrants. In response to each such request, each Registrant shall accurately and fully provide the College with the information requested using the Member Portal, or such other form or method specified by the College, by the due date set by the College. A College request for Registrant information may include the following:

…

(b) the address of all locations at which the Registrant practises medicine, if a Physician Registrant, or practises as a physician assistant, if a PA Registrant, in each case together with a description or confirmation of the services and clinical activities provided at all locations at which the Registrant practises;

Explanatory Note: This proposed by-law must be circulated to the profession.