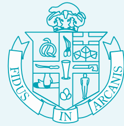
The College of Physicians and Surgeons of Ontario

Meeting of Council

September 20, 2019



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Friday, September 20, 2019 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 8:45 am.

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

August 22, 2019

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL

September 20, 2019

Council Chamber, 3rd Floor, 80 College Street, Toronto

Start time: 8:45 am

CALL TO ORDER

8:45 President's Announcements

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9:00 Registrar/CEO Report 15

9:45-10:05 MORNING BREAK

10:05 Protecting Personal Health Information – Draft Policy for Consultation...................... 16

For Decision

The College's *Confidentiality of Personal Health Information* policy is currently under review. A new draft policy entitled *Protecting Personal Health Information,* and a companion advice document, have been developed. Council is being asked to approve the draft policy for external consultation. The advice document will accompany the draft policy as part of the consultation process.

10:20 *Medical Records* – Draft Policies for Consultation...37

For Decision

The College's *Medical Records* policy is currently under review. Two new draft policies entitled *Medical Records Stewardship* and *Medical Records Documentation* have been

developed along with two companion *Advice to the Profession* documents. Council is being asked to approve the draft policies for external consultation. The advice documents will accompany the draft policies as part of the consultation process.

10:35 *Continuity of Care* – Revised Policies for Final Approval..69

For Decision

In May 2018, Council released a set of draft *Continuity of Care* policies for an extended six-month external consultation. Following the consultation and significant stakeholder engagement, the *Continuity of Care Policy Working Group* has revised the draft policies in light of the feedback received. Council is provided with an overview of the revisions made and is asked whether the revised set of *Continuity of Care* policies can be approved as policies of the College.

10:55 Closing a Medical Practice – Policy for Final Approval..106

For Decision

The College's current *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy is under review. An updated and newly titled *Closing a Medical Practice* policy was released for external consultation following the February 2018 meeting of Council. Council is provided with an overview of the revisions made in response to the feedback received from the consultation and is asked whether the revised draft *Closing a Medical Practice* policy can be approved as a policy of the College.

COUNCIL AWARD PRESENTATION

11:40 Council Award Recipient: Dr. Mark Spiller, Kirkland Lake, Ontario **...............................129**

12:00 LUNCH BREAK

1:00 Policy Redesign Implementation – Batch 2 130

For Decision

At its December 2018 meeting, Council approved a proposal to redesign College policies in order to enhance their utility for physicians. The first batch of redesigned policies was considered and approved by Council in May 2019.

Council is provided with an overview of the implementation plan put in place to facilitate the redesign process and is presented with the second batch of redesigned policies, along with some proposed housekeeping amendments to one policy. Council is asked whether each redesigned draft policy can be approved as a policy of the College.

1:15 ***Planning for and Providing Quality End-of-Life Care* – Policy Changes........................219**

For Decision

In May 2019 Council considered proposed revisions to the *Planning for and Providing Quality End-of-Life Care* policy as part of the policy redesign process. The revisions were developed in response to recent stakeholder feedback regarding the policy expectations in relation to "no-CPR" orders. At the time, Council felt that the revisions were substantive enough to warrant additional consideration at a future meeting. Since that time, a significant Court decision has been released clarifying physicians' obligations with respect to the writing of no-CPR orders and the provision of CPR. As a result, revisions are now being proposed that address *both* the stakeholder feedback received and the Court decision.

Council is provided with an overview of the history and evolution of this issue and is presented with proposed revisions for consideration. Council is asked whether the redesigned policy incorporating the proposed revisions can be approved as a policy of the College.

1:30 ***Effective Referral* – Policy Changes..243**

For Decision

Both the *Professional Obligations and Human Rights* and *Medical Assistance in Dying* policies have been the subject of significant debate due to the inclusion of the "effective referral" requirement. As part of the policy redesign process and following recent discussions with the Christian Medical and Dental Society, an analysis of the language used to describe the College's expectation was conducted in order to explore whether changes could be made to clarify, but not change, the College's expectation.

Council is provided with an overview of the most recent policy review processes, as well as the analysis that has been conducted, and is presented with proposed revisions for

consideration. Council is asked whether the redesigned policies incorporating the proposed changes can be approved as policies of the College.

1:45 *Criminal Record Screening* – Policy Changes 280

For Decision

During the policy redesign process for the *Criminal Record Screening* policy, issues arose and opportunities to streamline the policy were identified that warranted making some minor changes to the policy. Council is provided with an overview of the current policy, the issues and opportunities that have been identified, and the proposed amendments. Council is asked whether the revised draft policy can be approved as a policy of the College.

1:50 Transparency: Charges and Findings of Guilt from International Jurisdictions 284

For Decision

Council will be provided with an update on the issue of transparency regarding charges and findings of guilt from other jurisdictions. Council is being asked to approve by-law amendments to require the posting of charges and findings of guilt from international jurisdictions.

1:55 By-law Amendments – Housekeeping Matters 289

For Decision

Staff are proposing to put forward three non-substantive (housekeeping) amendments to the By-laws to correct and clarify certain provisions. Council is being asked whether it approves the motion for the required by-law amendments.

2:00 Governance Modernization 294

For Decision

In an effort to align with leading governance practices, the Governance Committee has made a series of non-legislative change recommendations to further its ongoing governance modernization work. Council is provided with an overview of these recommendations and is asked to approve the proposed by-law amendments required to accomplish these changes.

- *Standing Committees*
- *Term Limits*
- *Length of Committee Appointments*
- *Eligible Practice Criteria*
- *Exceptional Circumstances*

2:45-3:05	**BREAK**

3:05	**MEMBER TOPICS**

3:10 Governance Committee Report..........314

For Decision

- Election of 2019/2020 Academic Representatives on Council
- 2019-2020 Chair Appointments

For Information

- Committee Appointments

3:20 Pension Plan Resolution 319

For Decision

The Finance & Audit Committee is recommending to Council the approval of the Pension Plan resolution to wind down the current Defined Contribution Pension Plan, to implement the Healthcare of Ontario Pension Plan (HOOPP) and establish a new Defined Contribution Pension Plan for employees who choose to remain in a Defined Contribution arrangement.

3:40 <u>INFORMATION ITEMS</u>

1. **Government Relations Report 324**
2. **2020 Council and Executive Committee Meeting Dates 238**
3. **Discipline Committee – Table of Completed Cases 329**
4. **Policy Report..........410**

3:45 Motion to go in camera..416

ADJOURNMENT

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: **Council Meeting Minutes of May 30 and 31, 2019**

Date of Meeting: **September 20, 2019**

It is moved by ____,

and seconded by____, that:

The Council accepts the minutes of the meeting of the Council held on May 30 and 31, 2019

or

The Council accepts the minutes of the meeting of the Council held on May 30 and 31, 2019 with the following corrections:

**DRAFT PROCEEDINGS OF THE
MEETING OF COUNCIL OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
May 30 and 31, 2019**

May 30, 2019

Attendees:

Dr. Peeter Poldre (President)
Ms Hilary Alexander
Dr. Philip Berger
Mr. Harry Erlichman
Ms Joan Fisk
Dr. Michael Franklyn
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms Catherine Kerr
Mr. Mehdi Kanji
Mr. John Langs
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms Ellen Mary Mills
Ms Judy Mintz
Dr. Akbar Panju
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Robert Smith
Ms Gerry Sparrow
Ms Christine Tebbutt
Dr. Andrew Turner
Dr. Scott Wooder

Non-voting Academic Representatives on Council present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Janet van Vlymen

Regrets: Ms Joan Powell

CALL TO ORDER – DAY 1

President's Announcements

Dr. Poldre called the meeting to order at 9:00am and welcomed members and guests. He opened the meeting with a traditional land acknowledgement statement as a demonstration of recognition and respect for indigenous peoples.

Dr. Poldre welcomed the new public member, Mr. Mehdi Kanji and reported that Council now has a full complement of public members. In addition, Mr. Peter Pielsticker has been re-appointed to a three-year term. Finally Dr. Poldre welcomed back Dr. Michael Franklyn.

Council Meeting Minutes of March 1, 2019

01-C-05-2019

It is moved by Dr. Rob Smith and seconded by Dr. Deborah Hellyer that:

The Council accepts the minutes of the meeting of the Council held on March 1, 2019.

CARRIED

Executive Committee's Report to Council, January - March, 2019

The report was received with no comments.

REGISTRAR/CEO'S REPORT

Dr. Whitmore reported on the Enterprise System (a cloud-based, integrated system, containing streamlined, real-time data), the Quality Improvement program, as well as our communications strategy, including our improved web site (which now contains a page where patients can compliment their physician). On engagement, Dr. Whitmore has met with the RCPSC (Royal College of Physicians and Surgeons of Canada); Assistant Deputy Minister Patrick Dicerni, from the Ministry of Health and Long-Term Care; Mr. Hartley Stern, Executive Director/CEO of the CMPA (Canadian Medical Protective Association); HPARB (Health Professions Appeal and Review Board; the OMA (Ontario Medical Association) and HIROC (Healthcare Insurance Reciprocal of Canada) – all with the intention of improving relationships. Finally, Dr. Whitmore presented that through streamlining and introducing an Alternative Dispute Resolution process, we have been able to reduce the number of days it takes to contact complainants from 20 days to 1-2 days. A copy of the presentation is attached as **Appendix "A"** to these minutes.

GUEST SPEAKER

Council heard from Ms Julie Drury, Inaugural Chair of the Minister's Patient and Family Advisory Council for the Ontario Ministry of Health and Long-Term Care. A copy of the presentation is attached as **Appendix "B"** to these minutes.

MEMBER TOPICS

Mr. Craig Roxborough provided an update on recent Health Canada changes that close the regulatory gap for stem cell procedures.

COUNCIL AWARD PRESENTATION

Dr. Rob Gratton presented the Council Award to Dr. Marie Gear of Teeswater, Ontario.

STRATEGIC PLAN

Council was presented with the proposed strategic plan along with results of the comprehensive consultation. After discussion, Council chose the following Mission and Vision:

MISSION:
Serving the people of Ontario through effective regulation of medical doctors

VISION:
Trusted doctors providing great care

02-C-05-2019

It is moved by Mr. Peter Pielsticker and seconded by Dr. Judith Plante that:

The Council approves the 2020-2025 strategic plan for the College as presented (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

GOVERNANCE COMMITTEE REPORT

2019-2020 Executive Committee Election

03-C-05-2019

It is moved by Dr. Jerry Rosenblum and seconded by Dr. David Rouselle that:

The Council appoints Dr. Brenda Copps (as President), Dr. Akbar Panju (as Vice President), Ms Ellen Mary Mills (as Executive Member Representative), Mr. Peter Pielsticker (as Executive Member Representative), Dr. Judith Plante (as Executive Member Representative), and Dr. Peeter Poldre (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2019.

CARRIED

Governance Modernization

Council also discussed the following:

- The Governance Committee is reviewing the mandates and structure of all standing committees to ensure alignment with the strategic plan. After further review, it is recommended removing three CPSO standing committees: Council Awards Selection, Education and Outreach.

- The Governance Committee has reviewed best practices relating to term limits for committee members in an effort to promote succession planning and diversity. A 9-year term limit was discussed for members of any one committee and an 18-year limit for individuals who have participated in any combination of committees.

Further recommendations to follow, including timelines.

HARRY CAYTON REPORT: AN INQUIRY INTO THE PERFORMANCE OF THE COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA AND THE *HEALTH PROFESSIONS ACT*

Ms Maureen Boon reported on the 21 recommendations that came out of Mr. Cayton's inquiry. The College of Dental Surgeons of British Columbia has 30 days to respond to the recommendations. It is too early to determine whether or not there will be an impact in Ontario.

POLICY REDESIGN IMPLEMENTATION – BATCH 1

Mr. Craig Roxborough presented to Council on Batch 1 policies that are not under review, but have been redesigned for clarity and brevity.

04-C-05-2019

It is moved by Mr. Peter Pielsticker, and seconded by Ms Gerry Sparrow that:

The *Planning for and Providing Quality End of Life Care* policy will be removed from Batch 1 and come back at a future meeting.

CARRIED

05-C-05-2019

It is moved by Ms Joan Fisk, and seconded by Dr. Deborah Hellyer, that, except for the *Planning for and Providing Quality End of Life Care* policy,

The Council approves Batch 1 of the revised policies:

(a) "Accepting New Patients" (a copy of which forms Appendix "D" to the minutes of this meeting);
(b) "Blood Borne Viruses" (a copy of which forms Appendix "E" to the minutes of this meeting);
(c) "Cannabis for Medical Purposes" (a copy of which forms Appendix "F" to the minutes of this meeting);

(d) "Consent to Treatment" (a copy of which forms Appendix "G" to the minutes of this meeting);
(e) "Ending the Physician-Patient Relationship" (a copy of which forms Appendix "H" to the minutes of this meeting);
(f) "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" (a copy of which forms Appendix "I" to the minutes of this meeting);
(g) "Female Genital Cutting (Mutilation)" (a copy of which forms Appendix "J" to the minutes of this meeting);
(h) "Providing Physician Services During Job Actions" (a copy of which forms Appendix "K" to the minutes of this meeting);
(i) "Public Health Emergencies" (a copy of which forms Appendix "L" to the minutes of this meeting);
(j) "Telemedicine" (a copy of which forms Appendix "M" to the minutes of this meeting); and
(k) "Uninsured Services: Billing and Block Fees" (a copy of which forms Appendix "N" to the minutes of this meeting).

CARRIED

TRANSPARENCY

Charges and Findings of Guilt Posted on the Register

06-C-05-2019

It is moved by Dr. Scott Wooder and seconded by Mr. Mehdi Kanji that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 125, after circulation to stakeholders:

By-law No. 125

(1) Paragraph 49(1)19 of By-law No. 1 (the General By-law) is revoked and the following is substituted:

19. Where there has been a finding of guilt made against a member (a) under the *Health Insurance Act (Ontario)*, on or after June 1, 2015, (b) under any criminal laws of another jurisdiction, on or after January 1, 2019, or (c) under laws of another jurisdiction comparable to the *Health Insurance* Act (Ontario) or the *Controlled Drugs and Substances Act* (Canada), on or after January 1, 2019 and if the finding and/or appeal is known to the College:

(i) a brief summary of the finding;
(ii) a brief summary of the sentence;
(iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and
(iv) the dates of (i)-(iii), if known to the College.

(2) Paragraph 49(1)26 of the By-law No. 1 (the General By-law) is revoked and the following is substituted:

26. Where a member has been charged with an offence under the *Health Insurance Act* (Ontario), under any criminal laws of another jurisdiction or under laws of another jurisdiction comparable to the *Health Insurance Act* (Ontario) or the *Controlled Drugs and Substances Act* (Canada), and the charge is outstanding and is known to the College, the fact and content of the charge and, if known to the College, the date and place of the charge.

CARRIED

ADJOURNMENT – DAY 1

The meeting was adjourned at 4:03 pm.

____

Dr. Peeter Poldre, President

____

Ms Vanessa Clarke, Recording Secretary

DRAFT PROCEEDINGS OF THE
MEETING OF COUNCIL OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
May 30, 31, 2019

May 31, 2019

Attendees:
Dr. Peeter Poldre (President)
Ms Hilary Alexander
Dr. Philip Berger
Mr. Harry Erlichman
Ms Joan Fisk
Dr. Michael Franklyn
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Dr. Paul Hendry
Ms Catherine Kerr
Mr. Mehdi Kanji
Mr. John Langs
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms Ellen Mary Mills
Dr. Akbar Panju
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. John Rapin
Dr. Sarah Reid
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Elizabeth Samson
Dr. Robert Smith
Ms Gerry Sparrow
Ms Christine Tebbutt
Dr. Andrew Turner
Dr. Scott Wooder

Non-voting Academic Representatives on Council present:
Dr. Mary Bell, Dr. Terri Paul and Dr. Janet van Vlymen

Regrets: Ms Joan Powell, Dr. Patrick Safieh

CALL TO ORDER – DAY 2

BOUNDARY VIOLATIONS

Council was asked to approve the policy for external review.

07-C-05-2019

It is moved by Dr. Brenda Copps and seconded by Dr. Akbar Panju that:

The College engage in the consultation process in respect of the draft policy "Boundary Violations", formerly titled "*Maintaining Appropriate Boundaries and Preventing Sexual Abuse*"(a copy of which forms Appendix "O" to the minutes of this meeting).

CARRIED

DISCLOSURE OF HARM

Council was asked to approve this policy so it can be released for external consultation.

08-C-05-2019

It is moved by Dr. Deborah Hellyer and seconded by Dr. Paul Hendry that:

The College engage in the consultation process in respect of the draft policy "Disclosure of Harm" (a copy of which forms Appendix "P" to the minutes of this meeting).

CARRIED

PRESCRIBING DRUGS POLICY

Council was asked to approve this policy so it can be released for external consultation.

09-C-05-2019

It is moved by Mr. Pierre Giroux and seconded by Dr. Jerry Rosenblum that:

The College engage in the consultation process in respect of the draft policy "Prescribing Drugs" (a copy of which forms Appendix "Q" to the minutes of this meeting).

CARRIED

FINANCE AND AUDIT COMMITTEE

Approval of Financial Statements for 2018

10-C-05-2019

It is moved by Ms Christine Tebbutt and seconded by Ms Hilary Alexander that:

The Council approves the financial statements for the fiscal year ended December 31, 2018 as presented (a copy of which forms Appendix "R" to the minutes of this meeting).

CARRIED

Appointment of the Auditors for 2019

11-C-05-2019

It is moved by Ms Ellen Mary Mills and seconded by Mr. Pierre Giroux that:

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

CARRIED

Removing Criminal Record Check Fee and Fairness Commissioner Fee from Fees and Remuneration By-law

12-C-05-2019

It is moved by Dr. Brenda Copps and seconded by Mr. Paul Malette that:

By-law No. 127
1. Subsection 1(e) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked.

CARRIED

Pension Plan Resolution

13-C-05-2019

It is moved by Mr. Mehdi Kanji and seconded by Ms Joan Fisk that:

WHEREAS the College of Physicians and Surgeons of Ontario (the **"College"**) established the Employees' Retirement Savings Plan for The College of Physicians and Surgeons of Ontario, Registration No. 0951756 (the **"Plan"**) effective January 1, 1986; and

WHEREAS pursuant to Section 13.01 of the Plan, the College reserves the right to amend and terminate the Plan; and

WHEREAS the College wishes to fully terminate the Plan effective September, 30, 2019, or shortly thereafter, and replace it with a new defined contribution pension plan, the CPSO Retirement Savings Plan 2019 (**"New DCPP"**); and

WHEREAS the New DCPP will provide the same investment line up and the same contribution formula as are provided under the Plan as at date the Plan winds up, subject to any future amendments; and

WHEREAS the College, acting through its Council, wishes to delegate to the Executive Committee the necessary powers and duties to complete the wind-up of the Plan and to implement the New DCPP and to register the New DCPP with the applicable regulatory authorities; and

WHEREAS with the exception of the authority to determine the employer contribution formula under the New DCPP now and in the future, the College, acting through its Council also wishes to delegate to the Executive Committee the ability to determine all details in connection with the provisions, operation and administration of the New DCPP, including the power to adopt any subsequent compliance and plan design amendments that do not impact the employer contribution formula; and

WHEREAS employees hired on or after October 1, 2019 (or such later date as may be determined by the Executive Committee) will not be eligible to participate in the New DCPP and instead such employees will be eligible to participate in the Healthcare of Ontario Pension Plan (**"HOOPP"**); and

NOW THEREFORE IT IS RESOLVED THAT:

1. The Plan is fully terminated and wound-up with respect to members, former members and other persons entitled to payments under the Plan (collectively, **"Members"**) effective September 30, 2019 or such later date as may be determined by the Executive Committee (the **"Wind-up Date"**).

2. Contributions to the Plan shall be made with respect to service with the College up to and including the Wind-up Date.

3. The College shall notify the Members entitled to payments under the Plan in accordance with the provisions of the Ontario *Pension Benefits Act*.

4. Each Member shall have the required options provided to him regarding the payment of his benefit entitlement in accordance with the terms of the Plan, the Ontario *Pension Benefits Act* and the *Income Tax Act* (Canada).

5. A wind-up report for the Plan shall be prepared in accordance with the Ontario *Pension Benefits Act* and the regulations thereunder as may be required by the Financial Services Commission of Ontario (or its successor).

6. The Executive Committee is authorized to:
    a. approve all decisions relating to the wind-up of the Plan, including but not limited to determining the date on which such wind-up is to occur in accordance with section 1 (above);
    b. approve all decisions relating to the New DCPP, including but not limited to the terms and conditions of the New DCPP (with the exception of the employer contribution formula); and
    c. approve all amendments to the New DCPP, as may be required or recommended, in the future in connection with compliance and plan design changes that do not affect the employer contribution formula.

Effective October 1, 2019 or such later date as may be determined by the Executive Committee:

1. The New DCPP will be established.

2. The New DCPP shall provide the same investment line-up and the same contribution formula as are provided under the Plan as at the Wind-up Date, subject to any future amendments.

BE IT FURTHER RESOLVED THAT the College employees, as authorized by the College General By-law, are hereby authorized and directed to sign all documents and to perform any or all acts necessary or desirable to give effect to the foregoing resolution.

CARRIED

INFORMATION ITEMS

- **Policy Report**
- **Government Relations Report**
- **Discipline Committee Report of Completed Cases, May 2019**

Motion to Go In Camera

14-C-05-2019

It is moved by Mr. Peter Pielsticker and seconded by Dr. Akbar Panju that:

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

CARRIED

ADJOURNMENT – DAY 2

Council was adjourned at 11:40 am.

____
Dr. Peeter Poldre, President

____
Ms Vanessa Clarke, Recording Secretary

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: Executive Committee's Report to Council
April - June 2019
In Accordance with Section 12 HPPC

FOR INFORMATION

<u>April 23, 2019 Executive Committee Meeting</u>

4. Governance - Committee Appointments

<u>2-EX-Apr-2019</u> Upon a motion by Steven Bodley and seconded by Brenda Copps, and CARRIED, the Executive Committee appoints Ms. Judy Mintz to the Council Award Selection Committee.

<u>3-EX-Apr-2019</u> Upon a motion by Steven Bodley and seconded by Brenda Copps, and CARRIED, the Executive Committee appoints Dr. Jane Lougheed to the ICR Committee.

<u>May 24, 2019 Executive Committee Meeting</u>

1. Governance - Committee Appointments

<u>1-EX-May-2019</u> Upon a motion by Dr. Brenda Copps and seconded by Ms Ellen Mary Mills, and CARRIED, the Executive Committee appoints Mr. Shahid Chaudhry to the Inquiries, Complaints and Reports Committee.

<u>2-EX-May-2019</u> Upon a motion by Dr. Brenda Copps and seconded by Ms Ellen Mary Mills, and CARRIED, the Executive Committee appoints Dr. Holli Schlosser to the Premises Inspection Committee.

<u>3-EX-May-2019</u> Upon a motion by Dr. Brenda Copps and seconded by Ms Ellen Mary Mills, and CARRIED, the Executive Committee appoints Dr. Patrick Davison to the Premises Inspection Committee.

June 18, 2019 Executive Committee Meeting

3. Governance – Committee Appointments

3-EX-Jun-2019 Upon a motion by Steven Bodley and seconded by Akbar Panju, and CARRIED, the Executive Committee appoints Dr. Ted Xenodemetropoulos to the Premises Inspection Committee

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Contact: Peeter Poldre, President
Lisa Brownstone, x 472

Date: August 29, 2019

Registrar/CEO’s Report

No meeting materials

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: ***Protecting Personal Health Information*** **– Draft Policy for Consultation**

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The College engage in the consultation process in respect of the draft policy "Protecting Personal Health Information" (a copy of which forms Appendix "A" to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: ***Protecting Personal Health Information* – Draft Policy for Consultation**

FOR DECISION

ISSUE:

- The College's *Confidentiality of Personal Health Information* policy is currently under review. A new draft policy, titled *Protecting Personal Health Information*, has been developed along with a companion *Advice to the Profession* document.

- Council is provided with an overview of the policy review process undertaken to date, as well as the draft policy and advice document, and is asked to approve the draft policy for external consultation.

BACKGROUND:

- The current *Confidentiality of Personal Health Information* policy was last reviewed and approved by Council in 2005. A Working Group struck to undertake the policy review consists of Jerry Rosenblum (Chair), John Langs, and Patrick Safieh, with support from Michael Szul (Medical Advisor) and Marcia Cooper (Legal Counsel).

- Preliminary research was undertaken in accordance with the usual policy review process.[1] In addition, feedback on the current policy was solicited through two preliminary consultations: one in 2013[2] and, in light of significant changes in 2016 to the *Personal Health Information Protection Act, 2004*, another in 2017.[3]

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[1] This included a literature review of scholarly articles and research papers; a jurisdictional review of Canadian and international medical regulatory authorities; relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee; and feedback on the current policy from the College's Public and Physician Advisory Service.

[2] 14 responses were received via email, the online discussion page, and regular mail (including 1 from a physician, 2 from non-physicians, and 11 from organizations).

[3] 121 responses were received (15 through the online discussion page, including 2 organizational submissions, and 106 via the online survey). An overview of the feedback was provided to Council in September 2017 as part of the Policy Report.

- Relevant findings and themes from the research and the preliminary consultations are provided below, as key additions and revisions are outlined.

CURRENT STATUS:

- A draft *Protecting Personal Health Information* policy (**Appendix A**) and companion *Advice to the Profession* document (**Appendix B**) have been developed in response to the research and consultation feedback. An overview of the drafts' key features is set out below.

A. Draft *Protecting Personal Health Information* Policy

Policy Redesign

- In keeping with the policy redesign strategy, the draft has been developed with a focus on clarity, directness, and brevity, and now exclusively uses "must" in setting out expectations. Overall, the draft has achieved a 40% reduction in word count.

- The draft retains the majority of the current policy's mandatory expectations, as well as expectations using more ambiguous language (e.g., "physicians should…") where these have been interpreted as communicating a mandatory expectation.

- The draft also contains a definitions section, which includes new and updated key terms in response to feedback received during the preliminary consultations (e.g., "circle of care", "e-communication", "mobile device", and "lockbox").

Reducing Unnecessary Overlap

- Certain expectations in the current policy that are duplicated in other College policies have been removed from the draft, including expectations about:
    - information practices and security of records (captured by the current *Medical Records* policy and draft *Medical Records Stewardship* policy[4]); and
    - disclosure where another physician or health care provider is suspected to be incapable (captured by the *Mandatory and Permissive Reporting* policy).

Expanded Scope of Policy and Expectations

- The current policy's scope, focusing on confidentiality and unauthorized disclosure of personal health information (PHI), has been expanded in light of feedback to reflect the growing recognition and scrutiny of issues relating to patient privacy in health care.

[4] Council will be receiving the draft *Medical Records Stewardship* policy for consideration at the same time as the draft *Protecting Personal Health Information* policy.

- As a result, the draft policy has been re-titled *Protecting Personal Health Information*.

- Expectations have also been revised, where appropriate, to address patient privacy and unauthorized collection of, and access to, PHI (provisions 3.a. and 13).

Obtaining Valid Consent for Patients who are Minors

- In response to feedback, the draft policy contains new expectations that clarify how to obtain valid consent from patients under 16 (provisions 5 and 6).

Disclosures Permitted by Law

- The current policy requires physicians to make every reasonable effort to obtain the patient's consent before making a disclosure that is permitted by law (e.g., assisting in a police investigation).

- Given the practical difficulties created by this expectation, the draft requires the physician to notify the patient that the disclosure will be made (rather than to seek consent), subject to certain exceptions (provision 12). This aligns with the *Ending the Physician-Patient Relationship* policy.

Technology and Privacy Breaches

- Feedback from the preliminary consultations identified that the current policy's content on technology requires updating.

- The expectations on this topic have been modernized in the draft to better reflect how technology is being used to communicate PHI in medical practice, including:

    - an updated expectation to protect against inadvertent disclosure of PHI without authorization, including through fax, email, telemedicine, social media, and any other form of e-communication (provision 14);
    - updated expectations of physicians to protect PHI with reasonable security safeguards (provisions 15 and 16);
    - an updated expectation requiring express consent for e-communication (provision 17), while removing the current expectation for consent for phone communication;
    - a new expectation to ensure that mobile devices and cloud-based servers have reasonable security safeguards in place (provision 19); and
    - a new expectation regarding photographs and video recordings of a patient (provision 20).

- A new expectation has also been drafted to require compliance with all applicable legislative and regulatory requirements in the event of a privacy breach (provision 21).

B. Draft *Advice to the Profession: Protecting Personal Health Information* Document

- The draft *Advice to the Profession* document provides information to help physicians interpret and understand their confidentiality obligations. While it will be distributed as part of the consultation, it is intended as a communications tool not requiring Council approval.

- The draft advice document includes repurposed contextual content from the current policy that was identified during the preliminary consultation as useful to physicians, including:

  - disclosures without consent that are permitted or required by law; and
  - requests for PHI by family (including access and custodial parents) and friends.

- The draft advice document also adds new content that was included to address revisions to in the draft policy and feedback received during the consultation, such as:

  - the distinction between privacy and confidentiality, and the connection to snooping;
  - the concept of the circle of care as applied to practice;
  - disclosing PHI to family where the patient is deceased; and
  - e-communications, including best practices and resources for further information.

NEXT STEPS:

- Subject to Council's approval, the draft policy, accompanied by the companion advice document, will be released for consultation following the September 2019 Council Meeting.

- Feedback received through the consultation will be shared at a future Council meeting and used to further refine the drafts.

DECISION FOR COUNCIL:

1. Does Council approve the draft *Protecting Personal Health Information* policy for external consultation?

Contact: Heather Webb, ext. 753

Date: August 20, 2019

Attachments:
Appendix A: Draft *Protecting Personal Health Information* Policy
Appendix B: Draft *Advice to the Profession: Protecting Personal Health Information* Document

Protecting Personal Health Information

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

Circle of care: the group of health care providers treating a patient who need the patient's personal health information in order to provide health care. A person outside a patient's circle of care would include:

- a person or entity who is not a health care provider (e.g. family, friends, the police, an insurance company, or the patient's employer); and
- another health care provider, including a physician, where the PHI is being provided for a purpose other than providing health care to the patient (e.g. for market research).

For further information and examples, see the *Advice to the Profession* document.

E-Communications: electronic communication tools including email, messages transmitted through electronic medical record platforms, online forums, patient portals, social media applications, instant messaging and texting, and telemedicine (including audio and videoconferencing).[1]

Lockbox: a term used to describe a patient's express instruction to withhold or withdraw their consent to share all or part of their personal health information with another health care provider.[2]

Mobile device: includes, for example, a mobile phone, laptop, USB drive, external hard drive, tablet, and wearable device.

Personal health information (PHI): any information relating to a person's health that identifies the person, including, for example, information about their physical or mental health, family

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[1] See the CPSO's *Telemedicine* policy for additional expectations regarding telemedicine.
[2] When proclaimed in force, Part V.1 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (hereinafter "*PHIPA*") will govern "consent directives" and "consent overrides," which are similar concepts to the lockbox in the context of the provincial Electronic Health Record.

29 health history, information relating to payments or eligibility for health care, and health
30 numbers.[3]

31 **Substitute decision-maker (SDM)**: a person authorized to consent on behalf of a patient to the
32 collection, use, or disclosure of PHI about the patient.

33 Policy

34 This policy includes legislative requirements and professional obligations of physicians related
35 to the privacy and confidentiality of patients' PHI. It does not, and is not intended to, set out all
36 of the legislative requirements regarding privacy of PHI. Physicians are responsible for ensuring
37 they are familiar with all of the legislative requirements; the complexity of the law in this area
38 may warrant independent legal advice in specific circumstances.

39 ***General***

40 1. Physicians **must** only collect, use, or disclose a patient's PHI:
41
42 a. with the consent of the patient or SDM, and where it is necessary for a lawful
43 purpose; or
44 b. where permitted or required by law.
45
46 2. Physicians **must** collect, use, and disclose a patient's PHI only:
47
48 a. as necessary in the course of their duties; and
49 b. to the extent that it is reasonably necessary to meet the purpose for which it is
50 being collected, used, or disclosed.

51 ***Obtaining Consent to Collect, Access, Use, or Disclose PHI***[4]

52 Under the *Personal Health Information Protection Act, 2004*, consent may be either express or
53 implied.[5] Physicians who have received PHI from the patient, SDM, or another health care
54 provider for a health care purpose can rely on the patient's implied consent to disclose the PHI
55 within the patient's circle of care, unless they have reason to believe that the patient has
56 expressly withheld or withdrawn consent to do so.

---

[3] This list is non-exhaustive; a full legislative definition, along with certain exceptions, is found s. 4 of *PHIPA*.

[4] While *PHIPA* establishes rules about the collection, use, and disclosure of PHI, this policy largely focuses on expectations related to disclosure given the particular relevance to physicians' practice.

[5] Express consent is direct, explicit, and unequivocal, and can be given either verbally or in writing. Implied consent is inferred from the words or behaviour of the patient, or 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.

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57 3. Except as permitted or required by law, physicians **must** obtain the patient's express
58 consent before:
59
60 a. collecting, accessing, or using PHI where the physician is outside the patient's circle
61 of care in the circumstances; and
62 b. disclosing PHI to a person who is outside the patient's circle of care.
63
64 4. For consent to be valid, be it express or implied, physicians **must** ensure that it:
65
66 a. is a consent of the patient, if the patient is capable of consenting, or the SDM, if the
67 patient is incapable;[6]
68 b. is reasonable to believe that the patient knows the purposes of the collection, use,
69 or disclosure, and that they may give or withhold consent;[7]
70 c. relates to the information; and
71 d. is not obtained through deception or coercion.[8]

72 ***Consent from Minors***

73 The rules governing consent to decisions involving personal health information are found in the
74 *Personal Health Information Protection Act, 2004* and are different from those governing
75 consent to treatment found in the *Health Care Consent Act, 1996*.[9]

76 5. Physicians **must** obtain consent from the patient, regardless of the patient's age, if:
77
78 a. the patient is capable of consenting to a decision about their PHI; or
79 b. the information relates to a treatment decision[10] the patient has made.
80
81 6. Where the patient is capable of consenting to a decision about their PHI and is younger than
82 16 years old, and the information does *not* relate to a treatment decision[11] the patient has
83 made, the patient's parent is also permitted by *PHIPA* to give or refuse consent to a decision

[6] Patients are capable of consenting if they are able to understand information relevant to deciding whether to consent to the collection, use, or disclosure of their PHI, and to appreciate the reasonably foreseeable consequences of giving, not giving, withholding, or withdrawing their consent.
[7] Section 18(1)(b) of *PHIPA* describes this component of valid consent as "knowledgeable".
[8] See sections 18 to 28 of *PHIPA* for further information regarding the tests for consent and capacity to make decisions regarding the collection, use, and disclosure of PHI.
[9] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (hereinafter "*HCCA*").
[10] This includes "treatment" as defined in accordance with the *HCCA* and counselling provided under the *Child, Youth, and Family Services Act, 2017*, S.O. 2017, c. 14, Sched. 1.
[11] Ibid.

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84 about the patient's PHI; in these cases, physicians **must** respect the patient's decision over a
85 conflicting decision by the parent.

86 ***Withholding or Withdrawing Consent***

87 7. Except as permitted or required by law, physicians **must** respect a patient's decision to
88 withhold or withdraw their consent to a collection, use, or disclosure of PHI.
89
90 8. Where a patient indicates an interest in creating a lockbox, physicians **must**:
91
92 a. discuss the potential health risks and limitations associated with lockboxes with the
93 patient; and
94 b. document this discussion and the patient's decision in the patient's medical record.
95
96 9. Where the patient has not permitted the sharing of PHI that is reasonably necessary for
97 providing care:
98
99 a. the disclosing physician **must** notify the recipient physician or other health care
100 provider of the fact that there is additional relevant PHI that cannot be disclosed;
101 and
102 b. the recipient physician **must** consider whether the lockbox prevents them from
103 safely providing the treatment.
104
105 10. Where the recipient physician declines to provide non-emergency treatment due to lockbox
106 restrictions on accessing PHI,[12] the disclosing or recipient physician, as appropriate in the
107 circumstance, **must**:
108
109 a. explain the decision and reasoning to the patient; and
110 b. document this encounter in the patient's medical record.

111 ***Disclosures Permitted or Required by Law (Without Consent)***[13]

112 11. Where the disclosure of PHI is permitted by law without consent, physicians **must** use their
113 professional judgment in considering whether and how much PHI to disclose, taking into
114 account the specific circumstances.
115

[12] The *HCCA* sets out the rules for obtaining consent to treatment in an emergency. See the CPSO's *Consent to Treatment* policy for expectations relating to emergency treatment.
[13] See the *Advice to the Profession* document and the CPSO's *Mandatory and Permissive Reporting* policy for circumstances in which disclosures are permitted or required by law.

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116 12. Where PHI is to be disclosed as permitted or required by law, physicians **must** notify the
117 patient that the disclosure will be made and why, unless notification will:
118
119 a. pose a genuine risk of harm to the patient, the physician, the physician's staff, other
120 patients, or other third parties; or
121 b. undermine the purpose of the disclosure.

122 ***Security of Communications***

123 13. Physicians **must** take reasonable steps to protect PHI, including protection against theft,
124 loss, and unauthorized access, use, and disclosure of PHI.
125
126 14. In particular, physicians **must** take reasonable steps to protect PHI from being inadvertently
127 disclosed without authorization through:
128
129 a. in-person and telephone conversations, including as a result of being overheard by
130 others (e.g., staff or patients in reception or emergency room areas);
131 b. voicemail messages left for patients, taking into account that more than one person
132 may have access to voicemail at the patient's home or office;
133 c. faxes, including as a result of being sent to, or intercepted by, unintended recipients;
134 and
135 d. email, telemedicine, social media, and any other form of e-communication.
136
137 15. Physicians communicating PHI electronically **must** use technology with reasonable security
138 safeguards in place to protect the PHI, including:
139
140 a. strong, up-to-date, industry-standard encryption;
141 b. strong passwords; and
142 c. secure wireless networks.
143
144 16. Physicians communicating PHI electronically with colleagues **must** be reasonably assured
145 that the technology being used by the colleague has reasonable security safeguards in place
146 to protect the PHI, such as those listed in provisions 15.a., b., and c.
147
148 17. Physicians wishing to communicate PHI electronically with patients **must**:
149
150 a. obtain and document the patient's express consent to this form of communication;
151 and

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152 b. use their professional judgment to determine whether unsecure sharing is
153 appropriate in the particular circumstance and for the contemplated use.
154
155 18. When obtaining the patient's express consent to the unsecure communication of PHI
156 electronically, physicians **must** inform the patient about:
157
158 a. how this kind of e-communication will be used;
159 b. the type of information that will be communicated;
160 c. how the e-communication will be processed; and
161 d. the limitations and risks of using unsecure e-communication.

162 ***Security of Mobile Devices and the Cloud***

163 19. When using mobile devices or cloud-based servers to access, store, or back up PHI – even
164 temporarily – physicians **must** have in place reasonable security safeguards to protect PHI,
165 including:
166
167 a. strong, up-to-date, industry-standard encryption;
168 b. strong passwords; and
169 c. secure wireless networks.

170 ***Photographs and Video Recordings***

171 20. If photographs or video recordings of a patient are required for the purpose of providing
172 care, physicians **must**:
173
174 a. inform the patient about the purpose of the photograph or recording;
175 b. obtain express consent before taking a photograph or recording that identifies the
176 patient; and
177 c. include a copy of the photograph or recording in the patient's medical record.

178 ***Privacy Breaches***

179 21. Physicians **must** comply with all applicable legislative and regulatory requirements in the
180 event of a privacy breach, including notification and reporting requirements.[14]

[14] See the *Advice to the Profession* document for further information regarding privacy breaches.

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1 # Advice to the Profession: Protecting Personal Health Information

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

6

7 Protecting patients' personal health information (PHI) is fundamental to providing high quality
8 patient care. To establish and preserve trust in the physician-patient relationship, patients must
9 be confident that their PHI is protected. This Advice document is intended to help physicians
10 interpret and understand the legal and professional obligations to protect patients' PHI. If you
11 are uncertain about how to discharge any of these obligations in specific circumstances, you are
12 advised to consult the Canadian Medical Protective Association (CMPA), your legal counsel, or
13 the Information and Privacy Commissioner (IPC).

14 ## General Principles

15 ***What is the difference between confidentiality and privacy?***

16 Patients' PHI is protected when it remains confidential and private. Physicians are generally
17 familiar with the duty of confidentiality, which prohibits them from sharing information about a
18 patient without the patient's consent, unless permitted or required by law. In contrast, the duty
19 of privacy is broader and prohibits physicians from accessing PHI where they have no authority
20 to do so. At its essence, it is the difference between "don't share" and "don't even look!"[1]

21 These principles are reflected in the *Personal Health Information Protection Act, 2004* (*PHIPA*),
22 which sets out a framework for when health information custodians and their agents, including
23 physicians, are authorized to collect, use, and disclose PHI. While the legislation is complex, its
24 general principles impose an obligation on physicians to only access PHI on a "need to know"
25 basis, or where otherwise permitted or required by law to do so.

26 ***What is "snooping"?***

27 Snooping is when a health care provider accesses a patient's PHI without authorization – in
28 other words, when they have no need to know as part of their duties, and are not otherwise
29 permitted or required by law to access the PHI.

[1] Kate Dewhirst, "New snooping case for health privacy – Decision 74 of the IPC released," September 5, 2018.

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Some health care providers mistakenly believe that they are permitted to review a patient's PHI so long as they maintain the patient's confidentiality by not sharing it with anyone else. In reality, snooping is a breach of patient privacy. Unless authorized by law, physicians must have the patient's express consent to access the PHI where they do not need it to provide health care.[2] So, for example, physicians with technical sign-in ability may be snooping if they view health records where they have no need to know to provide care to the patient; the authority to sign in to an Electronic Health Record or Electronic Medical Record is not authority to access all or any records in the system.

PHIPA refers to "health information custodians" and "agents". What are these?

A "health information custodian" ("custodian") is a person or organization who, as a result of their power, duties, or work, has custody or control of PHI. This includes health care organizations such as hospitals, pharmacies, and laboratories, as well as some individual physicians (such as owners of a clinic, physicians working as a sole practitioner in their own practice) and some Family Health Organizations.[3]

In contrast, an "agent" is a person who is authorized by a custodian to perform certain activities on its behalf regarding PHI. Generally speaking, this includes physicians practising in hospitals and certain medical clinics. Administrative staff in a medical clinic or hospital may also be agents.

Agents may collect, use, or disclose PHI only as authorized and directed by their custodian. Custodians may permit their agents to collect, use, or disclose PHI only in certain circumstances, including if this is necessary for the agents to carry out their duties. Custodians are ultimately responsible for PHI, as well as the actions of their agents.

While *PHIPA's* framework is complex, custodians and agents are ultimately obliged to meet the same general expectations regarding the collection, use, and disclosure of PHI. The expectations in the policy therefore apply to *all* physicians, regardless of whether they are a custodian or an agent, as does the guidance in this Advice unless noted otherwise.

However, if you are a custodian, you should be aware of additional *PHIPA* rules that apply specifically to custodians, such as those regulating the retention, transfer, and destruction of records. If you are a custodian, you are advised to consult *PHIPA* and the CPSO's *Medical Records Stewardship* [hyperlink] policy for further information regarding these obligations.

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[2] Where express consent is required, you are advised to document it in the patient's medical record, either by including a paper copy of the consent form (where the consent is given in writing) or a record of the conversation (where the consent is given orally).
[3] This list is non-exhaustive; a full legislative definition, along with certain exceptions, is found s. 3 of *PHIPA*.

Who is found within the "circle of care"?

The term "circle of care" is not found in *PHIPA*, but is commonly used to determine whether a physician can rely upon implied consent to access and share PHI. The circle of care is made up of health care providers who need access to the patient's PHI in order to provide the patient with health care. The IPC document, *Frequently Asked Questions: Personal Health Information Protection Act* provides the following examples of who is within the circle of care:

- In an office setting, the circle of care may include the physician, a nurse, a specialist or other health care practitioner referred by the physician, and any other health care practitioner selected by the patient, such as a pharmacist or physiotherapist.
- In a hospital setting, the circle of care may include the attending physician and the health care team (residents, nurses, clinical clerks and employees assigned to the patient with the responsibility of providing care to the patient). The circle of care could include a person outside the hospital who will be involved in providing health care to the patient upon discharge from the hospital.

The circle of care does *not* include:

- Health care providers who are not part of the direct or follow-up treatment of a patient, as these individuals do not need the PHI to provide health care to the patient; and
- Non-health care providers, like family, friends, the police, an insurance company, and the patient's employer.

When does the circle of care begin and end?

PHIPA does not address timing with respect to when a physician formally enters or exits the circle of care. Determining if you are within the circle of case will be an assessment based on the role you are playing in the patient's care.

As an example, if you have provided the patient with treatment and are continuing to provide follow-up care to the patient, you are still within the circle of care and may assume you have implied consent to access their PHI to provide health care to the patient. However, a physician does not necessarily continue to be in a patient's circle of care indefinitely. If you are not directly providing health care and/or follow-up treatment, you may no longer have the right to rely on implied consent to access the patient's PHI.

When in doubt, check with your custodian (e.g., hospital) or the IPC to find out if you are permitted to access the patient's PHI.

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92 ***Am I snooping if I access a patient's PHI for education or quality improvement purposes?***

93 It is common for physicians to want to access a patient's PHI in order to understand and assess
94 the outcome of their treatment decisions, and *PHIPA* permits this kind of activity in certain
95 circumstances.

96 For example, a custodian may permit its agents to use PHI without consent for limited
97 secondary purposes. These purposes include:

98 - Education, such as where cases are reviewed with trainees and/or presented during
99 rounds (though keep in mind that PHI should not be used where other non-identifying
100 information will meet the purpose); and
101 - Risk management, error management, and quality improvement, such as where patient
102 outcomes are reviewed to evaluate the effectiveness of personal practice or programs.

103 If your custodian permits its agents (physicians) to access PHI for these purposes, you can do so
104 without consent of the patient to meet the purpose, subject to any restrictions or conditions
105 imposed by the custodian. If your custodian has not expressly permitted its agents to access PHI
106 for these purposes, you may not do so. You should therefore exercise caution and determine
107 whether you have proper authority to access a patient's PHI in these situations – and when in
108 doubt, check with your custodian to find out if you are permitted to do so.

109 If you are a custodian, *PHIPA* also permits you to disclose a patient's PHI to certain other
110 custodians where:

111 - you and the other custodian have both provided health care to the same patient; and
112 - you are disclosing the PHI to improve or maintain the quality of care you have provided
113 to that patient or to other patients receiving similar health care.

114 These rules permit custodians to discuss with each other the treatment and outcomes of care
115 they have provided to a patient. For further information you may wish to refer to s. 39(1)(d) of
116 *PHIPA*.

117 In any of the above circumstances, keep in mind that accessing information about a patient's
118 condition or outcome simply out of interest is *never* permitted under *PHIPA*.

119 ***What do I do if non-emergency treatment cannot be safely provided because of the existence***
120 ***of a lockbox?***

121 Where safe care cannot be provided due to the existence of a lockbox, the patient must be told
122 the reason why they cannot receive (or continue to receive) the care and treatment they seek.
123 The purpose of this discussion is to promote clear communication between the patient and

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124 physician, and to ensure that the patient has an informed understanding of the implications of
125 their decision to create the lockbox. This conversation may also provide an opportunity to
126 revisit the existence of the lockbox with the patient and to seek their express consent to access
127 the locked information for the purpose of the treatment.

128 Permitted and Required Disclosures

129 ***In what situations am I permitted to disclose PHI without consent?***

130 In some circumstances, *PHIPA* permits physicians to disclose PHI without consent. These
131 include disclosures relating to:

132 - **Assisting in a police investigation.** You are advised to consult legal counsel and/or the
133 CMPA in these circumstances.
134 - **Eliminating or reducing significant risk of serious harm** to a person or group of persons.
135 You are advised to document all activities in this respect in the patient's medical record.
136 - **Facilitating health care under exceptional circumstances**. If the disclosure is reasonably
137 necessary for the provision of health care and it is not reasonably possible to obtain the
138 patient's consent in a timely manner – for example, in an emergency situation where
139 the patient is not capable of consenting and an SDM is not readily available – you are
140 permitted to disclose relevant information to other physicians and certain other health
141 professionals.
142 - **Reporting physician (or other health care provider) incapacity and incompetence**,
143 where this is appropriate in the circumstances.
144 - **Regulating the medical profession**. You are permitted to disclose PHI to the CPSO for
145 the purpose of administering and enforcing the *RHPA, 1991*, including carrying out
146 regulatory duties such as investigations and assessments.
147 - **A proceeding or contemplated proceeding** in which you or your hospital is, or is
148 expected to be, a party or witness.

149 This list is not exhaustive; please refer to sections 38-50 of *PHIPA* and the CPSO's *Mandatory*
150 *and Permissive Reporting* policy for further information.

151 ***In what situations am I required to disclose PHI without consent?***

152 In some circumstances, you are required by the law to disclose a patient's PHI, regardless of
153 whether the patient consents. While not an exhaustive list, the following examples provide an
154 overview of the circumstances you might encounter most frequently:

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- **Mandatory reports** listed in the CPSO's policy on *Mandatory and Permissive Reporting*, including reports of suspected impaired driving ability under the *Highway Traffic Act* and reports to the Ontario Coroner under the *Vital Statistics Act* and the *Coroners Act*.
- **Disclosures required by the Ministry of Health and Long-Term Care** in order to monitor or verify claims for payment for health care, or for goods used for health care that are funded by the Ministry.
- **Reports required by the Workplace Safety and Insurance Board** in circumstances where health care is being provided to a worker claiming benefits under their workplace insurance plan.
- **Critical incident reports**, as required by the "Hospital Management" regulation[4] under the *Public Hospitals Act*.
- **Search warrants** (which grant the police broad authority to search for and seize evidence, including records) and **court summons** (which may require you to attend court with specific documents or materials). In these cases, you are advised to consult legal counsel and/or the CMPA, including their resources on physician interactions with police.

What do I do in the event of a privacy breach?

A "privacy breach" refers to a theft, loss, or unauthorized access, use, or disclosure of PHI that contravenes *PHIPA*. Reporting privacy breaches is the responsibility of custodians. In particular, custodians are required to notify the affected individuals of a privacy breach at the first reasonable opportunity. This notice is required by *PHIPA* to include a statement that the individual is entitled to make a complaint to the IPC under Part VI of PHIPA. Custodians are also required to report certain privacy breaches to the IPC, including where:

- PHI was stolen, lost or used or disclosed without authorization;
- there is reason to believe, after an initial privacy breach, that the PHI will be further used or disclosed without authorization;
- the breach is part of a pattern;
- the breach relates to a disciplinary action against a health profession college or non-college member; or
- the breach is significant, having regard to the circumstances, including the sensitivity, volume, and scope of the PHI involved.

In addition to notification of individual privacy breaches, custodians also required by *PHIPA* regulation to track and annually report to the IPC the number of times PHI was stolen, lost, or accessed, used, or disclosed without authorization in the previous calendar year. The annual

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[4] R.R.O. 1990, Reg. 965.

189 reporting requirement applies to all breaches, not just those that meet the above criteria for
190 individual notice.

191 For further information about privacy breaches, and what to include in notices and the annual
192 report to the IPC, see the CPSO's *Mandatory and Permissive Reporting* policy, the IPC
193 document *Responding to a Health Privacy Breach: Guidelines for the Health Sector*, and the
194 *PHIPA* and its regulation.

195 Requests for Information from Third Parties: Friends, Family, and Research

196 This section deals with requests for patient information from third parties. In all of the following
197 scenarios, the general rules under *PHIPA* apply: unless otherwise permitted or required by law,
198 PHI can only be shared with third parties with the express consent of the patient.

199 ***What do I do if a friend or family member, who is not the patient's SDM, requests access to***
200 ***the patient's medical information or records?***

201 It is not uncommon for physicians to be asked by a family member or friend about the condition
202 of a patient or for information about the patient's health, and these situations can be
203 challenging to manage. Where you cannot obtain the patient's consent to disclose their PHI,
204 you may be permitted to do so by law where the disclosure is required to:

205 • contact a relative, friend, or potential SDM if the patient is injured, incapacitated, or ill
206 and unable to give consent personally; or
207 • eliminate or reduce a significant risk of serious bodily harm to a person or group of
208 persons, including the patient.

209 In addition, where the patient is deceased, *PHIPA* allows you to disclose PHI in order to:

210 • identify the patient;
211 • advise of the patient's death and the circumstances of death; and
212 • provide information that relates to the patient where it is needed by a spouse, partner,
213 sibling, or child to make health care decisions.

214 When managing a request for information from family or friends, use your professional
215 judgment and limit disclosure about the patient's state of health unless one of the above
216 circumstances applies.

217 ***What do I do if a child patient's parent or a third party requests access to the patient's PHI?***

218 There may be instances where you are asked to disclose PHI to a patient's parents or a third
219 party, like a lawyer or mediator, including in situations where the parents have separated or

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divorced. Regardless of the parents' marital status, you must first consider whether consent must be obtained directly from the child patient. *PHIPA* presumes that individuals aged 16 and older are capable of consenting to the collection, use, or disclosure of their PHI, but the test for capacity is not strictly age-dependent: if the information relates to a treatment decision the child patient has made, you must obtain consent from the patient directly, even if they are accompanied by parent(s) or guardian(s).

If parental consent is needed, the parents' marital status will inform whether either parent may consent or if the consent of both parents is required. A family court order or the terms of a separation agreement may specify who has access to, and may make decisions about, the child's PHI. It is best practice to request a copy of the applicable court order or separation agreement prior to releasing any information, and to keep it in the patient's medical record.

Finally, *PHIPA* states that where the child patient under age 16 is capable of consenting to the collection, use or disclosure of their PHI, their decision will govern over a conflicting decision of their parent or guardian.

How do I manage a request for PHI in the context of couple, family, or group therapy?

Where therapy is being provided in a group setting, the express consent obtained from the patients will generally set out how their PHI will be shared amongst the therapy participants. However, special considerations may apply where PHI is recorded as part of an assessment of an individual patient within a group therapy context, or where a patient receives a combination of individual and group therapy. Be mindful that the patient may not have consented to sharing this specific PHI with the group and that you may need to protect it accordingly.

Where a third party (e.g. a mediator, lawyer, or the court) requests records relating to couple, family, or group therapy, the general *PHIPA* rule applies: you may not disclose PHI without patient consent unless permitted or required to so by law. In a therapy setting involving more than one patient, consent may be required from all the patients involved in the therapy, and the consent will need to be specific to the material requested.

Can I use PHI for research purposes?

Physicians sometimes undertake research using their own patients as participants. In other cases, they are requested by industry to identify eligible patients or to release general patient data for research that will be conducted by third party researchers.

PHI must only be used or disclosed for research purposes with patient consent or as permitted by law – that is, where the research ethics board that has approved the research has concluded that it is impractical to obtain patient consent and proper safeguards have been put in place.

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253 Where PHI will be used or disclosed (either with consent or as permitted by *PHIPA*), you are
254 reminded to only use or disclose as little PHI as possible to meet the research needs and to de-
255 identify the PHI whenever possible or required.

256 For further information see the CPSO's *Physicians' Relationships with Industry: Practice,*
257 *Education and Research* policy.

258 ***What are my obligations as an Independent Medical Examiner (IME)?***

259 An IME is a physician who provides a third party report about an individual with whom the
260 physician does not have a treating relationship. These reports are prepared for a third party
261 process (e.g. a legal proceeding), instead of for a health care purpose, and the information
262 collected in the course of an independent report is not considered PHI. The provisions of PHIPA
263 therefore do not apply; instead, the federal Personal Information Protection and Electronic
264 Documents Act will apply to the collection, use, and disclosure of personal information for this
265 purpose. Given that different rules govern the preparation of third party reports and the
266 conduct of a medical expert, please see the CPSO's *Third Party Reports* and *Medical Expert:*
267 *Reports and Testimony* policies for further information.

268 e-Communication

269 ***What are the benefits and risks of e-communication?***

270 Technology has provided physicians and patients alike with a more efficient way of maintaining
271 and communicating PHI. The CPSO recognizes and encourages physicians to capitalize on the
272 advantages that electronic record-keeping and e-communications have to offer.

273 At the same time, one of the major risks of using modern technology to communicate PHI is
274 that the PHI will be inadvertently disclosed to someone who should not have it. This can
275 happen in a variety of ways:

276 • Wifi networks and telemedicine communications can be unsecure (particularly free wifi
277 networks in public places);
278 • Emails can be sent to the wrong recipient or otherwise intercepted;
279 • Unauthorized readers can access computer files;
280 • Mobile devices can be lost or stolen; and
281 • Erased hard drives or USBs can contain private information.

282 Keep these risks in mind when considering whether e-communication is appropriate in the
283 particular circumstance.

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284 ***Where can I find more information about how to interpret and apply the expectations***
285 ***relating to strong passwords and encryption?***

286 The IPC provides guidance regarding the meaning of "strong passwords" and "strong
287 encryption", including in their documents titled *Safeguarding Privacy on Mobile Devices*
288 and *Health-Care Requirement for Strong Encryption*.

289 ***What are "reasonable security safeguards" in relation to e-communication?***

290 Reasonable security safeguards can refer to a range technical, physical, and administrative
291 measures, including policies, practices, and software, that collectively serve to protect PHI
292 when it is communicated electronically between physicians (or between physicians and
293 patients). There is no precise definition of a "reasonable security safeguard"; the kind of
294 safeguards that will be reasonable in the circumstances will depend on a variety of factors,
295 including the sensitivity of the PHI being communicated, the volume and frequency of the
296 communications, and whether there is an emergency or other urgent circumstances.

297 The IPC provides examples of technical, physical, and administrative safeguards in its Fact
298 Sheet: Communicating Personal Health Information by Email (September 2016).

299 ***What considerations apply when I wish to communicate electronically with patients?***

300 As noted in the policy, you must obtain and document the patient's express consent prior to
301 communicating electronically with patients. As a way of recording the patient's express
302 consent, you are advised to consult the written consent form template prepared by the CMPA.

303 You must also use your professional judgment to determine whether this form of
304 communication is appropriate in the particular circumstance and for the contemplated use. In
305 making this determination, you are advised to consider:

306 a. the degree of sensitivity of the PHI being conveyed;
307 b. the frequency of communication;
308 c. the purpose of the communication;
309 d. the patient's expectations;
310 e. the availability of alternative methods of communication; and
311 f. any time-sensitive or emergency considerations.

312 Ultimately, e-communication may be best suited for minor tasks, such as scheduling
313 appointments and appointment reminders, and not for urgent messages or time-sensitive
314 health issues.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: ***Medical Records*** **– Draft Policies for Consultation**

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The College engage in the consultation process in respect of the draft policies “Medical Records Stewardship” and “Medical Records Documentation” (a copy of which forms Appendix “ ” and “ ” to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: Medical Records – Draft Policies for Consultation

FOR DECISION

ISSUE:

- The College's *Medical Records* policy is currently under review. Two new draft policies entitled *Medical Records Stewardship* and *Medical Records Documentation* have been developed along with two companion *Advice to the Profession* documents.
- Council is provided with an overview of the policy review process undertaken to date and is asked to approve the draft policies for external consultation.

BACKGROUND:

- The current *Medical Records* policy sets out how medical records must be kept and contains expectations regarding the content of medical records. It was last reviewed in 2012.
- A Working Group was struck to undertake the policy review, consisting of Judith Plante (Chair), Robert Gratton, and Akbar Panju, with support from Lindsay Cader (Legal Counsel) and Angela Carol (Medical Advisor).
- The following has been undertaken in accordance with the usual policy review process:
    - Preliminary research was conducted;[1]
    - A consultation on the current policy was held in the fall of 2017;[2]
    - Relevant decisions of the Inquiries, Complaints, and Reports Committee were reviewed;
    - Feedback was obtained from departments that rely on the policy (e.g., Physician and Public Advisory Services and QA/QI (e.g., peer assessment)).
- Relevant findings and themes from the research and the preliminary consultation are provided below, as key additions and revisions are outlined.

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[1] Research included a jurisdictional scan and a review of scholarly articles and research papers, with a focus on digital health and electronic record-keeping.

[2] The College received a total of 58 responses to this consultation which included 17 comments on the College's online discussion page and 41 online surveys. An overview of the feedback was provided to Council in December 2017 as part of the Policy Report.

CURRENT STATUS:

- The current policy has been re-organized and divided into two, newly titled, draft policies which cover distinct topics related to medical records:
  - *Medical Records Stewardship* **(Appendix A)** sets out expectations related to the care, handling and management of medical records, particularly related to access and transfer, security and storage, and retention and destruction of records. In response to consultation feedback[3], the draft distinguishes between expectations that apply to all physicians and those that only apply to physicians who are custodians of the record.
  - *Medical Records Documentation* **(Appendix B)** sets out expectations related to *how* and *what* to document in medical records. The draft focuses on foundational principles for documenting the patient encounter (i.e., legibility, accuracy, comprehensiveness and timeliness) and the required content of all records.[4]
- In keeping with the policy redesign strategy, the drafts have been developed with a focus on clarity, directness, and brevity, and now exclusively use “must” in setting out expectations.
- Though the drafts address the majority of the substantive topics found in the current policy, along with some additional topics, the drafts have achieved a 63% reduction in word count. This is a result of evaluating existing content, moving contextual detail and recommendations into the advice documents, and removing duplicative expectations captured in other College policies.[5]
- Key additions and revisions made to the draft policies are outlined below.

A. Key Additions and Revisions: *Medical Records Stewardship* Draft Policy

<u>*Establishing Custodianship and Accountabilities*</u>

- In response to frequent complaints, disputes, and ambiguity regarding ownership of records, particularly in settings with a shared EMR, the draft policy includes the following:

[3] This feedback was received from both the Ontario Medical Association and OntarioMD.
[4] Other jurisdictions, such as Alberta, have taken a similar approach and have separate record-keeping standards to address these distinct topics.
[5] For example, expectations related to disclosure of personal health information, which are now captured in the draft *Protecting Personal Health Information* policy and medical records when a physician closes a practice (e.g., ceases to practice), which are now captured in the revised draft *Closing a Medical Practice* policy.

- A revised expectation that requires physicians who practise in settings with multiple contributors to a record-keeping system to have written agreements that set out custodianship and clear accountabilities for records (provision #2).
- A new expectation that reflects privacy legislation requiring physicians who are not the custodian of the record and who leave a group practice, to obtain patient consent to transfer the records of patients who are following them (provision #5).
- A new expectation that physicians must not allow conflicts over records to impact patient care (provision #6).

Refusing Access to Medical Records

- Expectations regarding physicians' legal obligations when they refuse access to records have been included in the draft. In particular, the requirement to notify patients in writing and to inform patients of their right to make a complaint to the IPC (provision #9).[6]

Timely Transfer of Records

- The College receives a number of questions about reasonable timelines for the transfer of records. The current policy suggests that transfer should take place in a timely fashion. The draft has been updated to align with *PHIPA* and now requires physicians to transfer copies of records in a timely manner, urgently if necessary, but no later than 30 days after a request (provision #13).[7,8]

Fees for Records

- In response to frequent complaints regarding excessive fees for copies of records and feedback that the policy should clarify and strengthen expectations regarding fees,[9] the draft policy contains new expectations that are consistent with the *Uninsured Services: Billing and Block Fees* policy. For example, the draft now requires physicians to consider the patient's ability to pay, when determining a reasonable fee (provision #19).[10]

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[6] The current policy acknowledges the patient's right to make a complaint to the IPC but not the physician's obligation to inform the patient of this right.

[7] Physicians are required under s. 54(2) of the *Personal Health Information Protection Act* (*PHIPA)* to respond to requests of records transfer as soon as possible, but no later than 30 days of the request. *PHIPA* also sets out provisions for expedited access and extensions.

[8] The policy additionally states that *what is timely will depend on whether there is any risk to the patient if there is a delay in transferring the records (e.g., exposure to any adverse clinical outcomes)*.

[9] For example, the Ontario Trial Lawyers' Association provided this feedback.

[10] The current policy *encourages* physicians to consider the patient's ability to pay.

Electronic Medical Records

- The majority of Ontario physicians maintain electronic medical records. As such, the draft policy includes new provisions for electronic record-keeping, particularly to address issues that have come to the College's attention through its regulatory activities:
    - In response to physicians sharing their EMR passwords and unauthorized access to electronic medical records that results, the draft policy prohibits physicians from sharing their credentials or passwords (provision #28b). This is consistent with the legal requirement for an audit trail and that all entries are identifiable.
    - In response to physicians using "homegrown" electronic record-keeping systems, the draft requires physicians to only use certified EMRs, unless they can independently verify that an unaccredited EMR meets privacy and security standards set out in *PHIPA* and the Regulation[11] (provision #32).
    - In response to a number of physicians being unable to navigate their EMRs during peer assessments, a new provision requires physicians to be proficient with their electronic record-keeping system in order to meet legislative and regulatory requirements and participate in regulatory processes (provision #33).12
    - The maintenance of dual record-keeping systems (i.e., both paper and electronic records) was identified in the feedback and research as being problematic (e.g., incomplete and disorganized records). In response, the draft requires setting an official date for the use of the new (electronic) system (i.e., a "go live date") and only documenting in that system from the official date onward (provisions 38 and 39).

B. Key Additions and Revisions: *Medical Records Documentation* Draft Policy

How to Document

- In an era of greater transparency (e.g., patient portals) and consistent with other regulators, the draft policy now requires documentation to be professional and non-judgmental, in accordance with the *Professional Obligations and Human Righ*ts policy (provision #1f).[13]
- In response to concerns about inaccurate records resulting from the inappropriate use of the cut and paste function, the draft policy sets out a new provision that physicians'

[11] Ontario Regulation 114/94, General, Section 20, made under the *Medicine Act, 1991*, S.O. 1991, c.30 (General Regulation under the *Medicine Act*).
[12] This expectation reflects a *Dialogue* article that was developed in response to this issue.
[13] The Medical Council of New Zealand, Medical Board of Australia, College of Occupational Therapists of Ontario, and College of Nurses of Ontario all set out expectations for appropriate comments in medical records (e.g., non-judgmental).

documentation must be unique to each patient encounter and provides refraining from inappropriate use of cut and paste as an example of what is meant by this expectation (provision #1e).

What to Document

- Consistent with other jurisdictions (e.g., Alberta) and with aim to focus on broadly applicable core requirements, the draft no longer sets out separate requirements for different specialties (i.e., family physicians and consultants/procedural medicine).

    - For example, appendices which provide recommendations for documenting specific encounters are no longer captured in the draft policy (i.e., specific record-keeping recommendations for psychotherapy, counseling, etc.).[14]

    - Additionally, content relating to discharges, referral requests, and consultation reports has been removed as these issues are being addressed in the revised draft *Transitions in Care* policy. Recommendations for documenting operative and procedural notes are now captured in the advice document.

- The current policy requires family physicians to maintain a Cumulative Patient Profile (CPP)[15] and strongly recommends this practice for specialists. The draft retains the requirement for primary care physicians and now requires all other physicians to use their professional judgment to determine whether to include a CPP, or equivalent health summary, considering factors such as the nature of the relationship and care being provided and whether this would reasonably contribute to quality care (provisions #7 and 8).

- Consistent with regulation[16] and the goal to increase accuracy and clarity of documentation the draft policy requires physicians to record *both* the date of the patient encounter and the date of documentation, where the dates differ (provision #3).

- To promote appropriate and comprehensive documentation, the draft requires physicians to use their professional judgment to determine whether to document discussions with others involved in the patient's care (e.g., telephone, email), giving consideration to factors such as whether the discussion informed treatment decisions (provision # 12).

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[14] The majority of survey respondents indicated that they do not refer to the policy appendices.
[15] A summary of essential information about a patient that includes critical elements of the patient's medical history and allows the treating physician, and other health care professionals using the medical record, to quickly get a picture of the patient's overall health.
[16] Documenting the date of the professional encounter is a requirement under Section 18 of the General Regulation under the *Medicine Act*; Section 19(2) of the Hospital Management Regulation under the *Public Hospitals Act* requires each entry in a medical record to indicate the date on which it was made.

C. Draft *Advice to the Profession* Documents

- The draft *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. While these documents are provided for Council's review and feedback and will be distributed as part of the consultation, they are intended to be nimble communications tools which do not require Council approval in the same way a policy requires approval.

- The draft companion advice document for the *Medical Records Stewardship* policy **(Appendix C)** provides general advice on issues including, the roles and obligations of custodians and agents, resources to assist with transitioning record-keeping systems, the value of using certified EMRs, best practices regarding privacy and security, guidance to help physicians set fees for patient chart reviews, and issues relating to retention.

- The draft companion advice document for the *Medical Records Documentation* policy **(Appendix D)** provides general advice on issues including, documenting using the SOAP format, what to include in operative and procedural notes, best practices for documenting chronic conditions, and guidance for the maintenance of CPPs in walk-in clinics.

NEXT STEPS:

- Subject to Council's approval, a consultation will be held following the September 2019 meeting of Council. Feedback received through the consultation will be shared at a future Council meeting and used to further refine the drafts.

DECISION FOR COUNCIL:

1. Does Council approve the draft policies for external consultation?

Contact: Tanya Terzis, Ext. 545

Date: August 30, 2019

Attachments:
Appendix A: Draft *Medical Records Stewardship* policy
Appendix B: Draft *Medical Records Documentation* policy
Appendix C: Draft *Advice to the Profession: Medical Records Stewardship*
Appendix D: Draft *Advice to the Profession: Medical Records Documentation*

1 # Medical Records Stewardship

2 *Policies* of the College of Physicians and Surgeons of Ontario (the "College") set out expectations for the
3 professional conduct of physicians practising in Ontario. Together with the *Practice Guide* and relevant
4 legislation and case law, they will be used by the College and its Committees when considering physician
5 practice or conduct.
6 Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations. When
7 'advised' is used, it indicates that physicians can use reasonable discretion when applying this
8 expectation to practice.
9
10 ## Definitions
11 **Stewardship:** For the purposes of this policy, stewardship refers to the care, handling, and
12 management of medical records.

13 ## Policy

14 1. Whether in paper or electronic format, physicians **must** comply with all relevant legislation[1]
15 and regulatory requirements related to medical record-keeping.

16 ### Establishing Custodianship and Accountabilities

17 2. Physicians who practise in a setting where there are multiple contributors to a record-
18 keeping system (e.g., a group or interdisciplinary practice, settings with a shared electronic
19 medical record (EMR)) **must** have a written agreement that establishes custodianship and
20 clear accountabilities regarding medical records stewardship.[2]
21
22 3. Physicians **must** ensure their agreements:
23
24 a. are in place prior to the establishment of the group practice, business arrangement,
25 or employment, or as soon as possible afterward;
26 b. comply with the *Personal Health Information Protection Act, 2004* (*PHIPA*) and with
27 the expectations set out in this policy; and

[1] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*); Part V of the General, O. Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act*, General Regulation); General, O. Reg., 57/92, enacted under the *Independent Health Facilities Act*, R.S.O.1990, c.1.3 (hereinafter *IHFA,* General Regulation); Hospital Management, Regulation 965, enacted under the *Public Hospitals Act*, R.S.O. 1990, c.P.40 (*Public Hospitals Act,* Hospital Management Regulation).
[2] Section 14(1) of the *Public Hospitals Act* sets out that patient medical records compiled in a hospital are the property of the hospital. For the purposes of this policy, the provisions set out in the *Public Hospitals Act*, along with the terms of a physician's hospital privileges can serve as the official agreement for physicians who work in hospitals.

28 c. address custody and control of medical records, including upon termination of
29 employment or the practice arrangement.[3]
30
31 4. Physicians with custody or control of records **must** give all former partners and associates
32 reasonable access to their patient medical records to allow them to prepare medico-legal
33 reports, defend legal actions, or respond to an investigation, when necessary.[4]
34
35 5. In accordance with *PHIPA*, in instances where a physician is moving to a new practice
36 location and does not have custody or control of the medical records of patients who
37 choose to follow them to the new practice location, the physician **must** obtain patient
38 consent to transfer copies of the records to the new location.
39
40 6. If there is a conflict regarding medical records custody or control, physicians **must not** allow
41 the conflict to compromise patient care.

42 Access and Transfer of Medical Records

43 *Access to Medical Records*

44 7. Physicians **must** provide patients and authorized parties[5] with access to, or copies of, all the
45 medical records in their custody or control upon request, unless an exception applies.[6]
46
47 8. Physicians **must** provide patients and authorized parties with explanations of any term,
48 code, or abbreviation used in the medical record, upon request.[7]
49
50 9. Where an exception applies and access is refused, physicians **must** inform the individual in
51 writing of the following:
52
53 a. the fact of the refusal;
54 b. the reason for the refusal; and

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[3] The Canadian Medical Protective Association's (CMPA) *Electronic Records Handbook* has additional advice for establishing such agreements.
[4] *PHIPA*, s. 41(1).
[5] Authorized parties include substitute decision-makers and estate trustees/executors of the estate where applicable, and third parties where consent has been obtained.
[6] *PHIPA*, s. 52; Section 52 of *PHIPA* contains a comprehensive list of the exceptions. There are also separate provisions for access to information related to an Independent Medical Exam. The CMPA's article, *Providing access to independent medical examinations* sets out advice on this issue.
[7] *PHIPA*, s. 54(1)(a).

55 c. the right of the patient to make a complaint to the Information and Privacy
56 Commissioner.[8]
57
58 10. Where physicians rely on an external facility or organization to retain records, such as a
59 commercial storage provider, diagnostic facility, or clinic, physicians **must** ensure that
60 access to records is possible when necessary.

61 ***Transferring Copies of Medical Records***

62 11. Physicians **must** retain original medical records for the time period required by the
63 Regulation (see *Medical Records Retention* below) and only transfer copies to others.
64
65 12. Physicians **must** only transfer copies where they have consent or are permitted or required
66 by law to do so.[9]
67
68 13. Physicians **must** transfer copies of medical records in a timely manner, urgently if necessary,
69 but no later than 30 days after a request.[10] What is timely will depend on whether there is
70 any risk to the patient if there is a delay in transferring the records (e.g., exposure to any
71 adverse clinical outcomes).
72
73 14. In some cases a summary or partial copy of the medical records may be preferred. Where
74 physicians opt to provide a summary or a partial copy of the medical record rather than a
75 copy of the entire record, physicians **must** ensure this is acceptable to the receiving
76 physician and/or the patient.
77
78 15. Physicians **must** transfer copies of medical records in a secure manner[11] and document the
79 date and method of transfer in the medical record.

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[8] *PHIPA,* s. 54(1)(c).

[9] For more information regarding disclosure, please refer to the College's *Protecting Personal Health Information* policy.

[10] *PHIPA*, s. 54(2). Physicians are required under *PHIPA* to respond to requests of records transfer as soon as possible, but no later than 30 days of the request. Sections 54(3) and 54(5) of *PHIPA* set out provisions for circumstances requiring expedited access and an extension.

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

80 ***Fees for Copies and Transfer of Medical Records*** [12]

81 16. Fulfilling a request for copying and transferring records is an uninsured service. As such,
82 physicians are entitled to charge patients, or third parties, a fee for obtaining a copy or
83 summary of their medical record. In doing so, physicians **must**:
84
85 a. provide a fee estimate prior to providing copies or summaries;[13] and
86 b. only charge fees that are reasonable.
87
88 17. When determining what is reasonable to charge, physicians **must** ensure that fees:
89
90 a. do not exceed the amount of "reasonable cost recovery";[14] and
91 b. are commensurate with the nature of the service provided and their professional
92 costs (i.e., reflect the cost of the materials used, the time required to prepare the
93 material and the direct cost of sending the material to the requesting individual).[15]
94
95 18. As part of determining a reasonable fee, physicians **must** consider the recommended fees
96 set out in the Ontario Medical Association's *Physician's Guide to Uninsured Services* ("the
97 OMA Guide")[16,17] and the applicable orders of the Information and Privacy Commissioner.[18]
98
99 19. Physicians **must** additionally consider the patient's ability to pay when determining a
100 reasonable fee.[19] In particular, physicians **must** consider the financial burden that these
101 fees might place on the patient and consider whether it would be appropriate to reduce,
102 waive, or allow for flexibility with respect to fees based on compassionate grounds.
103

[12] This requirement applies regardless of whether access is provided directly by a physician or an agent of the physician, such as a records storage company.
[13] *PHIPA*, s. 54(10).
[14] *PHIPA*, s. 54(11).
[15] In accordance with s. 1(1), paragraph 21 of O.Reg. 856/93 *Professional Misconduct*, enacted under the *Medicine Act, 1991* S.O. 1991. C.30 it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided.
[16]The OMA Guide is typically updated annually, and so physicians must ensure they have reviewed the most recent edition.
[17] While physicians are not obliged to adopt the recommended fees set out in the OMA Guide, in accordance with s. 1(1) paragraph 22 of the *Professional Misconduct Regulation*, it is an act of professional misconduct to charge more than the current recommended fees in the OMA Guide without first notifying the patient of the excess amount that will be charged.
[18] See Information and Privacy Commissioner orders HO-009 and HO-14.
[19] The Canadian Medical Association Code of Ethics #16 states that "In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient."

104 20. Physicians may take action to collect any fees owed to them, but **must not** put patients'
105 health and safety at risk by delaying the transfer of records until payment has been
106 received.[20]

107 ## Retention and Destruction

108 ### *Medical Records Retention*[21,22]

109 21. Even where records are copied and transferred, physicians **must** retain medical records in
110 their custody or control for the following time periods:
111
112 a. *Adult patients:* 10 years from the date of the last entry in the record.
113 b. *Patients who are children:* 10 years after the day on which the patient reached or
114 would have reached 18 years of age.[23,24]

115 ### *Destruction of Medical Records*

116 22. Physicians **must** only destroy medical records once their obligation to retain the record has
117 come to an end.
118
119 23. When destroying medical records, physicians **must** do so in a secure and confidential
120 manner[25] such that the reconstruction of the record is not reasonably foreseeable in the
121 circumstances. As such, physicians **must**, where applicable:
122
123 a. cross-shred all paper medical records;
124 b. permanently delete electronic records from all hard drives[26] and storage devices by
125 crushing or wiping clean with a commercial disk wiping utility; and
126 c. destroy any back-up copies of records.[27]

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[20] For additional guidance on fees please refer to the College's *Uninsured Services: Billing and Block Fees* policy.
[21] Retention requirements apply equally to records for patients that are living and deceased.
[22] Physicians who cease to practise family medicine or primary care have specific retention requirements under the law. For obligations related to medical records for physicians who cease to practice, see the College's *Closing a Medical Practice* policy. Hospitals have separate retention schedules for diagnostic imaging records set out in s. 20(4) of the *Public Hospitals Act*, Hospital Management Regulation. Independent health facilities have separate retention schedules for patient health records set out in s. 11(1) of the *IHFA,* General Regulation.
[23] *Medicine Act,* General Regulation, s. 19(1).
[24] Physicians are advised that s. 15(2) in the *Limitations Act*, *2002* allows for some legal proceedings to be brought forward 15 years after the act or omission on which the claim is based took place and thus may wish to retain records for longer than the 10 year requirement.
[25] *PHIPA*, s. 13(1).
[26] Where it is not possible to permanently delete records from the hard drive, the entire hard drive must be destroyed.
[27] For further information, consult the IPC's Fact Sheet #10 – *Secure Destruction of Personal Information*.

127 ## Storage and Security

128 ***Storage***

129 24. Physicians **must** ensure medical records in their custody or control are stored in a safe and
130 secure environment and in a way that ensures their integrity and confidentiality, including:
131
132 a. taking reasonable steps to protect records from theft, loss and unauthorized access,
133 use or disclosure, including copying, modification or disposal;[28]
134 b. keeping all medical records in restricted access areas or in locked filing cabinets to
135 protect against unauthorized access, loss of information and damage;
136 c. backing-up electronic records on a routine basis[29] and storing back-up copies in a
137 secure environment separate from where the original data is stored.
138
139 25. Where physicians choose to store medical records content that is no longer relevant to a
140 patient's current care separately from the rest of the medical record[30], physicians **must**
141 include a notation in the record indicating that documents have been removed from the
142 chart and the location where they have been stored.
143
144 26. Physicians **must** ensure medical records are readily available and producible when access is
145 required.

146 ***Security***[31]

147 27. Physicians with custody or control of medical records **must** have records management
148 protocols that regulate who may gain access to the medical records in their custody or
149 control and what they may do according to their role, responsibilities, and the authority
150 they have.[32]

---

[28] *PHIPA*, s. 12(1). What is reasonable in terms of records management protocols will depend on the threats and risks to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to an identifiable individual.
[29] The CMPA suggests daily or weekly back-ups be considered. The CMPA provides risk management advice regarding back-up and recovery practices for EMR systems in its *Electronic Records Handbook*.
[30] In accordance with section 14(2) of *PHIPA* and the retention requirements set out in the regulation and this policy.
[31] For expectations related to privacy breaches please refer to the College's *Mandatory and Permissive Reporting* policy.
[32] Records management protocols include both physical and logical access controls. Physical access controls are physical safeguards intended to limit persons from entering or observing areas of the physician's office that contain confidential health information or elements of an EMR system. Logical access controls are system features that limit the information users can access, modifications they can make, and applications they can run. Examples of the latter include the use of "lockboxes" and "masking" options to restrict access to personal health information at patient request.

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151 28. Accordingly, where an electronic record-keeping system is used:
152
153 a. physicians **must** ensure their systems are equipped with user identification and
154 passwords for logging on; and
155 b. physicians **must not** share their credentials or passwords.

156 29. Physicians with custody or control of medical records **must** ensure that:
157
158 a. all individuals who have access to medical records are bound by appropriate
159 confidentiality agreements; and
160 b. data sharing agreements incorporating the requirements in this policy are
161 established for all individuals who will have access to or who will be sharing patient
162 health information with one another.[33]

163
Electronic Records

164 ***System Requirements***

165 30. Physicians **must** only use electronic record-keeping systems (e.g., EMRs) that comply with
166 regulation.[34] In particular, physicians **must** only use electronic systems that:
167
168 a. Provide a visual display of the recorded information;
169 b. Provide a means of access to the record of each patient by the patient's name and,
170 if the patient has an Ontario health number, by the health number;
171 c. Are capable of printing the recorded information promptly;
172 d. Are capable of visually displaying and printing the recorded information for each
173 patient in chronological order;
174 e. Include a password or otherwise provide reasonable protection against
175 unauthorized access;
176 f. Maintain an audit trail (a record of who has accessed the electronic record) that:
177 i. records the date and time of each entry of information for each patient,
178 ii. indicates any changes in the recorded information,
179 iii. preserves the original content of the recorded information when changed
180 or updated, and
181 iv. is capable of being printed separately from the recorded information for
182 each patient;

[33] The CMPA's *Electronic Records Handbook* contains advice related to data sharing principles for Electronic Medical Record/Electronic Health Record agreements.
[34] *Medicine Act*, General Regulation, s. 20.

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183 g. Automatically back up files and allow the recovery of backed-up files or otherwise
184 provide reasonable protection against loss of, damage to, and inaccessibility of,
185 information.
186
187 31. Physicians **must** only use electronic record-keeping systems that are capable of capturing all
188 pertinent personal health information and allow the authorized user to access patient
189 information in an efficient manner.
190
191 32. Physicians **must** only use certified electronic record-keeping systems (e.g., EMRs) unless
192 they can independently verify that an unaccredited system meets the privacy and security
193 standards required by *PHIPA* and the standards set out in the Regulation.[35,36]
194
195 33. Physicians **must** be proficient with their electronic record-keeping system in order to:
196
197 a. meet the requirements for record-keeping set out in relevant legislation and this
198 policy; and
199 b. participate in all regulatory processes (e.g., College investigations and assessments).

200 ***Transitioning Records Management Systems***[37]

201 34. When transitioning from one record-keeping system to another, (i.e., a paper-based to
202 electronic system, or from one electronic system to another) physicians **must**:
203
204 a. maintain continuity and quality of patient care;
205 b. continue appropriate record-keeping practices without interruption;
206 c. protect the privacy of patients' personal health information; and
207 d. maintain the integrity of the data in the medical record.
208
209 35. To ensure integrity of the medical records, physicians who are transitioning from one
210 record-keeping system to another **must** have a quality assurance process in place that
211 includes:
212
213 a. written procedures that are developed and consistently followed; and
214 b. verification that the entire medical record has remained intact upon conversion
215 (e.g., comparing scanned copies to originals to ensure that they have been properly

[35] OntarioMD and Canada Health Infoway provide certification for privacy and security.
[36] *Medicine Act*, General Regulation, s. 20.
[37] For additional guidance related to transitioning record-keeping systems please refer to the companion Advice to the Profession document.

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216 scanned or converted).
217
218 36. Physicians who opt to destroy their original paper medical records once they have been
219 converted into digital format **must**:
220
221 a. use appropriate safeguards to ensure reliability of digital copies;
222 b. save scanned copies in “read-only” format; and
223 c. destroy medical records in accordance with the expectations set out in this policy.
224
225 37. Physicians who use voice recognition software or Optical Character Recognition (OCR)
226 technology to convert records into searchable, editable files **must** retain either the original
227 record or a scanned copy for the retention periods set out above.
228
229 38. So that complete and up to date information is contained in one central location, physicians
230 with custody or control of records **must:**
231
232 a. set a date whereby the new (electronic) system becomes the official record; and
233 b. inform all health care professionals who would reasonably be expected to
234 contribute or rely on the record, of this date.
235
236 39. Physicians **must** only document in the new system from the official date onward.

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1 # Medical Records Documentation

2 *Policies* of the College of Physicians and Surgeons of Ontario (the "College") set out expectations
3 for the professional conduct of physicians practising in Ontario. Together with the *Practice*
4 *Guide* and relevant legislation and case law, they will be used by the College and its Committees
5 when considering physician practice or conduct.
6 Within policies, the terms 'must' and 'advised' are used to articulate the College's expectations.
7 When 'advised' is used, it indicates that physicians can use reasonable discretion when applying
8 this expectation to practice.

9 ## Definitions

10 **Cumulative Patient Profile (CPP) or equivalent patient health summary:** A summary of
11 essential information about a patient that includes critical elements of the patient's medical
12 history and allows the treating physician, and other health care professionals using the medical
13 record, to quickly get a picture of the patient's overall health.

14 ## Policy

15 ### Documenting the Patient Encounter

16 1. Physicians **must** comply with all relevant legislation[1] and regulatory requirements related to
17 medical record-keeping.
18
19 2. The goal of the medical record is to "tell the story" of the patient's health care journey. As
20 such, physicians' documentation in the medical record **must** be:
21
22 a. legible;[2]
23 b. understandable to health care professionals reading the record, including avoiding
24 the use of abbreviations that are known to have more than one meaning in a clinical
25 setting;
26 c. accurate;
27 d. complete and comprehensive, containing:
28 i. all relevant information;
29 ii. information that conveys the patient's health status and concerns;

---

[1] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*); Part V of the General, O. Reg., 114/94, enacted under *the Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act*, General Regulation); General, O. Reg., 57/92, enacted under the *Independent Health Facilities Act*, R.S.O.1990, c.1.3 (hereinafter *IHFA,* General Regulation); Hospital Management, Regulation 965 enacted under the *Public Hospitals Act*, R.S.O. 1990, c.P.40 (hereinafter *Public Hospitals Act*, Hospital Management Regulation). *Health Insurance Act*, R.S.O.1990, c. H.6.

[2] *Medicine Act,* General Regulation, s. 18(3).

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30 iii. any pertinent details that may be useful to the physician or future health care
31 professionals who may see the patient or review the medical record; and
32 iv. documentation that supports the treatment or procedure provided;
33 e. unique to each patient encounter (e.g., refraining from inappropriate use of cut and
34 paste);
35 f. professional and non-judgmental, in accordance with the College's *Professional*
36 *Obligations and Human Rights* policy;
37 g. identifiable and contain a signature or audit trail that identifies the author;
38 h. written in either English or French; and
39 i. organized in a chronological and systematic manner.
40
41 3. Physicians **must** date each entry in the medical record. Where the date of the patient
42 encounter differs from the date of documentation, physicians **must** record both dates.[3]

43 ***Documentation on the physician's behalf***

44 4. In circumstances where an entry is made on the physician's behalf, physicians **must** ensure
45 that the expectations set out in this policy are met.[4]

46 ***Timing of Documentation***

47 5. To support the safe delivery of care, physicians **must** document their patient encounters as
48 soon as possible.

49 ***Use of Templates***

50 6. In keeping with the requirements of accuracy and completeness set out in 2(c) and 2(d)
51 above, physicians **must**:
52
53 a. avoid the use of templates that are pre-populated, where possible;
54 b. refrain from using overly general templates;
55 c. only use templates that allow entry of free-text or that can be customized to allow
56 for greater descriptive detail; and
57 d. verify that the entries populated using a template accurately reflect the encounter
58 and that all pertinent details about the patient's health status have been captured.

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[3] Documenting the date of the professional encounter is a requirement under s. 18 made of the *Medicine Act,* General Regulation; s. 19(2) of the *Public Hospitals Act,* Hospital Management Regulation requires each entry in a medical record to indicate the date on which it was made.

[4] There are circumstances where a physician's records are transcribed on the physician's behalf. In these circumstances the notation "dictated but not read" is often used to signify that that the physician has not yet reviewed the transcription for accuracy. The Canadian Medical Protective Association's article*"Dictated but not read": Unreviewed clinical record entries may pose risks* sets out advice on how to mitigate risks when dictating medical record entries or reports.

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What to Document: Medical Records Content

CPP or Equivalent Patient Health Summary

7. Primary care physicians **must** include an easily accessible, up to date CPP, or an equivalent patient health summary, in each patient medical record.

8. All other physicians **must** use their professional judgement to determine whether to include a CPP or an equivalent patient health summary in each patient medical record, considering a variety of factors, such as the nature of the physician-patient relationship (e.g., whether it is a sustained physician-patient relationship[5]), the nature of the care being provided, and whether the CPP or equivalent summary would reasonably contribute to quality care.

9. Physicians **must** capture in the CPP or equivalent summary, the following, where applicable:[6]

   a. patient identification (i.e., name, address, phone number, date of birth, OHIP number);
   b. personal and family data (e.g., occupation, life events, habits, family medical history);
   c. past medical history (e.g., past serious illnesses, operations, accidents, genetic history);
   d. risk factors;
   e. allergies and drug reactions;
   f. ongoing health conditions (e.g., problems, diagnoses, date of onset);
   g. health maintenance (e.g., periodic health exams, immunizations, disease surveillance);
   h. names of any consultants involved in the patient's care;
   i. long-term management needs (e.g., current medication, dosage, frequency);
   j. major investigations;
   k. date the CPP was last updated; and
   l. contact person in case of emergencies.

Clinical Notes

10. Physicians **must** document evidence of the following for all patient encounters:

[5] A sustained physician-patient relationship is physician-patient relationship where care is actively managed over multiple encounters.
[6] There may be variations in content and format of the CPP or equivalent patient health summary based on the physician's practice area and the nature of the physician-patient relationship (i.e., whether there is a sustained physician-patient relationship).

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91 a. a focused relevant history;
92 b. an assessment and an appropriate focused physical exam (where indicated);
93 c. a diagnosis and/or differential diagnosis (where indicated); and
94 d. a management and follow-up plan.
95
96 11. Physicians **must** capture the following in each patient medical record:
97
98 a. any prescriptions issued in accordance with the College's *Prescribing Drugs* policy;
99 b. informed consent in accordance with the College's *Consent to Treatment* policy and
100 any consents to treatment obtained in writing;
101 c. all tests, referrals, and consultations requisitioned, including a copy of the referral
102 note, and any associated reports and results;[7]
103 d. any treatments, investigations, or referrals that have been declined or deferred, and
104 the reason, if any, given by the patient;
105 e. any operative and procedural records;[8] and
106 f. any discharge summaries.[9]
107
108 12. Physicians **must** use their professional judgement in determining whether to document the
109 details of discussions with other health care professionals involved in the patient's care (e.g.,
110 by telephone, email, etc.), considering factors such as whether the discussion informed the
111 care and treatment of the patient.

112 ***Telephone and Electronic Communications with Patients***

113 13. Physicians **must** capture in the medical record (e.g., document or upload, where relevant)
114 details of all communication with patients where health information about the patient is
115 collected and exchanged (e.g., including via telephone, e-mail,[10] patient portals or other
116 digital platforms) similar to any other patient encounter.

117 **Corrections to Medical Records**

118 Where electronic medical record-keeping systems are used, audit trails achieve the expectations
119 set out in provision 14 below.
120

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[7] For additional guidance regarding information that must be contained in a referral note and consultation report, please refer to the College's *Transitions in Care* policy.
[8] Guidance for documenting operative and procedural notes is set out in the *Advice to the Profession* document.
[9] Sections 19(4) and 19(5) of the *Public Hospitals Act*, Hospital Management Regulation set out a number of additional requirements for documentation in a hospital setting. Physicians who practise in hospitals are advised to refer to the legislation for information about the specific requirements.
[10] For expectations related to e-mail communications with patients please refer to the College's *Protecting Personal Health Information* policy.

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121 14. In accordance with the *Personal Health Information Protection Act, 2004*, in instances where
122 it is necessary to modify a medical record to ensure accuracy and completeness, physicians
123 **must** date and initial the additions or changes and either:
124
125 a. remove and store the incorrect information separately and ensure there is a notation
126 in the record that allows for the incorrect information to be traced; or
127 b. maintain the incorrect information in the record but clearly label it as incorrect, and
128 ensure the information remains legible (e.g., by striking through incorrect
129 information with a single line).[11]
130
131 15. Where a patient requests a correction to the medical record but the physician feels it is
132 unwarranted, the physician **must** act in accordance with *PHIPA*, including**:**
133
134 a. giving the reasons for the refusal;
135 b. informing the patient that they are entitled to prepare a statement of disagreement
136 that sets out the correction; and
137 c. attaching the statement of disagreement to the medical record, upon request.[12]

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[11] *PHIPA,* s. 55(10).
[12] *PHIPA*, s. 55(11). For additional requirements pertaining to corrections, please refer to s. 55 of *PHIPA*.

Advice to the Profession: Medical Records Stewardship

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.

A number of aspects of healthcare have transformed over time including the increase in collaborative care models and the increased use of digital health. With respect to medical record-keeping, the widespread adoption of electronic medical records (EMRs) has particularly changed the way that medical records are used and managed. Navigating the stewardship of medical records can be a complex and daunting task for physicians, particularly in this era of digital health where there may be questions about ownership and accountabilities. This companion Advice document is intended to help physicians interpret their obligations as set out in the *Medical Records Stewardship* policy and provide guidance around how these expectations may be effectively discharged. This advice is also intended to help physicians navigate their roles and responsibilities and provide links to resources on best practices.

Roles and Obligations Regarding Medical Records

The Medical Records Stewardship policy sets out expectations for physicians with custody or control of their records (i.e., the custodian of the records) and expectations for physicians more broadly (all physicians). Aren't physicians always the custodians of their patient medical records? How do I determine what my role and responsibilities are regarding medical records?

Physicians are not always the custodians of their patient medical records. Physicians will either be the custodian of their medical records or an agent of the custodian. These roles and their corresponding obligations are set out in the *Personal Health Information Protection Act, 2004* (*PHIPA)*.

A *health information custodian* (custodian) refers to a person or organization who has custody or control over personal health information (PHI) as a result of, or in connection with, their duties or work.[1] The custodian is generally the individual or organization responsible for maintaining patient medical records and ensuring obligations regarding medical records are met. Examples of scenarios where physicians may be the custodians of their records include physicians who are the owners of a clinic, or a physician who works as a sole practitioner in their own practice.

[1] "Health information custodian" is defined at s. 3(1) of the *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*).

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34 An *agent* refers to individuals granted permission by a custodian to act on their behalf and
35 handle personal health information, as required by their duties.[2] Physicians working as
36 employees or working in hospitals are examples of physicians who may be acting as agents. In
37 these scenarios the custodian might be the hospital, clinic, or owner of a clinic, including
38 someone who is not a health care professional.

39 Roles, responsibilities and rights to medical records are generally determined by *PHIPA* and the
40 agreements physicians enter into upon employment or establishment of a practice. Written
41 agreements help to ensure clarity regarding custodianship.

42 ***The Medical Records Stewardship policy requires physicians who work in settings where there***
43 ***are multiple contributors to a record-keeping system (e.g., a group or interdisciplinary***
44 ***practice, settings with a shared EMR) to have written agreements that address medical***
45 ***records custody and clear accountabilities regarding medical records stewardship. Why do I***
46 ***have to do this?***

47 The move away from a sole practitioner model of care and increased use of electronic records
48 has resulted in some ambiguity about physicians' roles and responsibilities regarding their
49 patient medical records, particularly where there is a common or shared EMR system.
50 Questions or conflicts related to ownership, responsibilities and rights of access often arise
51 when a physician leaves a group practice or practice environment involving a shared EMR, and
52 there is no written agreement in place regarding records. To avoid conflicts related to medical
53 records and to ensure compliance with medical records obligations, physicians must have
54 written agreements that address these issues, and ensure agreements are in place prior to the
55 establishment of the group practice, business arrangement, or employment, or as soon as
56 possible afterward.[3]

57 ***What if I am concerned that the custodian of my patient medical records is not acting in***
58 ***accordance with applicable legislation and the expectations of the Medical Records***
59 ***Stewardship policy?***

60 Physicians who are not the custodians of their patient medical records may feel they have
61 limited control over the record-keeping system or procedures where they practise. Where
62 physicians are concerned that the facility's record-keeping practices do not meet the
63 requirements of the *Medical Records Stewardship* policy, or there are disputes about records,
64 physicians are advised to seek legal advice and may wish to consult the Canadian Medical

[2] "Agent" is defined at s. 2 of *PHIPA.*

[3] The Canadian Medical Protective Association's *Electronic Records Handbook* has additional advice for establishing such agreements.

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65 Protective Association (CMPA). As required by the *Medical Records Stewardship* policy,
66 physicians must not allow disputes about records to impact patient care. Written agreements
67 regarding medical records responsibilities can help physicians resolve conflicts that may arise
68 and provide assurance that the expectations of the policy are being met.

69 Transitioning to an (other) electronic record-keeping system

70 ***What should I consider when deciding which EMR vendor to choose?***

71 Choosing an EMR vendor is a crucial step in the process of transitioning to electronic records
72 and warrants careful attention and due diligence. Physicians are not necessarily experts in
73 technology and may need assistance in evaluating and choosing the appropriate vendor.
74 Physicians are encouraged to seek support from OntarioMD to determine the appropriate
75 system for their practice needs.

76 EMR systems vary in terms of capabilities, space requirements to accommodate hardware, data
77 storage capacity, and degree of control over the data within the EMR and the functions it can
78 perform. When making a choice about an EMR, it is important to consider the type of system
79 that best meets a physician's unique practice needs, including the following:

80 • objectives they hope to achieve with an EMR,
81 • the functions they require within their EMR,
82 • requirements set out in policy and legislation,
83 • privacy and security functions of the software,
84 • advice from colleagues or experienced EMR users about the advantages and
85 disadvantages of particular systems,
86 • the support and training offered by the EMR vendor,
87 • the stability of the company to provide continued support for the foreseeable future,
88 and
89 • vendor policies about software upgrades and data access provisions in case of a
90 departure from a physician group.

91 Physicians are encouraged to seek legal review of contracts with EMR vendors prior to entering
92 into any agreements with vendors.

93 ***What are some resources to help me transition to an (other) EMR system?***

94 The *Medical Records Stewardship* policy sets out expectations for physicians when transitioning
95 to a new record-keeping system to ensure security and integrity of records, and that quality
96 care is maintained during the transition. Transitioning to an EMR, or to a new EMR, can be a
97 daunting, time consuming, and expensive process for physicians but is ultimately intended to

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98 enhance the physician's practice. Physicians seeking additional guidance related to transitioning
99 systems are encouraged to refer to the following resources:

100 1) Information and Privacy Commissioner of Ontario's (IPC's) *A Practical Tool for*
101 *Physicians Transitioning from Paper-Based Records to Electronic Health Records*
102 *2)* CMPA's *Electronic Records Handbook*
103 3) OntarioMD's *EMR Data Migration Guide for Community Care Practices*
104 4) OntarioMD's *Transition Support Guide*

105 Using Certified EMRs

106 ***I am required by the Medical Records Stewardship policy to only use electronic record-keeping***
107 ***systems (e.g., EMRs) that are certified unless I can independently verify that an unaccredited***
108 ***system meets the privacy and security standards required by PHIPA and the standards set out***
109 ***in the Regulation.***[4] ***Why is this necessary and how can I determine which EMRs are certified?***

110 Physicians may not be experts in information technology or security and thus they may rely on
111 vendors to ensure their EMRs are secure. Certification of EMRs offers assurances to physicians
112 that their systems meet privacy and security standards that they would otherwise have to verify
113 independently (i.e., logging user activity, role-based access controls).

114 There are two certification processes that can ensure privacy and security standards are met.
115 The provincial program is run by OntarioMD and the national program is run by Canada Health
116 Infoway. Physicians may wish to consult these organizations for a list of certified EMRs.

117 Maintaining Privacy and Security Standards

118 ***I am required to maintain privacy and security standards. Are there resources to help me***
119 ***navigate my obligations? What are some best practices when it comes to ensuring privacy***
120 ***and security of medical records?***

121 To ensure maintenance of privacy and security standards, physicians are advised to remain up-
122 to-date about evolving industry standards and to be aware of orders of the Information and
123 Privacy Commissioner of Ontario.[5]

124 Physicians with custody or control of their medical records are additionally advised to routinely
125 conduct privacy assessments, or audits, of all processes to maintain an understanding of the
126 privacy risks of their practice, particularly those related to their medical record-keeping
127 practices. The CMPA suggests that completing this process is especially prudent when

[4] Ontario Regulation 114/94, General, Section 20, made under the *Medicine Act, 1991*, S.O. 1991, c.30.
[5] Orders of the IPC can be found on the Commission's website at www.ipc.on.ca.

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128 transitioning medical record-keeping systems as it can help physicians identify and minimize the
129 risks associated with the implementation, or change, of an EMR system. For guidance on how
130 to conduct a privacy assessment, physicians may wish to consult the IPC's *Planning for Success:*
131 *Privacy Impact Assessment Guide*.

132 ***Is it appropriate to stay logged into an EMR?***

133 No. Physicians are required by the *Medical Records Stewardship* policy to ensure their
134 electronic record-keeping systems are equipped with user identification and passwords for
135 logging on and are prohibited from sharing their credentials or passwords. Physicians are also
136 required by the *Medical Records Documentation* policy to have identifiable entries. As such,
137 physicians are reminded of the importance of logging out after they are finished documenting
138 in an electronic medical records system.

139 ***The College requires that I be proficient with my electronic record-keeping system but I have***
140 ***just switched from paper records to an EMR and am still learning how to use my new system.***
141 ***Are there resources that can assist me in gaining proficiency?***

142 The College recognizes that becoming skilled with a new system may depend on a number of
143 factors and that it may take some physicians longer than others to do so. As such, physicians
144 are advised that there are resources that can assist them in gaining proficiency with their
145 system. For example, OntarioMD's Peer Leader program provides consulting services that can
146 help physicians become more efficient with their EMR, optimize their existing EMR functions,
147 and improve clinical decision support. For more information on the Peer Leader program
148 physicians may wish to consult OntarioMD's website.

149 Use of Commercial Services

150 ***What are my responsibilities when I engage commercial services to assist with managing my***
151 ***patient medical records?***

152 Physicians who are the custodians of their medical records are ultimately responsible for
153 ensuring that medical records are stored and maintained according to legal requirements and
154 the principles set out in the *Medical Records Stewardship* policy. It is important to know that
155 the same standards apply when physicians engage commercial providers for services such as
156 storage, maintenance, scanning, destruction, and other medical record-keeping related tasks.
157 As such, it is generally good practice to:

158 1) Use due diligence when selecting and engaging service providers;
159 2) Make any agreements with such providers in writing;

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3) Ensure agreements reflect the same legal and regulatory requirements that apply to physicians who have custody or control of records;
4) Seek legal counsel or contact the CMPA for advice in these circumstances.

Fees for Medical Records Review

Am I allowed to charge patients or third parties requesting copies of records for a review of records prior to transfer?

Yes. Physicians are entitled to charge a reasonable fee for copying and transferring patient medical records, which may require a review of the records prior to transfer. The *Medical Records Stewardship* policy sets out a number of considerations for determining a reasonable fee.

In keeping with the requirements set out in the policy, a charge for the review of records prior to provision must also be reasonable and commensurate with the professional service provided. Where records meet the requirements in the *Medical Records Stewardship* and *Medical Records Documentation* policies, an extensive review would rarely be necessary. When charging for a review of records prior to transfer, the fees should be justifiable and reflect the nature and reason for the review.

Medical Records Retention

Should I maintain my medical records for longer than the period required by the Regulation?

A provision in the *Limitations Act*, *2002* allows for some legal proceedings against physicians to be brought forward 15 years after the act or omission on which the claim is based took place. As a result, notwithstanding the 10 year retention requirements set out in regulation and reflected in the College's *Medical Records Stewardship* policy[6], physicians are advised to consider maintaining medical records for a minimum of 15 years from the date of the last entry in the record in order to ensure that physicians will be able to provide evidence should it be required in any future legal proceedings brought against them.

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[6] Section 19(1) of the General, O. Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 requires medical records to be retained for 10 years from the date of the last entry in the record for adult patients and 10 years after the day on which the patient reached or would have reached 18 years of age, for patients who are children.

Advice to the Profession: Medical Records Documentation

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 importance of good medical record-keeping

The medical record is a tool that supports each encounter patients have with the health professionals involved in their care. It allows physicians to track their patients' medical history and identify problems or patterns that may help determine the course of health care. The goal of the medical record is to "tell the story" of the patient's health care journey. Medical records can take the form of a paper or electronic record.

Medical records serve many roles in health care. Not only does good medical record-keeping contribute to quality patient care and continuity of care but medical records can also serve a number of other purposes. For instance:

- Optimizing the use of resources, (e.g., by reducing duplication of services);
- Providing essential information for a wide variety of purposes, including:
  - billing,
  - research,
  - investigations (by the Coroner's Office, or the College),
  - legal proceedings,
  - insurance claims; and
- Serving as a valuable tool for self-assessment by allowing physicians to reflect on and assess the care they have provided to patients (i.e., through patterns of care recorded in the electronic medical record (EMR)).

This document is a companion document to the College's *Medical Records Documentation* policy and provides guidance with respect to how to satisfy the expectations set out in the policy as well as best practices for documenting specific patient encounters.

Subjective Objective Assessment Plan (SOAP)

Is there a specific format I should use to document my patient encounters?

One of the most widely recommended methods for documenting a patient encounter is the Subjective Objective Assessment Plan (SOAP) format. The SOAP format is a structured method for documenting the patient encounter. While other documentation methods are acceptable,

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33 using this format will ensure the obligations set out in the *Medical Records Documentation*
34 policy are satisfied. Considerations for aspects of care that would be captured by each element
35 of SOAP are set out below.

36 **Subjective Data:** The subjective elements of the patient encounter are those which are
37 expressed by the patient (e.g., patient reports of nausea, pain, tingling). This includes the
38 following, where applicable:

39 • Presenting complaint and associated functional inquiry, including the severity and
40 duration of symptoms;
41 • Whether this is a new concern or an ongoing/recurring problem;
42 • Changes in the patient's progress or health status since the last visit;
43 • Review of medications, if appropriate;
44 • Review of allergies, if applicable;
45 • Past medical history of the patient and their family, where relevant to the presenting
46 problem;
47 • Patient risk factors, if appropriate;
48 • Salient negative responses.

49 **Objective Data**: Objective data are the measurable elements of the patient encounter and any
50 relevant physical findings from the patient exam or tests previously conducted are documented
51 in this section. This includes the following, where applicable:

52 • Physical examination appropriate to the presenting complaint;
53 • Positive physical findings;
54 • Significant negative physical findings as they relate to the problem;
55 • Relevant vital signs;
56 • Review of consultation reports, if available;
57 • Review of laboratory and procedure results, if available.

58 **Assessment**: The assessment is the physician's impression of the patient's health issue. This
59 includes the following, where applicable:

60 • Diagnosis and/or differential diagnosis.

61 **Plan:** The physician's plan for managing the patient's condition includes the following, where
62 applicable:

63 • Discussion of management options;
64 • Details of consent, in accordance with the College's *Consent to Treatment* policy;
65 • Tests or procedures ordered and explanation of significant complications, if relevant;

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66 • Consultation requests including the reason for the referral, if relevant;
67 • New medications ordered and/or prescription repeats including dosage, frequency,
68 duration and an explanation of potentially serious adverse effects;
69 • Any other patient advice or patient education (e.g., diet or exercise instructions,
70 contraceptive advice);
71 • Follow-up and future considerations;
72 • Specific concerns regarding the patient, including any decision by the patient not to
73 follow the physician's recommendations.

74 ## Record-keeping for Specific Types of Encounters

75 The expectations set out in the *Medical Records Documentation* policy apply to all physicians,
76 however the College recognizes that a physician's practice area and the nature of the physician-
77 patient relationship (e.g., whether it is a sustained relationship) will influence the type of
78 records and documentation maintained by each physician. As required by the *Medical Records*
79 *Documentation* policy, documentation in a medical record must always support the treatment
80 or procedure that takes place. Advice for documenting operative and procedural notes is set
81 out below.

82 ***What should I include in an operative note?***

83 In general, a typical operative note will include the following:

84 • Name of the patient and the appropriate identifiers such as birth date, OHIP
85 number, address, and hospital identification number if applicable;
86 • Name of the family physician (and referring health professional if different from the
87 family physician);
88 • Operative procedure performed;
89 • Details of consent, in accordance with the College's *Consent to Treatment* policy;
90 • Date and time on which the procedure took place;
91 • Name of the primary surgeon and assistants;
92 • Name of the anaesthetist (if applicable) and type of anaesthetic used (general, local,
93 sedation);
94 • Pre-operative and post-operative diagnoses (if applicable); and
95 • A detailed outline of the procedure performed, including:
96 o administration of any medications or antibiotics,
97 o patient positioning,
98 o intra-operative findings,
99 o prostheses or drains left in at the close of the case,

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100 - complications including blood loss or need for blood transfusion,
101 - review of sponge and instrument count (i.e., a statement of its correctness at
102 the conclusion of the case), and
103 - patient status at the conclusion of the case (stable and sent to recovery room
104 vs. remained intubated and transferred to ICU).
105 • Any required follow-up.

106 ***What should I include in a diagnostic or interventional procedural note?***

107 In general, a typical diagnostic or interventional procedural note will include the following:

108 • Name of the patient and the appropriate identifiers such as birth date, OHIP
109 number, address, and hospital identification number if applicable;
110 • Name of the family physician (and referring health professional if different from the
111 family physician);
112 • Procedure performed;
113 • Details of consent, in accordance with the College's *Consent to Treatment* policy;
114 • Date and time on which the procedure took place;
115 • Name of the physician performing the procedure and assistants if applicable;
116 • Name of the anaesthetist if applicable and type of anaesthetic used (general, local,
117 sedation); and
118 • A detailed outline of the procedure performed including:
119 - administration of any medications,
120 - complications,
121 - findings, and
122 - recommendations based on the findings if applicable; and
123 • Any required follow-up.

124 Physicians are required by the *Medical Records Documentation* policy to document their
125 patient encounters in a timely manner. In keeping with this requirement, physicians are advised
126 to dictate or transcribe operative and procedural notes on the day on which the procedure took
127 place, or where this is not feasible, as soon as possible after the procedure.

128 ***How should I document chronic conditions? Are there additional tools that can help me with***
129 ***this documentation?***

130 Flow sheets are a record-keeping tool that can assist physicians in documenting and tracking
131 important clinical information over time. They are often used to track chronic conditions and
132 deal only with one disease (e.g., diabetes mellitus). There are a number of benefits to the use of
133 flow sheets and thus their use is considered a best practice for treating patients with chronic

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134 conditions. Flow sheets permit physicians to easily see trends, which enhances their ability to
135 identify the appropriate treatment, easily retrieve information, and support continuity of care.

136 ***If I work in a walk-in clinic do I need to maintain a Cumulative Patient Profile[1] (CPP) for each***
137 ***patient?***

138 The *Medical Records Documentation* policy requires primary care physicians to include an easily
139 accessible, up to date CPP or an equivalent patient health summary in each patient medical
140 record and requires all other physicians to use their professional judgement to determine
141 whether to include one. The policy sets out considerations for determining whether a CPP is
142 required. For example, the nature of the physician-patient relationship (e.g., whether it is a
143 sustained physician-patient relationship), the nature of the care being provided, and whether
144 the CPP or an equivalent summary would reasonably contribute to quality care.

145 Physicians who practise in walk-in clinics should evaluate whether a CPP is required for a given
146 patient. For example, the more often or more complex care that is being provided, the more
147 likely a CPP would be necessary to facilitate quality care.

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[1] A summary of essential information about a patient that includes critical elements of the patient's medical history and allows the treating physician, and other health care professionals using the medical record, to quickly get a picture of the patient's overall health.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: ***Continuity of Care*** **– Revised Policies for Final Approval**

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The Council approves:

(a) The policy "Availability and Coverage" (a copy of which forms Appendix " " to the minutes of this meeting);
(b) The revised policy "Managing Tests", formerly titled "Test Results Management", (a copy of which forms Appendix " " to the minutes of this meeting);
(c) The policy "Transitions in Care" (a copy of which forms Appendix " " to the minutes of this meeting); and
(d) The policy "Walk-in Clinics" (a copy of which forms Appendix " " to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: ***Continuity of Care* – Revised Policies for Final Approval**

FOR DECISION

ISSUE:

- In May 2018, Council released a set of draft *Continuity of Care* policies for an extended six-month external consultation.
- Following the consultation and significant stakeholder engagement, the *Continuity of Care Policy Working Group* has revised the draft policies in light of the feedback received.
- Council is provided with an overview of the revisions made and is asked whether the revised set of *Continuity of Care* policies can be approved as policies of the College.

BACKGROUND:

- Work to develop new policy content relating to *Continuity of Care* started following the May 2016 Council meeting. This work was undertaken in tandem with a review of the College's current *Test Results Management* policy which was identified as a key component of continuity of care.
- Given the scale and scope of the project, a *Continuity of Care Policy Working Group* was convened to oversee the policy development and review process.
    - The Working Group is comprised of Brenda Copps (Chair), Kevin Glasgow,[1] Barbara Lent, Peeter Poldre, Joan Powell, Ron Pratt, and David Rouselle and is supported by Keith Hay (Medical Advisor), Alice Cranker (Legal Counsel), and policy staff.
- A comprehensive process was undertaken in order to develop the new *Continuity of Care* policy content and to update the current *Test Results Management* policy.
    - This included a comprehensive literature review, external consultations, College staff engagement, two public opinion polls, stakeholder presentations to the Working Group, and a discussion session with Council.

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[1] Dr. Glasgow is a College Assessor with expertise in walk-in clinics.

- This work culminated in the development of a set of *Continuity of Care* companion policies dealing with distinct but inter-related issues and organized under an ‘umbrella’ *Continuity of Care* policy which set out core principles and expectations. The companion policies were: *Availability and Coverage*; *Managing Tests*; *Transitions in Care*; and *Walk-in Clinics*.

- In May 2016, Council approved the draft policies for external consultation and in response to a request from the Ontario Medical Association (OMA), Council directed that the consultation period be extended from the usual 60 days to 6 months to allow for appropriate engagement on this important initiative.

- More information on the genesis of this project and the policy review and development process can be found in the May 2018 Council materials.

CURRENT STATUS:

- Following Council’s approval, the draft policies were released for external consultation and 680 responses[2] were received as part of the consultation. Ongoing updates regarding the feedback received were provided to Council as part of the Policy Report in Council Materials, including in the March 2019 Council materials.
    - In brief, while elements of the draft policies received support from many respondents, a general theme that emerged in the feedback was the concern that the expectations would unduly burden individual physicians, requiring them to provide solutions to broader system level issues.
    - Respondents often offered more moderate steps physicians could take to help address continuity of care issues.

- In addition to the external consultation, many additional engagement activities were undertaken during this period.
    - *OMA Engagement*: Multiple meetings with the OMA occurred to identify areas of agreement and areas of practical concern, including a presentation of their feedback directly to the Working Group.
    - *Citizen Advisory Group*: The Citizen Advisory Group[3] was engaged to help identify key priority issues among patients and caregivers and to seek feedback on what constitutes reasonable expectations for physicians.

[2] 257 written responses and 423 survey responses
[3] The Citizen Advisory Group is comprised of patients and caregivers from across the province and used by a partnership of health regulatory Colleges in Ontario in order to help bring the patient voice and perspective to health-care regulation in the province.

- *Stakeholder Summits*: Two three hour forums were organized in order to engage a variety of stakeholder organizations, health-care providers, and patients in a discussion on key element of the draft policies.

- *Public Opinion Polling*: An additional survey of the general public was conducted in order to assess the public's expectations on key issues that were emerging in the consultation feedback (e.g., access by phone/voicemail, after-hours care, coverage for temporary absences, etc.).

- *Presentation to Leadership Groups*: Presentations were delivered to the Ontario Hospital Association's Provincial Physician Leadership Council and at the College's *Chiefs' and Presidents'* and *Future Leaders Day* events in order to solicit feedback and engage with key leaders in the field.

- In response to all of the feedback obtained through the consultation and activities listed above, the Working Group directed that a number of changes to the policies be made. An overview of specific and substantive changes that have been made to each policy is provided under the headings below.

- A number of changes were also made to the format, structure, and content of the policies due, in part, to the *Policy Redesign* process. Significant higher level or organizational changes that have been made include:

  - In line with the policy redesign process, the set of policies is now accompanied by a single *Advice to the Profession: Continuity of Care* document (**Appendix E)**.

  - In keeping with the policy redesign process, the revised policies contain only mandatory expectations. All permissive expectations contained in the draft policies have been eliminated, repurposed as general guidance in the *Advice* document, or, in rare instances, modified and reframed as a mandatory expectation.

  - The draft 'umbrella' policy has been eliminated with important contextual or explanatory information being repurposed in the *Advice* document.

  - The commitment to develop a companion 'white paper' identifying and providing potential solutions for system-level issues has been de-prioritized. Instead, content has been added to the *Advice* document that highlights existing and potential changes to the system that would support continuity of care.

  - The development of a patient companion document is still underway and has been identified as an opportunity to support fulfillment of the new 'Meaningful Engagement' strategic priority. The option of co-designing this document with the Citizen Advisory Group is currently being explored.

Availability and Coverage

- The revised draft *Availability and Coverage* policy (**Appendix A**) retains the spirit and intention of the draft policy but has been updated to ensure the policy better reflects the realities of practice while still setting an appropriate minimum standard.

Phone and voicemail

- In response to feedback regarding the risks and potential burden associated with requiring physicians to allow voicemail messages to be left outside of operating hours, the revised policy has been narrowed to only require the voicemail option during business hours.

After-hours Care

- The draft policy included a requirement that physicians have a plan in place to coordinate patient care after-hours in order to minimize unnecessary visits to walk-in clinics or the ER.

- In response to feedback that this would unduly burden individual physicians and would be akin to requiring continuous access to care, the expectation has been revised to focus on informing patients about when and where to access appropriate care outside office hours.

Temporary Absences from Practice

- The draft policy requirement that physicians make coverage arrangements for patient care during temporary absences has been refined to require physicians to take "reasonable steps" (where what is reasonable depends on a variety of factors) to make coverage arrangements and to notify patients of appropriate access points to care if no arrangements can be made. This change was made in response to feedback that there are some instances where it simply will not be possible to arrange coverage.

- Following an additional jurisdictional comparison, the draft policy requirement to arrange coverage to ensure that test results are reviewed and that appropriate follow-up can occur during temporary absences has been refined to also apply to consultation reports that require immediate attention during the temporary absence.

Coverage for Critical Test Results

- The draft policy requirement that physicians ensure critical test results can be received and responded to 24 hours a day, 7 days a week has been revised to avoid giving the impression that physicians must be personally available to provide care at all times.

- Consistent with the position of the current *Test Results Management* policy and other jurisdictions across Canada, the revised draft policy expectation has been updated to clarify

that the expectation only applies to *critical test results* and that the intent is to enable the receipt and review of critical test results and appropriate communication to the patient when immediate emergency intervention is needed; not to provide patient care directly.

- Notably, the Ontario Association of Medical Laboratories (OAML) identified after-hours coverage for critical test results as an essential requirement and encouraged the College to strengthen our position to ensure that patients can be quickly and appropriately directed to emergency care when it is needed.

Managing Tests

- The revised draft *Managing Tests* policy (**Appendix B**) has been updated in number of ways in order to focus on the most essential elements of test results management.

Copying Primary Care Providers on Requisitions

- The draft policy requirement that primary care providers be copied on test requisitions has been removed. Stakeholder feedback, including from the OMA, identified concerns with this requirement including: increased administrative burden, increased 'noise' in a physician's practice, and unnecessarily sharing results outside a primary care provider's scope of practice.

Tracking Tests

- The current *Test Results Management* policy contains expectations in relation to tracking test results. These expectations were refined in the draft policy to provide clarity regarding what tracking involves (e.g., verifying the patient did the test) and when tracking must be done (i.e., for high-risk patients and for patients not at high-risk as professional judgment dictates).

- The draft requirements were viewed as unreasonably burdensome or practically difficult to operationalize by many, including the OMA, Canadian Medical Protective Association (CMPA), and Ontario College of Family Physicians (OCFP).

- Informed by the feedback received the policy was revised to eliminate the requirement to *verify* that the patient has done the test and align more closely with the language of the current *Test Results Management* policy.

'No News is Good News'

- The draft policy permitted the use of 'No News is Good News' practices in certain circumstances and provided that patients are given the option of calling in for their results.

- Feedback was divided, with many noting that 'No New is Good News' is an essential practice management tool and others, including a prominent patient advisor, calling for an outright elimination of this practice. The OMA and OCFP suggested that allowing patients to call in for results would be challenging for busy practice.

- Recognizing the need to strike a balance between practice management issues and patient access to their test results, as well as the importance of minimizing the potential for test results to be missed, the draft policy position has been retained in the revised draft. A small amendment was made to clarify that patients can also book an appointment to receive the results rather than call in.

Receiving Results in Error or Incidentally

- The draft policy set expectations regarding instances where physicians receive a test result in error or incidentally receive a result but have reason to believe the ordering physician did not or will not get the result. In each case, the draft policy required physicians to take positive steps to ensure the ordering physician, or patient, is notified of the result depending on the circumstances.

- Based on the feedback received, including from the OMA, OCFP and CMPA, and in consultation with the OAML the expectation for physicians who receive a result in error has been revised to require notifying only the laboratory who will then take responsibility for ensuring the result is communicated to the appropriate provider. Expectations regarding the incidental receipt of test results have been removed.

Transitions in Care

- While the core expectations of the draft have been retained in the revised draft *Transitions in Care* policy (**Appendix C**), a number of updates were made in response to practical challenges raised in the feedback or calls for more specific requirements.

Patient Handovers in Hospital

- The draft policy included 'advice' aimed to help support and better manage patient handovers in hospitals. Patient handovers were identified as a particular point of weakness by the Citizen Advisory Group, but respondents including the OMA felt that the draft expectations failed to recognize the plurality of ways in which handovers occur and system level factors that influence these practices.

- Given the importance of a good patient handover, the expectations were re-framed in terms of a 'must', but significant revisions were made that more clearly allow for flexibility while emphasizing the importance of a real-time and comprehensive patient handover where there is opportunity for the provider assuming responsibility to ask questions.

Hospital Discharges

- In response to feedback from the Ontario Hospital Association (OHA) revisions were made to clarify that the policy expectations regarding hospital discharges applied in the context of a discharge to home. These revisions align the policy with Health Quality Ontario's draft standard on the same issue.

- Given strong support for the draft requirement that physicians complete discharge summaries in a timely manner, and calls from the OHA, OCFP, and the Ontario Trial Lawyers Association to adopt a 48-hour (or shorter) timeline, the revised draft policy was amended to include a 48-hour completion requirement. Notably, the OMA felt that the College should avoid specific timelines and defer to hospital policies regarding this issue.

Planning for and Tracking Referrals

- The draft policy included expectations for referring physicians regarding the need or value of giving advance consideration to whether a referral is in scope for a consultant physician, whether the consultant is accepting patients, and whether the consultant's practice is accessible to the patient have all been removed in response to stakeholder feedback that these expectations, while worthy, were impractical and aspirational.

- The draft policy requirement to track all referrals has been amended to focus only on those referrals where urgent care is required to ensure the patient will get access to the care that is needed. Stakeholder feedback indicated that a broad requirement would be administratively burdensome and challenging to comply with.

Acknowledging Referrals

- The draft requirement that consultant physicians acknowledge a referral within 14 days has been retained. The OMA specifically called for the removal of this timeline, but the draft expectation otherwise received broad support from stakeholders. A minor revision was made to manage vacations, acknowledging that the 'clock starts' when physicians return from a temporary absence. While this revision will add an element of variability to the requirement, it was viewed as a necessary amendment to reflect the realities of practice.

- The draft expectations regarding providing recommendations for another provider when the consultant cannot accept the referral have been removed. Feedback suggested that consultants simply won't always have this information available, and so this content has been reframed as best practice and advice in the companion *Advice* document.

Communication of Appointment Information

- Feedback overwhelmingly indicated a need to revise the draft expectation that referring physicians communicate consultation appointment information with the patient. The revised draft policy has been updated to put the onus on the consultant physician.

Content of Discharge Summaries, Referral Requests, and Consultation Reports

- The draft policy included specific requirements regarding the content of discharge summaries, referral requests, and consultation reports. These positions were developed in response to early feedback that these types of documents are often incomplete and do not always support the intended purpose of these documents.

- In response to the draft policy, the OMA recommended allowing for more flexibility and framing the specific content in terms of advice or a recommendation.

- Ultimately, a revised approach was adopted that seeks to strike a balance between ensuring these documents fulfill their purpose, while recognizing that this can be done in a number of ways. In particular, the revised draft policy:

    - Requires that physicians provide the information needed to achieve the intended goal of the document (e.g., the information needed to understand the hospital admission, care that was provided, and post-discharge needs);
    - Requires physicians to use their judgment to determine what information to include; and
    - Identifies specific information that is *typically* contained in each.

Distributing Discharge Summaries and Consultation Reports

- Revisions were made to focus the distribution requirements for discharge summaries and consultation reports on only the most essential providers who need to receive the document, rather than trying to identify a broader set of individuals who may benefit from knowledge of the admission/consultation.

Walk-in Clinics

- The revised draft *Walk-in Clinics* policy (**Appendix D**) fundamentally retains the core elements of the draft policy; however, two substantive changes were made.

Information sharing with other health-care providers

- The draft policy included a requirement the physicians practising in a walk-in clinic send a record of each encounter to the patient's primary care provider (and others, as appropriate). Feedback received identified practical limitations and consequences to operationalizing this requirement (e.g., administrative burden, incomplete information, increased 'noise', privacy concerns).

- In response, the revised policy no longer requires that information sharing be done as a matter of course, but rather only where the patient has requested that this be done or

where it is a matter of patient safety. The revised draft policy also acknowledges that the record may need to be shared through the patient, rather than directly to the provider.

Providing comprehensive primary care to patients without a primary care provider

- The draft policy included a recommendation that physicians practising in walk-in clinics provide comprehensive primary care (to the extent possible) to patients who lack a primary care provider and routinely visit the same walk-in clinic for all their care needs.

- In keeping with the policy redesign process and in response to stakeholder feedback, this recommendation has been removed and framed as general advice in the companion *Advice* document.

CONSIDERATIONS:

- Typically, policies come into effect the same day they are approved by Council. The OMA has expressed concern regarding physicians' ability to comply with these policies upon approval as there are elements of the revised draft policies that may require physicians to modify how they manage their practice. As such, they have proposed that the College adopt a more gradual or phased in implementation approach that explicitly grants physicians a compliance 'grace' period.

- Many elements of the revised draft policies are already expectations of the College that have been refined or updated through this review process.

    - Most notably, the College's expectations set out in the current *Test Results Management* policy have, for the most part, been retained in the revised *Managing Tests* draft policy with relatively minor changes. Additionally, some expectations captured in the *Transitions in Care* policy are updates to expectations currently set out in the *Medical Records* policy.

- While it would not be appropriate to grant a grace period for these expectations, as the College already expects compliance, there are elements in the revised draft policies which may require physicians to change their practice.

- Recognizing this fact and responding to the OMA's request, a notice can be published on each policy indicating that physicians have 30 days from approval to align their practice with any of the new policy expectations.

NEXT STEPS:

- Should Council approve the revised draft policies, they will be announced in *Dialogue*, published on the College's website, and a broad communications strategy will be undertaken to promote awareness among the profession.

DECISION FOR COUNCIL:

1. Does Council approve the revised *Continuity of Care* draft policies as policies of the College?

Contact: Dr. Brenda Copps
Craig Roxborough, Ext. 339
Lynn Kirshin, Ext. 243

Date: August 30, 2019

Attachments:
Appendix A: Revised *Availability and Coverage* Policy
Appendix B: Revised *Managing Tests* Policy
Appendix C: Revised *Transitions in Care* Policy
Appendix D: Revised *Walk-in Clinics* Policy
Appendix E: *Continuity of Care: Advice to the Profession*

Availability and Coverage

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

Sustained physician-patient relationship: A physician-patient relationship where care is actively managed over multiple encounters.

Temporary leaves of absence: Vacations and leaves of absence (e.g., parental leave, educational leave),[1] as well as unplanned absences due to, for example, illness or family emergencies.

Policy

Being Available by Phone (or other means)

1. Physicians **must** have an office telephone that is answered and/or allows voicemails to be left during regular business hours.[2]

2. Physicians **must** ensure that the outgoing voicemail message is up to date and accurate, indicating, for example, office hours, any closures, and relevant information regarding coverage arrangements or access to appropriate care outside of regular office hours and during temporary absences from practice.

3. Physicians **must** ensure that voicemail messages are reviewed and responded to in a timely manner. What is timely will depend on, for example, when the message was left and the impact to patient safety that may be caused by a delay in responding.

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[1] This does not include suspensions of a physician's certificate of registration. For expectations relating to suspensions, please see the *Closing a Medical Practice* policy.
[2] In a group practice, institutional, or departmental setting, there may be a common phone and voicemail system shared among a number of physicians.

29 a. Physicians who offer electronic means of secure communication[3] **must** similarly
30 ensure that messages are reviewed and responded to in a timely manner.

31 ***Communicating with Other Health-Care Providers***

32 4. Physicians **must** respond in a timely manner when contacted by other physicians or health-
33 care providers who want to communicate or request information about a patient. What is
34 timely will depend on, for example, the impact to patient safety that may be caused by a
35 delay in responding.
36
37 5. Physicians **must** include their professional contact information when ordering a test, writing
38 a prescription, or making a referral[4] and **must** provide relevant coverage contact
39 information directly to other health-care providers (e.g., laboratories, diagnostic facilities)
40 where it is appropriate to do so.

41 ***Facilitating Access to Appointments***

42 6. Physicians providing care as part of a sustained physician-patient relationship **must**
43 structure their practice in a way that allows for timely access to appointments for urgent or
44 time-sensitive issues.

45 ***Supporting Access to Appropriate After-hours Patient Care***

46 7. Physicians providing care as part of a sustained physician-patient relationship **must** inform
47 patients of when and where to access appropriate care outside of regular office hours (e.g.,
48 Telehealth, local walk-in clinics, emergency department, any coverage arrangements that
49 have been made[5], etc.).[6]

50 ***Managing Care During Temporary Absences from Practice***

51 8. Physicians who will be unavailable during temporary absences from practice **must** make
52 specific coverage arrangements with another health-care provider(s) to:
53 a. Receive, review, and provide or coordinate immediate care that is required during
54 the temporary absence for all outstanding tests; and

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[3] For example, e-mail or a messaging portal. All communication must comply with privacy legislation, including, the *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3 Sched. A. (hereinafter, *PHIPA*).
[4] See the College's *Managing Tests*, *Prescribing Drugs*, and *Transitions in Care* policies for more information.
[5] This would include any after-hours or weekend coverage arrangements that are made as part of contractual agreements with the Ministry of Health and Long-Term Care.
[6] Provision 2 of this policy sets out expectations regarding the type of information that is appropriate to include on an outgoing voicemail message. Otherwise, the policy is not prescriptive about how physicians must inform patients and allows for flexibility.

55 b. Receive, review, and provide or coordinate immediate care that is required during
56 the temporary absence for outstanding consultation reports.
57
58 9. Physicians **must** also have a plan or coverage arrangement in place that allows other health-
59 care providers to communicate or request information pertaining to patients under their
60 care during temporary absences from practice.
61
62 10. Physicians providing care as part of a sustained physician-patient relationship **must** make
63 reasonable efforts to arrange for another health-care provider(s) to provide care to patients
64 during planned temporary absences from practice. What is reasonable will depend on, for
65 example, the length of the absence, the needs of the physicians' patients, and the health-
66 care provider and/or health system resources available in the community.
67 a. If specific arrangements are made, physicians **must** inform patients seeking care
68 during the temporary absence of these arrangements;[7] or
69 b. If after reasonable efforts are made it is not possible to make specific arrangements,
70 physicians **must** inform patients seeking care during the temporary absence about
71 appropriate alternative access points of care (e.g., Telehealth, local walk-in clinics,
72 emergency department, etc.).

73 ***Coordinating Coverage for Critical Test-Results***

74 11. Physicians **must** ensure that *critical test results*[8] can be received and reviewed at all times,
75 including outside of regular office hours and during temporary absences from practice, and
76 that appropriate steps can be taken to notify patients if immediate emergency intervention
77 is required.

[7] Again, provision 2 of this policy sets out expectations regarding the type of information that is appropriate to include on an outgoing voicemail message. Otherwise, the policy is not prescriptive about how physicians must inform patients and allows for flexibility. For example, staff could notify patients upon calling the office or in some instances physicians may elect to proactively inform patients depending on, for example, the nature and length of their leave.

[8] Critical test results are those that are of such a serious nature that immediate patient management decisions may be required. See the *Managing Tests* policy and the *Advice to the Profession* companion document for more information.

Managing Tests

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

Test Result: Includes results for tests performed at laboratories, diagnostic facilities (including imaging facilities), and in physicians’ offices, and also includes pathology results.

Critical Test Result: Results of such a serious nature that immediate patient management decisions may be required.[1]

Clinically Significant Test Result: A test result determined by a physician to be one which requires follow-up in a timely fashion, urgently if necessary. Physicians determine the clinical significance of a test result using their clinical judgment and knowledge of the patient’s symptoms, previous test results, and/or diagnosis.

Follow-up: Communication of the test result to the patient in an appropriate manner and taking appropriate clinical action in response to the test result.

Policy

Test Results Management System

1. In order to ensure appropriate follow-up on test results can occur, physicians **must** have an effective test results management system that enables them to:
    a. record all tests they order;
    b. record all test results received;
    c. record that all test results received by physicians have been reviewed;
    d. identify patients who have a high risk of receiving a clinically significant result, and critical and/or clinically significant test results; and
    e. record that a patient has been informed of any clinically significant test results and the details of the follow-up taken by the physician.

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[1] See the *Advice to the Profession* document for more information.

31 2. Physicians who are not responsible for choosing the test results management system **must**
32 be satisfied that the system in place has the capabilities listed above.

33 ***Tracking Tests***

34 3. For patients who have a high risk of receiving a clinically significant test result, physicians
35 **must** track their test results when they are not received when expected.[2]
36
37 4. For patients who are not at high risk of receiving a clinically test significant result, physicians
38 **must** use their professional judgment to determine whether to track a test result. In
39 making this determination, physicians **must** consider the following factors:
40 a. the nature of the test that was ordered,
41 b. the patient's current health status,
42 c. if the patient appears anxious or has expressed anxiety about the test, and
43 d. the significance of the potential result.
44
45 5. Physicians **must** either personally track test results or assign[3] this task to others.

46 ***Follow-up***

47 6. Ordering physicians **must** ensure that follow-up on test results received occurs in
48 accordance with provisions 7 through 17.
49
50 a. In certain health-care environments, the ordering physician may not be the same
51 physician who receives the test result (e.g., in an emergency department or a walk-
52 in clinic). In these situations, ordering physicians **must** either delegate, assign[4] or
53 otherwise ensure that there is another person that is responsible for coordinating
54 the follow-up or that there is a system in place to do so.

[2] Tracking could include following-up with a laboratory and/or diagnostic facility, or the patient to find out where the test result is.
[3] If the task does not include a controlled act, the physician would be assigning the task to the other person.
[4] If a task includes performance of a controlled act, then the physician may delegate it to another person. When delegating a controlled act, physicians must comply with the College's *Delegation of Controlled Acts* policy. One of the controlled acts under the *Regulated Health Professions Act, 1991* S.O. 1991, Chapter 18 (*RHPA*) is "communicating a diagnosis". Specifically, the wording in the *RHPA* states: "Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis". Please also see footnote 3.

55 *Communication of Test Results*

56 7. When in receipt of a clinically significant test result, physicians **must** always communicate
57 the test result to their patient and **must** do so in a timely manner.
58
59 8. For test results that are not clinically significant, physicians **must** use their professional
60 judgment to determine whether to communicate a test result, and if doing so, when to
61 communicate the test result.
62
63 9. Physicians **must** use their professional judgment to determine how to best communicate a
64 test result; for example, over the phone or, at the next appointment. In making this
65 determination, physicians **must** consider a variety of factors, including,
66 a. the nature of the test,
67 b. the significance of the test result,
68 c. the complexity and implications of the test result,
69 d. the nature of the physician-patient relationship,
70 e. patient preferences/needs, and
71 f. whether the patient appears anxious or has expressed anxiety about the test.
72
73 10. Physicians **must** use their professional judgment to determine the circumstances where it
74 makes sense for other health-care providers and/or non-medical staff to communicate test
75 results. The factors physicians **must** consider include:
76 a. the nature of the test,
77 b. whether the patient appears anxious or has expressed anxiety about the test,
78 c. the significance or implications of the test result, and
79 d. whether communicating the test result would mean communicating a diagnosis.[5]
80
81 11. When relying on others to communicate test results, physicians **must** have a mechanism in
82 place that enables them to respond to any follow-up questions that the patient may have.
83
84 12. Physicians **must** ensure that the communication of test results adheres to their legal[6] and
85 professional obligations[7] to maintain patient confidentiality and privacy.

[5] Please see footnote 4.
[6] The *Personal Health Information Privacy Act* S.O. 2004, Chapter 3 Schedule A (*PHIPA*) sets out requirements with respect to collecting, using and disclosing a patient's personal health information.
[7] See the College's *Medical Records* and the *Confidentiality of Personal Health Information* policies for more information. The *Confidentiality of Personal Health Information* policy states that "the College advises physicians that messages left for patients on a voice mail that is not private or with a third party should not contain any personal health information of the patient, such as details about the patient's medical condition, test results or other personal matters".

86 13. Physicians **must** ensure that all attempts made to either communicate the test result to the
87 patient and/or to book a follow-up appointment to discuss a test result are documented in
88 the medical record. [8]

89 *'No News is Good News' Strategies*

90 14. Physicians **must** only use a 'no news is good news' strategy for managing test results if they
91 are confident that the test result management system in place is sufficiently robust to
92 prevent test results from being missed and that no news really means good news.
93
94 15. Physicians **must** use their professional judgment to determine when a 'no news is good
95 news' strategy is appropriate in each instance and **must** consider the following factors in
96 making this determination:
97 a. the nature of the test that was ordered,
98 b. the patient's current health status,
99 c. if the patient appears anxious or has expressed anxiety about the test, and
100 d. the significance or implications of the potential result.
101
102 16. Physicians **must** inform patients as to whether they are using a 'no news is good news'
103 strategy and **must** tell patients that they have the option to personally contact the
104 physician's office or make an appointment to come into the office to hear their results.

105 *Clinically Appropriate Action Following Receipt of Test Results*

106 17. When physicians receive a critical and/or clinically significant test result for a test that they
107 have ordered, they **must** take clinically appropriate action. The timeliness of these actions
108 will depend on the significance of the test result. Physicians can take clinically appropriate
109 actions personally or they can assign or delegate this task to others.[9]

110 *Receiving Test Results in Error*

111 18. Physicians who receive a critical or clinically significant test result in error (e.g., same or
112 similar name or contact information) **must** inform the laboratory or diagnostic facility of
113 the error.

114 ***Communication and Collaboration with other Health-Care Providers***

115 19. Physicians in receipt of a test result **must** use their professional judgment to determine if it
116 is necessary to share a patient's test result with other relevant health-care providers whose

[8] Including those attempts made by staff on behalf of the physician.
[9] Please see footnotes 3 and 4.

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117 ongoing care of the patient would benefit from that knowledge and, if sharing the test
118 result, the timeliness with which to share it.[10] The timeliness of the communication will
119 depend on the degree to which the information may impact patient safety, including
120 exposure to adverse clinical outcomes.
121
122 20. Physicians whose role is to interpret and report test results (e.g., a radiologist, pathologist,
123 laboratory medicine physician) **must** contact the health-care provider who ordered the test
124 when there is an unusual, unexpected or urgent finding to ensure that this information is
125 communicated quickly and that it does not go astray.[11]

126 ***Patient Engagement***

127 21. When ordering a test, physicians **must** inform patients of the significance of the test, the
128 importance of getting the test done (in a timely manner, as appropriate), and the
129 importance of complying with requisition form instructions.

130 ***Availability and Coverage***

131 22. Physicians **must** comply with the expectations relating to availability and coverage for test
132 results as set out in the *Availability and Coverage* policy.

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[10] Under the *PHIPA* physicians can assume they have consent to share relevant test results with those in the patient's circle of care unless consent to do so has been expressly withdrawn by the patient.
[11] For example, a physician interpreting a prenatal ultrasound where there is a risk to the fetus would phone the referring health-care provider in addition to generating a written report.

Transitions in Care

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

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

Policy

Keeping Patients Informed About Who is Involved in Their Care

1. Within hospitals or health-care institutions where care is provided by a team of changing individuals, physicians **must** coordinate with others on the team to keep patients informed about who has primary responsibility for managing their care (i.e., their most responsible provider).[1]

2. Referring physicians **must** clearly communicate to patients what the physician's anticipated role will be in managing care during the referral process, including how patient care and follow-up may be managed and by whom, and keep patients informed about any changes that occur in their role.

3. Consultant physicians[2] **must** clearly communicate to patients the nature of their role, including which element(s) of care they are responsible for and the anticipated duration of care, and keep patients informed about any changes that occur in their role.
    a. When it is possible to do so, consultant physicians **must** also clearly communicate when the physician-patient relationship has reached its natural conclusion or when it is anticipated that it will reach its natural conclusion.[3]

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[1] Recognizing that the scopes of practice of other health-care providers are evolving and that other health-care providers may have overall responsibility for managing patient care, this section of the policy has adopted the term "most responsible provider" as opposed to "most responsible physician" (see the Canadian Medical Protective Association's "The most responsible physician: a key link in the coordination of care" for more information).
[2] This policy uses the term "consultant physician" in order to capture any physician, including primary care physicians, who accept referrals.
[3] See as well the College's *Ending the Physician-Patient Relationship* policy.

27 ***Managing Patient Handovers in Hospitals and Health-Care Institutions***

28 4. When handing over primary responsibility for patients to another health-care provider,
29 physicians **must** facilitate a comprehensive and up to date exchange of information and
30 allow for discussion to occur or questions to be asked by the health-care provider assuming
31 responsibility.[4]

32 ***Discharging Patients from Hospital[5] to Home***

33 5. Prior to discharging an inpatient from hospital to home,[6] physicians **must** ensure that they
34 or a member of the health-care team has a discussion with the patient and/or substitute
35 decision-maker about:
36 a. Post treatment or hospitalization risks or potential complications;
37 b. Signs and symptoms that need monitoring and when action is required;
38 c. Whom to contact and where to go if complications arise;
39 d. Instructions for managing post-discharge care, including medications (e.g.,
40 frequency, dosage, duration); and
41 e. Information about any follow-up appointments or outpatient investigations that
42 have been or are being scheduled or that they are responsible for arranging and a
43 timeline for doing so.
44
45 6. Physicians **must** take reasonable steps to facilitate the involvement of the patient's family
46 and/or caregivers in the discharge discussion where the patient or substitute decision-
47 maker indicates an interest in having them involved and provides consent to share personal
48 health information.
49
50 7. Physicians **must** use their professional judgment to determine whether to support this
51 discussion with written reference materials, and if so, the specific nature of the materials. In
52 making these determinations, physicians **must** consider a variety of factors including:
53 a. the health status and needs of the patient;
54 b. post treatment or hospitalization risks or potential complications;
55 c. the need to monitor signs or symptoms;

[4] The information may be exchanged through a variety of methods including: in person, via e-communication, or static communication methods such as a patient information board within a hospital department. Similarly, any discussion that is required can be done in-person, or through the phone, text, or other methods of e-communication, so long as doing so is in compliance with physicians' obligations under *Personal Health Information Protection Act, 2004* S.O. 2004, c. 3 Sched. A. (hereinafter, *PHIPA*).
[5] This includes people who have been admitted as inpatients to any type of hospital, including complex continuing care facilities and rehabilitation hospitals
[6] Home is broadly defined as a person's usual place of residence and can include, for example, institutions such as a retirement home or long-term care.

56 d. whether follow-up care is required;
57 e. language and/or communication issues that may impact comprehension;
58 f. whether those involved in the discussion are experiencing stress or anxiety which
59 may impair their ability to recall and act on the information shared; and
60 g. where the patient is being discharged to.

61 ***Completing and Distributing Discharge Summaries***

62 8. The most responsible physician **must** complete a discharge summary for all inpatients
63 within 48 hours of discharge.[7]
64
65 9. The most responsible physician **must** include in the discharge summary the information
66 necessary for the health-care provider(s) responsible for post-discharge care to understand
67 the admission, the care provided, and the patient's post discharge health care needs. While
68 physicians **must** use their professional judgment to determine what information to include
69 in the discharge summary, it will typically include:
70 a. Relevant patient and physician identifying information;
71 b. Reason(s) for admission;
72 c. Any diagnoses or differential diagnoses at discharge;
73 d. A summary of how active medical problems were managed (including major
74 investigations, treatments, or outcomes);
75 e. Medication information, including any changes to ongoing medication and the
76 rationale for these changes;
77 f. Follow-up care needs or recommendations; and
78 g. Appointments that have or need to be scheduled, any relevant and outstanding
79 outpatient investigations, tests, or consultation reports.
80
81 10. The most responsible physician **must** use language that is understandable to the health-
82 care providers who will receive the discharge summary.
83
84 11. The most responsible physician **must** direct that the discharge summary be distributed to
85 the patient's primary care provider, if there is one, and/or another health-care provider
86 who will be primarily responsible for post-discharge follow-up care.

87 12. If a delay in the completion or distribution of the discharge summary is anticipated, the
88 most responsible physician **must** provide a brief summary of the hospitalization directly to
89 the health-care provider responsible for follow-up care in a timely manner.

[7] Physicians are reminded that they must complete the discharge summary within 48 hours of discharge in order to bill the Ontario Health Insurance Plan for a patient visit on the day of discharge.

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90 13. Where follow-up care is time-sensitive or the patient's condition requires close monitoring,
91 the most responsible physician **must** also consider whether direct communication with the
92 health-care provider assuming responsibility for follow-up care is warranted.

93 ***Making Referrals***[8]

94 14. Referring physicians **must** have a mechanism in place to track referrals where urgent care is
95 needed, in order to monitor whether referrals are being received and acknowledged.
96 a. Referring physicians **must** engage patients in this process by, for example, informing
97 them that they may contact the referring physician's office if they have not heard
98 anything within a specific time-frame.
99
100 15. Referring physicians **must** make a referral request in writing and include the information
101 necessary for the consultant health-care provider to understand the question(s) or issue(s)
102 they are being asked to consult on. While physicians **must** use their professional judgment
103 to determine what information to include in the referral request, typically this will include:
104 a. Patient, referring physician, and, if different, primary care provider identifying
105 information;
106 b. Reason(s) for the consultation and any information being sought or questions being
107 asked;
108 c. The referring physician's sense of the urgency of the consultation; and
109 d. Summary of the patient's relevant medical history, including medication information
110 and the results of relevant tests and procedures.
111
112 16. If the patient's condition requires that a consultation be provided urgently, a verbal referral
113 request may be appropriate, although the referring physician **must** follow-up with a written
114 request.

115 ***Acknowledging Referrals***

116 17. Consultant physicians **must** acknowledge referrals in a timely manner, urgently if necessary,
117 but no later than 14 days from the date of receipt.[9]
118
119 18. When acknowledging the referral, consultant physicians **must** indicate to the referring
120 health-care provider whether or not they are able to accept the referral.

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[8] The expectations set out in this policy apply broadly to all referrals with the exception of effective referrals that are made when physicians choose to limit the services they provide for reasons of conscience or religion. Specific expectations for effective referrals are set out in the College's *Professional Obligations and Human Rights* and *Medical Assistance in Dying* policies.
[9] The date of receipt would be the first day of practice for physicians returning from vacations or other temporary absences from practice (as defined in the *Availability and Coverage* policy).

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a. If they are, consultant physicians **must** provide an anticipated wait time or an appointment date and time to the referring health-care provider. When providing an anticipated wait time, consultant physicians **must** follow-up once an appointment has been set.
b. If they are not, consultant physicians **must** communicate their reasons for declining the referral to the referring health-care provider.

Communicating Consultant Appointments with Patients

19. Consultant physicians **must** communicate the anticipated wait time or the appointment date and time to the patient, unless the referring physician has indicated that they intend to do so, and **must** allow patients to make changes to the appointment date and time directly with them. When providing an anticipated wait time, consultant physicians **must** follow-up once an appointment has been set.

Preparing and Distributing Consultation Reports

20. Following an assessment of the patient (which may take place over more than one visit), consultant physicians **must** prepare a consultation report that includes the information necessary for the health-care provider(s) involved in the patient's care to understand the patient's health status and needs. While physicians **must** use their professional judgment to determine what information to include, this will typically include:
    a. Relevant patient, consultant physician, and referring health-care provider identifying information;
    b. The date(s) of the consultation;
    c. The purpose of the referral;
    d. A summary of the relevant information considered, including a review of systems, physical examinations and findings, and the purpose and results of tests or investigations;
    e. A summary of the conclusions reached, including any diagnoses or differential diagnoses;
    f. Treatments initiated or recommended, along with their rationale, including medications or changes in ongoing medications;
    g. Outstanding investigations and referrals, along with their rationale;
    h. Important advice given to the patient; and
    i. Recommendations regarding follow-up and whether ongoing care from the consultant physicians is needed.

21. When consultant physicians are involved in the provision of ongoing care, they **must** prepare follow-up consultation reports when there are new finding or changes are made to

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157 the patient's care management plan. While physicians **must** use their professional judgment
158 to determine what information to include, this will typically include:
159 a. The original problem and any response to treatment;
160 b. Subsequent physical examinations and their findings;
161 c. The purpose and results of additional tests or investigations; and
162 d. Conclusions, recommendations, and follow-up plan(s).
163
164 22. Consultant physicians **must** distribute consultation reports to the referring health-care
165 provider and, if different, the patient's primary care provider.
166
167 23. Consultant physicians **must** distribute the consultation report and any subsequent follow-up
168 reports in a timely manner, urgently if necessary, but no later than 30 days after an
169 assessment or a new finding or change in the patient's care management plan. What is
170 timely will depend on the nature of the patient's condition and any risk to the patient if
171 there is a delay in sharing the report.
172 a. If urgent, a verbal report may be appropriate, although the consultant physician
173 **must** follow-up with a written consultation report.

174 ***Record Keeping of Referral Requests and Consultation Reports***

175 24. Both referring and consultant physicians **must** keep a copy of the referral request and any
176 consultation reports in their respective patient medical records. Where the referring and
177 consultant physician have access to a common medical record, referral requests and
178 consultation report may be contained in that common medical record.

179 ***Using Technology to Prepare and Distribute Referral Requests and Consultation Reports***

180 25. Physicians who use technology to assist in the preparation and distribution of referral
181 requests or consultation reports **must** ensure that they are accurate and follow-up with the
182 receiving health-care provider if any errors are identified after the referral or consultation
183 report has been sent.

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Walk-in Clinics

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

Walk-in Clinic: Medical practices that provide care to patients where there may be no existing association between the patient and the practice, where there may be no requirement to book appointments, and where the care provided is generally, although not always, episodic in nature. This includes urgent care centres, but does not include hospital-based emergency departments.

Policy

This policy does not provide an exhaustive catalogue of all physician expectations that apply in the walk-in clinic practice setting and other College policies set out expectations for physicians that apply in this setting as well.[1]

Supporting Patients

1. Physicians practising in a walk-in clinic **must** use their professional judgement to determine whether it would be appropriate to sensitively remind patients:
    a. That there are differences between episodic care and care that is provided as part of a sustained physician-patient relationship[2];
    b. About the benefits of seeing their primary care provider, if they have one, for care within their physician's scope of practice; and/or
    c. About the benefits of having a primary care provider and encouraging them to seek one out, if they don't already have one.

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[1] For example: *Medical Records*, *Confidentiality of Personal Health Information*, *Professional Obligations and Human Rights*, etc.

[2] As defined in the *Availability and Coverage* policy, a sustained physician-patient relationship is one where care is actively managed over multiple encounters.

28 2. Physicians practising in a walk-in clinic who are asked for assistance in finding a primary care
29 provider **must** be as helpful as possible in supporting the patient.[3]

30 **Meeting the Standard of Practice**

31 3. Physicians practising in a walk-in clinic **must** meet the standard of practice of the
32 profession, which applies regardless of whether care is being provided in a sustained or
33 episodic manner.
34 a. For example, physicians practising in a walk-in clinic **must** conduct any assessments,
35 tests, or investigations that are required in order for them to appropriately provide
36 treatment and **must** provide or arrange for appropriate follow-up care.[4]
37
38 4. Physicians practising in a walk-in clinic who limit the care or services they provide due to the
39 episodic nature of walk-in clinic care[5] **must:**
40 a. Make decisions to limit the services they provide due to the episodic nature of walk-
41 in clinic care in good faith;
42 b. Communicate any limitations to patients in a clear and straightforward manner; and
43 c. Communicate appropriate next steps to patients seeking care or services that are
44 not provided, considering factors such as the urgency of the patient's needs and
45 whether other health-care providers are involved in the patient's care.

46 **Managing Tests and Referrals**

47 5. Physicians practising within a walk-in clinic who order tests **must**:
48 a. Comply with the expectations set out in the *Managing Tests* policy, including
49 providing appropriate follow-up on test results; and
50 b. Comply with relevant expectations set out in the *Availability and Coverage* policy, in
51 particular those relating to coordinating coverage for *critical* test results.
52
53 6. Physicians practising in a walk-in clinic who make referrals **must** provide or arrange for the
54 provision of necessary follow-up care, including reviewing consultation reports.

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[3] Examples include directing patients to a colleague who is accepting new patients or to an organization that may be able to assist, such as a Community Health Centre, local hospital or emergency room, or other organization. The College's Physician and Public Advisory Service (PPAS) may also be able to provide some general tips and advice to patients seeking a new provider. PPAS can be reached toll free at 1-800-268-7096 ext. 603.
[4] See, as well, provisions 5 through 7 in this policy.
[5] Among other factors, a physician's practice environment may determine their scope of practice at a particular point in time. This is distinct from limitations that result from a moral or religious objection where specific expectations apply (see the College's *Professional Obligations and Human Rights* policy).

55 7. Physicians practising in a walk-in clinic **must not** rely on the patient's primary care provider
56 or another health-care provider involved in the patient's care to provide or coordinate
57 appropriate follow-up for tests they have ordered or referrals they have made, unless the
58 other providers have agreed to assume this responsibility.

59 **Coordinating with Primary Care Providers**

60 8. Physicians practising in a walk-in clinic **must** provide the patient's primary care provider (if
61 there is one) with a record of the encounter[6] when:
62 a. The patient makes a request to do so; or
63 b. In their opinion, one is warranted from a patient safety perspective and the patient
64 has provided consent to do so.
65
66 9. If it is not possible to send the record of the encounter directly to the patient's primary care
67 provider (e.g., where there is uncertainty regarding their identity or incomplete contact
68 information), physicians practising in a walk-in clinic **must** provide the patient with the
69 record of the encounter and inform them of the importance of sharing it with their primary
70 care provider.

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[6] This may include, for example, a record of any tests ordered, diagnoses reached, any treatment and advice provided, any referrals that were made, and any follow-up care that was arranged or advised, etc.

1 # Advice to the Profession: Continuity of Care

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

6 Continuity of care is an essential component of patient-centred care and is critical to patient
7 safety. While it can be understood in a number of ways, central themes often include the
8 importance of patient experiences with the health care system being connected and
9 coordinated, and the importance of information exchange across different parts of the health-
10 care system.

11 In order to set out expectations pertaining to continuity of care, the College has developed a set
12 of inter-related policies addressing a range of issues. They are: *Availability and Coverage*,
13 *Managing Tests*, *Transitions in Care*, and *Walk-in Clinics*. This document is intended to help
14 physicians interpret their obligations as set out in these policies and to provide guidance
15 around how these obligations may be effectively discharged. It also provides some background
16 information on the scope of these policies and the role of patients, technology and the health-
17 care system in facilitating continuity of care.

18 ## *Facilitating Continuity of Care*

19 ### ***The Role of Physicians and the College***

20 Physicians hold a prominent and important role in the health-care system and in turn are key
21 facilitators of continuity of care. However, the College recognizes that physicians are not solely
22 responsible for ensuring that continuity of care is achieved as often there are health system-
23 level factors that are beyond the control or influence of individual physicians that impact
24 continuity of care.

25 The College's approach to helping minimize breakdowns in continuity of care is to focus on the
26 issues or elements of continuity of care that are within the control or influence of physicians.

27 ### ***The Importance of Patient Engagement and Technology***

28 Patients have an important and growing role to play in facilitating continuity of care, as actions
29 they take may contribute to or help prevent breakdowns in continuity of care. Engaging

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30 patients in their care and providing them with the information and tools they need to navigate
31 the system may help minimize patients falling through the cracks.

32 Technology has an important role to play in facilitating continuity of care as well, and there are
33 already many ways in which technological solutions can help. For example, there are
34 technologies that may assist with test results management, facilitating access and/or coverage,
35 facilitating information exchange between health-care providers, and improving transitions in
36 care, especially as it pertains to handovers within health-care institutions, hospital discharges,
37 and the referral and consultation process.

38 Both engaging patients in their health-care and adopting technological solutions where they are
39 reasonably available have the potential to meaningfully facilitate continuity of care. Doing so
40 will also complement physicians' efforts in this regard and together many potential breakdowns
41 may be avoided.

42 ***An Evolving System***

43 Preventing all breakdowns in continuity of care cannot be achieved through physician actions
44 alone. The expectations set out in the continuity of care policies aim to help close some of the
45 cracks in the system, but system level changes are also needed in order to complement,
46 support, and enhance the expectations the College has set out.

47 Fortunately, continuity of care is an issue that is driving a lot of the change we are seeing in our
48 system and many of our partners in the health-care system are also working to support a
49 coordinated and connected health-care system.

50 While most physicians are using electronic medical records (EMRs), there is still work being
51 done to ensure these different systems are talking with one another and eventually work
52 together so that patients effectively have one record that follows them wherever they go.
53 Significant strides have already been made on this front. Physicians looking to enhance their
54 practice can register for a ONE ID account through the College's Member's Portal to access
55 existing digital health services available from eHealth Ontario such as the clinical viewer and
56 ONE Mail.[1] ONE ID also enables access eConsult[2] which seamlessly and securely connects, for
57 example, family physicians with specialists in order to seek their opinion on specific patient
58 issues in a direct and timely manner and, increasingly, directly through their EMR.

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[1] See eHealth Ontario for more information on ONE ID.
[2] See OntarioMD (https://www.ontariomd.ca/pages/overview-of-econsult.aspx) or the Ontario Telemedicine Network (https://otn.ca/patients/econsult/) for more information.

59 Similarly, patient portals are becoming more common, allowing patients to access their test
60 results directly and in some cases, view their entire health record. Changes in the way hospitals
61 develop discharge summaries, with a focus on patient needs and comprehension also has the
62 potential for better supporting transitions from hospital to home and minimizing breakdowns
63 that occur and is an approach that is being adopted across Ontario.[3] Further growth in terms of
64 access to these emerging tools will help to support patients and facilitate continuity of care.

65 Additionally, changes in the way the system is resourced and how incentives for health-care
66 providers are used all have the potential to bring positive change. For example: hospital fast
67 track systems[4] in emergency departments can help staff quickly treat patients; improved
68 resources and changes to incentives may help support increased access to appropriate after-
69 hours care or care during physician absences from practice; a centralized referral and
70 consultation process may help reduce wait times and lost referrals; and enhancements to tools
71 like Telehealth that help patients decide where and when to seek care. These are all examples
72 of a system that is or can further evolve to better support patients and minimize breakdowns in
73 continuity of care.

74 *Availability and Coverage*

75 ***Why has the College set out expectations relating to physician availability and making***
76 ***arrangements for care when physicians are not available?***

77 Continuity of care does not mean that individual physicians need to personally be available at
78 all times to provide on-demand care and continuous access to patients. Doing so would
79 negatively impact the quality of care being provided and compromise physician health.
80 However, in order to facilitate continuity of care and minimize risks to patient safety, the
81 College has set out expectations for physicians, recognizing that their role in facilitating
82 continuity of care includes being available and responsive to patients and health-care providers
83 involved in their patients' care and helping patients navigate the health care system and access
84 appropriate care when their physicians are unavailable.

[3] See the University of Health Network's OpenLab work on *Patient Oriented Discharge Summaries*, which are now being adopted by hospitals across Ontario.
[4] See for example St. Joseph's Health Care Toronto's "SuperTrack" program.

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85 ***Why does the policy require physicians to be available by phone? Why not through other***
86 ***means of communication? How does this expectation apply to group practices, institutions or***
87 ***department based practices?***

88 Good communication and collaboration are fundamental components of high quality care, but
89 are not possible if patients and health-care providers are unable to contact physicians. While
90 recognizing that physicians may offer a variety of ways to communicate with patients and other
91 health-care providers, the policy sets out expectations about being available by phone and
92 voicemail as this is still the default mode of communication for many and possibly the only
93 mode of communication that some patients may have access to.

94 Physicians practising as part of a group practice or within an institutional or department-based
95 environment may rely on a central and shared phone and voicemail to discharge this
96 expectation.

97 ***Does the policy require physicians to arrange for after-hours coverage?***

98 No. The policy requires physicians to inform patients about appropriate access points to the
99 health care system when in need of after-hours care. This may include any arrangements they
100 have made with other providers or it may mean directing patients to, for example, Telehealth
101 or the emergency department where it would be appropriate and reasonable to do so. It's
102 important to note that depending on the nature of a physician's practice, the legal concept of
103 duty of care may require taking additional steps to help patients access the right kind of care
104 (e.g., post-operative follow-up, obstetrical care, etc.). What this means will depend on the
105 physician's practice type, and so physicians may wish to seek legal advice for further clarity.

106 ***The policy requires physicians who are going to be unavailable during temporary absences***
107 ***from practice to take reasonable steps to make coverage arrangements for patient care.***
108 ***What are reasonable steps?***

109 As the policy notes, what is reasonable will depend on a variety of factors. In general, longer
110 absences increase the risk to patients and will require additional effort on the physician's part
111 to make sure patients have access to appropriate care. In some cases it may be quite difficult to
112 make coverage arrangements with another physician of the same specialty and whose practice
113 is within a reasonable distance. As such, the policy recognizes that other options might be
114 appropriate, including informing patients about appropriate access points such as the
115 emergency department, where no other options are reasonably available.

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116 Additional expectations are set out for managing test results, referrals, and information sharing
117 during temporary absences from practice as these issues can be managed differently than
118 providing direct care and pose additional risks to patient safety that are otherwise difficult to
119 mitigate without coverage.

120 ***How can physicians support patients in accessing the right kind of care and supporting***
121 ***continuity of care when they are not available?***

122 Patients have a role to play in managing their care. In particular, it's important for patients to
123 understand the value of seeing physicians with whom they have a sustained relationship and
124 how this contributes to continuity of care. Physicians can help patients understand that,
125 notwithstanding the convenience of going to a walk-in clinic or emergency department, if they
126 are able to wait to see their own physicians, they may contribute to a more continuous care
127 experience.

128 Physicians can also help encourage patients to develop a list of their medications and health
129 conditions so that when they go to an emergency room, walk-in clinic, or other health-care
130 provider providing coverage, they can share that information and support the provision of the
131 best possible care.

132 *Managing Tests*

133 ***Should primary care providers be copied on test requisitions?***

134 Where an ordering physician is not a patient's primary care provider, it is generally good
135 practice to copy the patient's primary care provider on the requisition form so that they are
136 kept in the loop regarding tests that are being ordered and the results that come in. Under the
137 *Personal Health Information Protection Act, 2004*, physicians can generally assume that they
138 have consent to share relevant information with the patient's primary care provider unless the
139 patient has expressly withdrawn consent.

140 That said, there may be instances where patients would not want a particular test result shared
141 with their primary care provider and so it will be important for the ordering physician to
142 consider whether express consent should be obtained. This is particularly true for physicians
143 ordering tests in the context of a walk-in clinic and specific expectations regarding information
144 sharing are set out in the *Walk-in Clinics* policy.

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145 ***What is a critical test result?***

146 A critical test result is one where the nature of the result is such that immediate patient
147 management decisions may be required. The Ontario Association of Medical Laboratories'
148 *Guideline for Reporting Laboratory Test Results* sets out the criteria for how labs define a critical
149 lab result and the necessary steps labs must take in response. The guidelines state that a
150 'critical' value is one that "shows a marked deviation from reference ranges, with no clear
151 indication to the laboratory that these are expected deviations. Results of this nature may
152 indicate a significant risk of a life-threatening event." If in receipt of a critical result, the labs will
153 call clinicians 24 hours a day, 7 days a week to report the result to facilitate prompt medical
154 intervention if required.

155 The Canadian Association of Radiologists also sets out standards in their *Communication of*
156 *Diagnostic Imaging Findings*. This standard provides guidance on when verbal or other direct
157 communication with the referring or ordering physician is needed, including the detection of:

158 - Conditions carrying the risk of acute morbidity and/or mortality which may require
159 immediate case management decisions.
160 - Disease sufficiently serious that it may require prompt notification of the patient, clinical
161 evaluation, or initiation of treatment.
162 - Life or limb threatening abnormalities which might not have been anticipated by the
163 referring physician.

164 ***What does the Canadian Medical Protective Association (CMPA) say about managing tests,***
165 ***and specifically about what a physician should do if a test result is received in error?***

166 The CMPA is a national organization and provides broad advice about a number of medico-legal
167 issues. For Ontario-specific information, physicians are advised to look at the CPSO policy and
168 advice document regarding managing test results. However, physicians may find this CMPA article
169 helpful.

170 ## *Transitions in Care*

171 ***When should physicians have a discussion with the patient and/or those assisting in their care***
172 ***about being discharged from hospital?***

173 Transitions from hospital to home present a number of challenges, and breakdowns in
174 continuity of care may occur. A comprehensive discussion in advance of the patient's discharge
175 can help the patient or their caregiver understand how to manage the transition and any post-

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176 discharge care. Where possible, it's helpful for this discussion to happen in advance of the
177 discharge rather than waiting until just before the discharge. The more time patients and
178 caregivers have, the more likely they are to process the information, ask questions, and prepare
179 for the discharge. Waiting until just before the discharge to share important information may
180 increase stress and anxiety for patients and caregivers.

181 ***Does the policy require discharge summaries to be transcribed and distributed within 48***
182 ***hours? What are best practices for dictating discharge information and completing the***
183 ***discharge summary?***

184 The policy *does not* require that the discharge summary be transcribed and distributed within
185 48 hours, as transcription and distribution processes are often beyond the control of individual
186 physicians. Rather, the policy requires the most responsible physician to complete their
187 component of the discharge summary within 48 hours of discharge. This aligns with the OHIP
188 billing requirements and means, for example, that the physician has completed their dictation
189 within 48 hours. While the policy requires that this be done within 48 hours of discharge, it's
190 generally considered best practice for physicians to complete their dictation at the time of
191 discharge as doing so will contribute to the timely completion and distribution of the discharge
192 summary.

193 ***Are there best practices that referring physicians can keep in mind to help reduce delays?***

194 Even in the absence of a comprehensive database of all specialists, their respective speciality or
195 sub-specialty, and information about whether a consultant physician is accepting patients,
196 physicians can turn their minds to these issues prior to making a referral. Giving consideration
197 to whether the patient's condition(s) is (are) within the scope of practice of the consultant
198 physician and whether that consultant is accepting patients will help minimize delays in the
199 process. Similarly, when making referrals it can be helpful to give some consideration to
200 whether the consultant physician's practice will be accessible to the patient (e.g., the location
201 of the practice, physical accessibility, etc.)

202 ***The policy requires that physicians track referrals that are urgently needed. What about other***
203 ***referrals?***

204 While the policy requires consultant physicians to acknowledge referrals within 14 days from
205 the date of receipt and urgently if necessary, referring physicians have a role to play in this
206 process as well and can track to make sure the referral is received and acknowledged. While
207 the policy sets our expectations for tracking urgent referrals, in the course of their practice
208 physicians may identify non-urgent referrals that warrant a bit more attention as well.

209 Generally speaking, best practice could involve a plan to do referral reconciliations every week
210 or so, as a status check on any outstanding referrals.

211 ***The policy requires consultant physicians to acknowledge a referral in a timely manner,***
212 ***urgently if necessary, but no later than 14 days. What does the policy mean by***
213 ***"acknowledge"?***

214 An acknowledgment lets the referring health care provider know whether the referral is going
215 to be accepted and if so, what an estimated or actual appointment date is. There is no
216 requirement to see the patient within 14 days, just a requirement to review the referral and
217 close the loop. This allows the referring physician to make alternative arrangements if needed.

218 When referrals aren't acknowledged, care can be significantly delayed. This is especially true
219 when the referral is for an issue that is out of scope for the consultant physician.
220 Acknowledging these quickly and getting a response to the referring physician will allow them
221 to make alternative arrangements, rather than waiting days or weeks only to hear that they
222 have to start the process again with another provider. It also has the benefit of allowing
223 consultants to focus their attention on those referrals that are in scope rather than letting out
224 of scope referrals pile up.

225 ***Do consultant physicians have any obligation to suggest another provider if they're unable to***
226 ***take on the referral?***

227 No. However, specialists may have more information about their colleagues than referring
228 physicians do and so to the extent that they are able to provide assistance in re-directing the
229 referral, it would be helpful to do so and would contribute to positive collegiality within the
230 profession. This is especially true in instances where the referral is urgent or for particularly
231 niche issues.

232 *Walk-in Clinics*

233 ***When and why does the policy require physicians practising in a walk-in clinic to send a record***
234 ***of the encounter to the patient's primary care provider?***

235 Patients seek care from walk-in clinics for a variety of reasons, but breakdowns in care can
236 happen and physicians practising in walk-in clinics can take steps to help avoid these
237 breakdowns. In particular, because there is not always coordination between the care provided
238 in walk-in clinics and other parts of the health-care system, the policy requires physicians
239 practising in walk-in clinics to provide the patient's primary care provider with a record of the

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240 encounter when the patient asks or when it's warranted from a patient safety perspective and
241 consent has been obtained. This will help to make sure that the patient's primary care provider
242 can provide future care that is informed by this experience. Of course, physicians are also free
243 to send a record of the encounter in other instances where there might be some benefit in
244 doing so and the patient provides consent.

245 Notably, the policy recognizes that it will not always be easy to send information to the primary
246 care provider and so allows for information to flow through the patient where it's not possible
247 to send the information directly because, for example, there is uncertainty about who the
248 primary care provider is or incomplete contact information.

249 ***Does the policy set out expectations for physicians practising in walk-in clinics who are***
250 ***providing care to patients without a primary care provider?***

251 No. Walk-in clinics are not intended to be a substitute or replacement for a sustained
252 relationship between a primary care provider and a patient. Rather, they are intended to
253 provide episodic care where there is no expectation of a sustained relationship beyond any
254 follow-up care that is required to address the presenting concern(s). That said, there are some
255 patients who have real difficulty finding a primary care provider and routinely visit the same
256 walk-in clinic for care. To the extent that physicians can, these patients would benefit greatly
257 from additional care beyond the usual walk-in clinic experience. While there are limits to what
258 can be done, even working together with other physicians in the practice to help these patients,
259 for example, monitor and manage basic elements of a chronic condition or provide annual
260 physicals, would benefit them greatly.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: Closing a Medical Practice – Revised Policy for Final Approval

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The Council approves the revised policy "Closing a Medical Practice", formerly titled "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", (a copy of which forms Appendix " " to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: Closing a Medical Practice – Revised Policy for Final Approval

FOR DECISION

ISSUE:

- The College's current *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy is under review.
- An updated and newly titled *Closing a Medical Practice* policy (attached as **Appendix A**) was released for external consultation following the February 2018 meeting of Council.
- Council is provided with an overview of the revisions made in response to the feedback received from the consultation and is asked whether the revised draft *Closing a Medical Practice* policy (attached as **Appendix B**) can be approved as a policy of the College.

BACKGROUND:

- The current policy was first approved by Council in September 2006 and last updated in 2007. It sets out expectations for physicians with respect to practice management measures they should take before they stop practising or in situations where they will not be practising for an extended period time due to retirement, relocation, leave of absence or as a result of disciplinary action by the College.
- The policy review was undertaken with the assistance of Dr. Judith Plante (Council Member), Dr. Michael Szul (Medical Advisor), and Ms. Elisabeth Widner (Legal Counsel).
- Following extensive research including a literature review, jurisdictional research, internal data collection and a review of relevant legislation and case law, as well as a preliminary consultation, a draft *Closing a Medical Practice* policy was developed and approved for external consultation by Council in February 2018. The general consultation on the draft

policy took place from February 26, 2018 to May 7, 2018. The College received a total of 102 consultation responses.[1]

- All stakeholder feedback was posted publicly on the consultation-specific page of the College's website and a comprehensive report of survey results is available on the consultation page.

- Broadly speaking, stakeholders expressed support for the draft policy. A large majority of respondents found the draft policy to be easy to understand, well organized and clearly written. As well, the majority of respondents found the draft policy to be comprehensive.

- Following the consultation process, the policy review was delayed in order to align with the development of the Continuity of Care policies, in particular, the Availability and Coverage policy which deals with temporary absences from practice.

CURRENT STATUS:

- In response to the consultation feedback, a revised draft policy was developed along with a companion document entitled *Advice to the Profession: Closing a Medical Practice* (attached as **Appendix C**). These documents have been drafted in accordance with the Policy Redesign strategy that was approved by Council in December 2018.

A. Revised Draft Policy

- The revised draft policy generally maintains the expectations that were set out in the consultation draft; however, some revisions have been made and the most pertinent ones are outlined below.

  Suspensions

- Early in the policy review process, a decision was made to consider temporary absences from practice, including suspensions, as part of the *Continuity of Care* policy development process and to remove them from this policy.

- However, upon further consideration it was determined that suspensions were more like a practice closure than a temporary absence from practice as physicians are not able to

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[1] These included 35 comments on the College's online discussion page (30 physicians, 1 member of the public and, 4 organizations), and 67 online surveys (55 physicians, 8 members of the public, 2 other health care professionals, 1 organization and 1 preferred not to say). The organizational respondents were: the Canadian Medical Protective Association, the Information and Privacy Commissioner of Ontario, the Professional Association of Residents of Ontario, and a medical records storage company.

practise medicine while suspended. In effect, the practice is closed for the duration of the suspension even if temporary and short in duration.

- As a result, content regarding suspensions was added back into the revised policy in the section dealing with the unique expectations that apply in the context of revocation.

Scope of Policy

- Although the majority of survey respondents agreed that the draft policy clearly articulates its application to all physicians, some stakeholders had concerns that the differences in expectations between consultants and primary care practitioners were not clear. As well, there were questions about how the policy would apply to a physician in a group practice.

- Therefore, the scope of the policy was clarified by noting that the policy applies to physicians who work in group practices or institutional settings; it is also noted that some of the expectations in the policy only apply in specific circumstances, for example, if a physician is actively managing a patient's care.

Planning

- Taking steps to proactively plan for unexpected practice closures has been made a mandatory expectation to address feedback from the Information and Privacy Commissioner of Ontario (IPCO) who encouraged the College to strengthen the policy and require physicians to develop succession plans and routinely review and update those plans. In addition, there was consultation feedback that stated if the College would like a formal succession plan to be created, this should be stated clearly.

- In addition, information from the OMA and the IPCO about what to do when the unexpected happens has been added to the resource section of the *Advice to the Profession* companion document to address questions raised in the consultation about unexpected practice closures.

Notification to Patients

- Council should note that the majority of survey respondents agreed with the notice period. However, the 90-day patient notice period expectation was modified to be more flexible where a successor is taking over a practice to address Council member feedback that the policy should distinguish between the notification period where an alternative for care is made and those where it is not, as a 90-day wait for someone to take over a practice is actually a barrier to making the transfer likely. It also addresses consultation feedback asking us to reduce the period to 60 days in order to place less limits on physician movement and employment.

- The majority of survey respondents agreed with the expectation to only notify patients to whom they are actively providing care; however, some stakeholders found the term "actively providing care" confusing and thought it should be clearly defined; therefore, this concept has been clarified in the *Advice to the Profession* companion document.

- Additionally, some respondents were confused about the requirement to notify only active patients and the additional legislative responsibility of custodians to notify all patients of the location of their medical record. This has been clarified in the revised draft policy.

Methods of Notification

- The provision with respect to methods of notification has been expanded allowing for notification by phone and in-person at a scheduled appointment, in addition to written notification by mail or secure e-mail, to address the concerns of some stakeholders that sending letter mail to each patient would be cost-prohibitive. This change reflects the current policy position.

Arranging Ongoing Care

- The majority of survey respondents agreed with the expectations around arranging ongoing care. Some clarity was requested with respect to clarifying what the College means by taking "reasonable steps" to arrange ongoing care and this has been addressed in the *Advice to the Profession* companion document. In addition, language has been added to the draft policy to delineate what can be considered in determining what is reasonable; for example, patient needs, and resources available in the community.

B. Draft Advice to the Profession Companion Document

- The draft *Advice to the Profession: Closing a Medical Practice* companion document provides additional information, and answers to frequently asked questions.
    - Most notably, the document includes more explanation about the meaning of actively managing a patient's care, steps a physician can take to arrange ongoing care, and notification.
    - It also provides information about records requirements.
    - Additionally, it includes a resources section identifying key resources from key stakeholders including, the OMA, CMPA, and IPCO.

- This document is intended to be a nimble communications tool that does not require Council approval in the same way a policy requires approval. This will allow for changes to be made between policy review cycles to address new or emerging concerns or questions.

NEXT STEPS:

- Should Council approve the revised draft policy, it will be published in *Dialogue* and will replace the current *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy on the College website.

DECISION FOR COUNCIL:

1. Does Council approve the revised *Closing a Medical Practice* draft policy as a policy of the College?

Contact: Lynn Kirshin, Ext. 243

Date: August 30, 2019

Attachments:

Appendix A: Consultation Draft - Closing a Medical Practice policy
Appendix B: Revised Draft Closing a Medical Practice policy
Appendix C: Advice to the Profession: Closing a Medical Practice

Closing a Medical Practice

Executive Summary:

This policy sets out the College's expectations for physicians when permanently closing a medical practice. Physicians may close their medical practice for a variety of reasons including retirement, resignation, relocation, revocation of a member's certificate of registration by the College, or where the sudden illness or death of a physician forces the practice to close. Key topics and expectations include:

- *Notification:* A minimum of ninety days' notice must be provided to patients prior to a planned practice closure. Notification must also be provided to hospitals or other facilities where the physician holds privileges, employers, and to the College of Physicians and Surgeons of Ontario. The contents of this notice, timelines for providing it, and acceptable methods of communication are set out in the policy.
- *Facilitating Continuity of Care:* When a physician closes a medical practice, steps must be taken to minimize the impact on patients and to not impede patients' ability to access care. This includes assisting patients in arranging care from another health-care provider, meeting expectations around medical records, facilitating access to prescription medication, and managing any outstanding test results.

INTRODUCTION

Physicians may permanently close their medical practice for a variety of reasons including retirement, resignation, relocation, revocation of a member's certificate of registration by the College, or where the sudden illness or death of a physician forces the practice to close. In order to minimize the impact on patients, physicians, or a designate in the event of a closure due to sudden illness or death, must take positive steps to preserve continuity of care in the best interests of patients. This policy sets out what is expected of physicians when they permanently close their medical practice.

PRINCIPLES

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

1. Acting in the best interests of their patients;

32 2. Communicating and collaborating effectively with patients and other health-care
33 providers to minimize breakdowns in continuity of care and risk to patient safety;
34 3. Maintaining public trust in the profession by not abandoning patients;
35 4. Participating in the self-regulation of the medical profession by complying with the
36 expectations set out in this policy.

37 SCOPE

38 This policy applies to all physicians regardless of practice area or speciality who are
39 permanently closing their medical practice. A physician who closes a medical practice may be
40 ceasing to practise medicine (due to retirement, resignation, revocation, illness or death) or
41 may be continuing to practice at a new location (i.e. relocation).[1]

42 In cases where physicians are closing their medical practice due to relocation, the physician is
43 required to take the steps outlined in the 'Notification' section of the policy, but would only
44 have to meet the expectations set out in the 'Facilitating Continuity of Care' section of the
45 policy for patients who will not be moving to the relocated practice.

46 This policy does not apply in situations where the physician is temporarily absent from practice
47 but is planning to return to the same practice (e.g., parental leave, educational leave,
48 suspension of the physician's certificate of registration). Temporary absences from practice will
49 be addressed in the Continuity of Care suite of policies, currently under development.

50 POLICY

51 Physicians must comply with the expectations set out in this policy when permanently closing a
52 medical practice.

53 This policy begins by setting out expectations related to notification including the timeline,
54 method, and contents that must be included in this notice, and then outlines the steps that
55 physicians are expected to take in order to facilitate continuity of care when closing a medical
56 practice.

57 Planning

58 The College recognizes that in some cases a practice closure may be sudden, due to illness or
59 death of the physician. All physicians are advised to take steps to ensure their medical practice
60 is appropriately managed in the event of an unexpected illness or death. This includes

[1] Please see the Frequently Asked Questions (FAQ) document for more information about specific scenarios and details regarding closure of a medical practice including relocating a practice and a physician's departure from a group practice.

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61 identifying a designate to facilitate compliance with the policy in the event the physician is
62 unable to do so. Physicians may wish to contact the Canadian Medical Protective Association or
63 the Ontario Medical Association for further information or practice management resources.

64 Notification

65 Notice must be provided to the following:

66 - Patients or their substitute decision-maker;
67 - Hospitals and other facilities where the physician holds privileges, and employers; and
68 - College of Physicians and Surgeons of Ontario.

69 Physicians are advised to give consideration to others that may require notification. This may
70 include other health-care providers actively involved in a patient's care that would benefit from
71 awareness of the practice closure, the Ministry of Health and Long-Term Care[2], and frequently
72 used laboratories or pharmacies.

73 i. Notice to Patients

74 Notice to patients or their substitute decision-maker must be provided a minimum of ninety
75 days' prior to a planned practice closure. The physician is only expected to notify patients to
76 whom they are actively providing care.[3]

77 There will be circumstances where it will not be possible to provide ninety days' notice due to
78 unforeseen circumstances such as sudden illness or death or where a member's certificate of
79 registration is revoked by the College. In these circumstances, physicians, or a designate in the
80 case of illness or death, must provide notice as soon as they learn of the need for the practice
81 closure.

82 Physicians are reminded that they must meet their legal and ethical obligations to protect
83 patient confidentiality when providing notification of a practice closure.[4]

84 ii. Contents of Notice

85 Notice to patients must include the following:

[2] For more information see HealthForceOntario, "Transition Out of Practice: A Guide for Physicians" available at: http://www.healthforceontario.ca/UserFiles/file/ToPS/TransitionOutOfPractice-en.pdf.
[3] For example, where a specialist's involvement with a patient has already reached its natural or expected conclusion prior to the practice closure, notification would not be required. Please see the FAQ document for more information on this and other scenarios.
[4] For more information on physicians' obligations to maintain patient confidentiality see the Confidentiality of Personal Health Information policy.

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86 • The date of the closure;
87 • Information about whether another health-care provider is available to assume
88 responsibility for the patient's care, either through designating a successor or through a
89 potential transfer of the patient to another medical practice. In this case, direction must
90 be given to patients about how to proceed, depending on whether the patient wants
91 their care to be transferred or if the patient wishes to pursue other options for care;
92 • If applicable, notice of a transfer of records to a physician's successor[5] and any timelines
93 for retaining the records;
94 • If no physician is available to assume responsibility for the medical practice or patients,
95 then notice of that fact; and
96 • Where patients can access their medical records or where a request for access or
97 transfer can be made.

98 **iii. Methods of Notification**

99 Physicians must take the following steps:

100 • In all cases, each patient must be directly notified of the intended practice closure with
101 written notice, either by letter mail or secure email. A sample letter of notice is
102 contained in Appendix A.
103 • Physicians must also ensure that the office voicemail message is up to date and accurate
104 and indicates the planned closure date.

105 Notification can also be supplemented with one or more of the following methods.

106 • In person, at a scheduled appointment;
107 • Telephone call;
108 • Printed notice, posted in the office;
109 • A notice posted on a website; and/or
110 • Newspaper advertisement.

111 **iv. Notification to Hospitals, Facilities and Employers**

112 Physicians are advised to exercise judgement about the contents and methods of notification
113 provided to hospitals, facilities, and employers.

114 **v. Notification to the College of Physicians and Surgeons of Ontario**

[5] The *Personal Health Information Protection Act, 2004* s. 42(2) states, "where this is not reasonably possible to notify patients in advance of a transfer of records, physicians must notify patients as soon as possible after the transfer has occurred."

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115 With the exception of physicians who have had their certificate of registration revoked, all
116 physicians who are closing a medical practice must notify the College through one of two
117 options:

118 - Physicians who are resigning from membership are required to complete a resignation
119 form as soon as reasonably possible.[6]
120 - For those physicians who are closing a medical practice, but are remaining a member of
121 the College,[7] they are required to notify the College of a change in their practice
122 address within 30 days of it occurring. [8] Physicians are advised to consult the College
123 webpage for additional information on how to report this change.

124 All physicians who have closed a medical practice must notify the College of the arrangements
125 made for storing and accessing patient medical records by contacting the College's Membership
126 Services department.

127 Facilitating Continuity of Care

128 When closing a medical practice, physicians must take steps to minimize the impact on patients
129 and to not impede a patient's ability to access care. The following outlines the College's
130 expectations of physicians in facilitating continuity of care.[9]

131 i. Arranging Ongoing Care

132 Physicians must take reasonable steps to arrange for the ongoing care of their patients.
133 Although some physicians may be able to arrange for a successor to take over their entire
134 practice or a part of their practice[10], the College recognizes that this will not be possible in
135 many circumstances. Physicians must be as helpful as possible to the patient in finding a new
136 health-care provider and are advised to consider the specific needs of the patient when
137 considering what assistance to provide.

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[6] Additional information and the resignation form can be accessed here: http://www.cpso.on.ca/Member-Information/Membership-Info-Fees/Resignation-from-Membership
[7] This could include circumstances such as where a physician is relocating their practice; maintaining their membership with the College but practicing outside of the province; or where a physician is ceasing to practise (i.e. retiring) but is maintaining their certificate of registration. Please see the FAQ document for more information about these specific scenarios.
[8] College by-law requires physicians to report any change of a practice address within 30 days.
[9] Broader expectations for physicians' role in facilitating continuity of care, unrelated to closing a medical practice, will be set out in the forthcoming Continuity of Care policies.
[10] Physicians must accept new patients in a manner that is fair, transparent, and respectful of the rights, autonomy, dignity and diversity of all prospective patients. For more information on physicians' professional and legal obligations when accepting new patients, see the Accepting New Patients policy.

138 For many patients, it will be sufficient to provide them with information about how they can
139 access ongoing care, using the resources listed on the College website. Patients who may be
140 categorized as higher-need, marginalized and/or complex[11] may require additional assistance in
141 transferring to another health-care provider and physicians are advised to make particular
142 efforts to arrange for the ongoing care of these patients.

143 **ii. Medical Records**

144 Patients must have access to their medical records even if the physician has closed their
145 medical practice. As such, the College advises all physicians to proactively plan for how they
146 will meet their obligations under the *Personal Health Information Protection Act, 2004 (PHIPA)*
147 and ensure patients have continued access to their medical records in the event of a planned or
148 unplanned practice closure. In all cases, the physician will continue to be the custodian of the
149 records until complete custody and control passes to another person or entity that is legally
150 authorized to hold them.

151 When a physician closes a medical practice two options are available with respect to patient
152 records:

153 • They may be transferred to another person legally authorized to hold them; or

154 • They may be retained for the periods set out in the College's Medical Records policy.

155 In accordance with regulation, a physician who ceases to practise medicine can destroy records
156 of family medicine and primary care after two years, as long as patients are notified of this
157 timeline and given the option to transfer the records to another physician within those two
158 years.[12] Physicians are advised to refer to the College's Medical Records policy for detailed
159 information on obligations with respect to the transfer, retention, and destruction of medical
160 records.

161 If a physician dies, the estate trustee of the physician is deemed to be the custodian of the
162 records until custody and control of the records passes to another person who is legally
163 authorized to hold them.[13] Where uncertainty arises over responsibilities with regard to the
164 medical records of a deceased physician, the College suggests seeking independent legal advice
165 or contacting the College's Physician Advisory Service.

166 **iii. Facilitating Access to Prescription Medication**

[11] These patients include those requiring urgent access to care, those with chronic conditions, an activity-limiting disability, mental illness, or other socio-economic factors.
[12] O. Reg. 114/94, General, enacted under the *Medicine Act*, 1991; S.O. 1991, c. 30, s. 19(1)(2).
[13] *PHIPA* s. 3(12). Where there is no estate trustee, the person who has assumed responsibility for administration of the deceased custodian's estate is deemed to be the custodian of the records.

167 The physician must make reasonable efforts to facilitate access to prescription medication. This
168 will involve one of the following:

169 - Where medically appropriate, and where the physician is maintaining a license to
170 practise in Ontario, provide the patient with renewals or repeats of the required
171 medication(s) in order to allow the patient reasonable time to find alternative care;[14] or
172 - Arrange for or advise the patient to attend another physician as soon as possible to have
173 their prescription(s) renewed.

174 The physician must also advise patients that repeats or renewals for prescriptions written prior
175 to the date of the resignation or revocation will not be legally valid after the date of resignation
176 or revocation.

177 Physicians are reminded of their obligation to keep their prescription pads safe and must take
178 steps to destroy[15] these upon ceasing to practise.

179 **iv. Test Results Management and Reports**

180 Physicians must comply with the College's Test Results Management policy[16].

181 Physicians who are resigning or have had their license revoked must advise patients that
182 standing orders for laboratory or other tests will not be legally valid after the date of
183 resignation or revocation.

184 Further, following resignation or revocation, physicians are not permitted to interpret test
185 results, prepare reports, or provide follow-up care. However, if only administrative work is
186 required to finalize a report, a physician may complete this report following resignation or
187 revocation. Administrative work includes editing draft reports, summarizing conclusions, or
188 signing reports completed prior to resignation or revocation.

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[14] If a physician is providing patients with repeats or renewals of prescriptions, the physician is reminded of their obligation under College by-law to hold professional liability protection.
[15] The Information and Privacy Commissioner (IPC) of Ontario provides guidance on the secure destruction of personal information. For paper records, the IPC notes that destruction "means cross-cut shredding, not simply continuous (single strip) shredding, which can be reconstructed". More information can be found on the IPC website.
[16] The Test Results Management policy is currently under review and will be included in the Continuity of Care suite of policies, once revised and approved.

1 # Closing a Medical Practice

2
Policies of the College of Physicians and Surgeons of Ontario (the "College") set out
3 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
4 and its Committees when considering physician practice or conduct.

5 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
6 discretion when applying this expectation to practice.

7 ## Definitions

8 **Practice closure:** Occurs when physicians cease to practise (due to retirement, resignation,
9 revocation, suspension, illness or death) or continue to practise but at a new location (i.e.,
10 relocation).

11 ## Policy

12

13 This policy applies to all physicians who are closing a medical practice, including those who
14 work in group practices or institutional settings, regardless of practice area or speciality. Some
15 of the expectations set out in the policy only apply in specific circumstances and this is noted in
16 the policy.

17 ***Planning for unexpected practice closures***

18 1. Physicians **must** take steps to proactively plan for unexpected practice closures due to
19 death or illness[1] so that their practice is managed appropriately and in compliance with this
20 policy and physicians' legal obligations. This could include, for example, identifying a
21 designate to facilitate compliance with the policy in the event the physician is unable to do
22 so.[2]

23 ***Facilitating access to ongoing care following a practice closure***

24 2. Physicians **must** take reasonable steps to arrange for the ongoing care of patients when
25 they close a practice, including instances where a practice is relocated and patients are
26 unable or choose not to move with the practice. What is reasonable will depend on the

[1] This does not include temporary leaves of absence due to family emergencies or illness, but rather instances where the physician's health is compromised to the point that they can reasonably expect that they will be closing their practice.
[2] For more information please see the resources section of the *Advice to the Profession* document.

27 reason for the practice closure, patient needs, and the health-care providers and/or health
28 system resources available in the community.[3]

29 ***Facilitating access to prescription medication***

30 3. Where a renewal or repeat of a prescription is necessary to allow a patient a reasonable
31 amount of time to find another provider, physicians who maintain their certificate of
32 registration **must** provide a renewal or repeat when one is clinically indicated.
33
34 4. Physicians who do not maintain their certificate of registration, or where it would be
35 clinically inappropriate[4] for physicians to provide a renewal or repeat, **must** take reasonable
36 steps to arrange for another provider to assume responsibility for the prescription, or
37 where this is not possible, inform the patient of the need to attend to another provider as
38 soon as possible.

39 ***Ensuring follow-up for outstanding tests***

40 5. Physicians **must** ensure that appropriate follow-up occurs for tests ordered by the physician
41 where the test results are pending.[5]

42 ***Ensuring patient access to medical records***

43 6. Physicians **must** ensure that patients have continued access to their medical records
44 following practice closure.
45
46 7. Physicians **must** ensure that records are retained for 10 years from the date of the last entry
47 in the record or, in the case of patients who are children, 10 years after the day on which
48 the patient reached or would have reached 18 years of age subject to the exception below.[6]
49 a. Family physicians or those providing primary care have the option to destroy
50 medical records after two years. In order to exercise this option, physicians **must**:
51 i. cease to practise medicine;

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[3] This could include for example, finding a successor to take over the practice or informing patients about how to find a new provider. See the *Advice to the Profession* document for more information.
[4] For example, the physician would not be able to monitor the patient's medications.
[5] Physicians who do not have a certificate of registration (e.g. have been revoked or suspended) must not engage in the practice of medicine including performing any controlled acts.
[6] Physicians are advised that s. 15(2) in the *Limitations Act*, *2002* allows for some legal proceedings to be brought forward 15 years after the act or omission on which the claim is based took place and thus may wish to retain records for longer than the 10 year requirement.

ii. notify each patient that the records will be destroyed two years after the notification and that the patient may obtain the records or have them transferred to another physician within the two years; and

iii. only destroy records after two years from the date of notification.[7]

Notifying patients of practice closures

8. Physicians **must** notify patients whose care is being actively managed[8] of a practice closure. In cases where the patient is incapable, physicians **must** notify the patient's substitute decision-maker.
    a. Physicians with custody of the medical record have additional notification obligations and **must** notify *all* patients if they intend to transfer custody of the medical record.[9]

9. Physicians **must** provide patients with at least 90 days' notice of the planned closure.
    a. In instances where a successor will be in place to take over the practice the notice period may be shortened, but physicians **must** use their professional judgment to determine an appropriate timeframe that does not unduly impair their patients' ability to find a provider other than the planned successor.
    b. In instances of sudden or unexpected closures (e.g., illness or death, revocation or suspension) where it is not possible to provide 90 days' notice, physicians (or their designate) **must** provide notice as soon as possible after learning of the need for a practice closure.

10. Physicians **must** include the following information when notifying patients of the practice closure:
    a. The date of the closure;
    b. Whether a successor is taking over part or all of the practice, and options for patients if no successor is available or they do not choose to continue with the planned successor; and
    c. Information about how to access or request transfer of their medical record including, whether or not records are being transferred to another person or entity.

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[7] O. Reg. 114/94, General, enacted under the *Medicine Act*, 1991; S.O. 1991, c. 30, s. 19(1)(2).

[8] For example, where a specialist's involvement with a patient has already reached its natural or expected conclusion prior to the practice closure, notification would not be required. Please see the *Advice to the Profession* document for more information.

[9] The *Personal Health Information Protection Act, 2004* states that where it is not reasonably possible to notify patients in advance of a transfer of records, physicians must notify patients as soon as possible after the transferred has occurred (S. 42(2)).

11. Physicians **must** notify the patient directly, either in writing (i.e., letter-mail or secure email), by telephone, or in person at a scheduled appointment.[10]

Notifying the College of practice closures

12. Physicians who are resigning from membership **must** complete a resignation form.[11]

13. Physicians who are closing a medical practice, but are maintaining their membership with the College,[12] **must** notify the College of a change in their practice address within 30 days of the change.[13]

14. With the exception of physicians who are closing a practice due to a change in practice location, physicians who have closed their medical practice **must** notify the College of the arrangements they have made for storing medical records by notifying the College's Membership Services department.

Notifying others of practice closures

15. Physicians **must** notify hospitals or other facilities where they hold privileges and any employers of their practice closure.

16. Physicians **must** use their professional judgement to determine whether other health-care providers involved in the patient's care would benefit from notification of their practice closure and notify them as warranted.

Limitations following a resignation, revocation or suspension

17. Physicians who resign or have their certificate of registration revoked or suspended by the College **must** inform patients that:
    a. Standing orders for laboratory or other tests are not valid after the date of resignation, revocation, or suspension; and
    b. Prescription repeats/renewals written prior to the date of resignation, revocation, suspension are not valid after the date of resignation, revocation or suspension.

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[10] Caution should be exercised when leaving messages on voicemail or with a third party due to concerns regarding patient confidentiality and privacy rights. For more information, please see the CPSO's policy on *Confidentiality of Personal Health Information*.
[11] Additional information and the resignation form can be accessed on the College's website.
[12] This could include circumstances such as where a physician is relocating their practice; maintaining their membership with the College but practising outside of the province; or where a physician is ceasing to practise (i.e. retiring) but is maintaining their certificate of registration.
[13] College by-law requires physicians to report any change of a practice address within 30 days. Physicians can consult the College's website for additional information on how to report this change.

110 18. Following a resignation, revocation, or suspension, physicians **must not** interpret test
111 results, prepare reports[14], or provide follow-up care.

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[14] Only administrative work required to finalize an outstanding report can be completed during the suspension period, or following resignation or revocation. Administrative work includes editing draft reports, summarizing conclusions or signing reports completed prior to resignation, revocation or suspension.

Advice the Profession: Closing a Medical Practice

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 who are closing their medical practice often contact the College to seek guidance about the measures they should take before they close their medical practice. The College also receives calls from patients asking how they can obtain their medical records, obtain outstanding prescriptions, or laboratory reports because their physician has closed their practice.

This document is intended to help physicians interpret their obligations as set out in the *Closing a Medical Practice* policy and provide guidance around how these obligations may be effectively discharged.

Notification

The policy requires that physicians notify patients whose care is being actively managed. What does "actively managing care" mean?

There are straightforward examples where it is clear that a physician is actively managing a patient's care. For example, you are seeing the patient on a regular basis or even only annually. In addition, actively managed would include patients who are rostered with your practice and being counted as part of your contract, or where you are writing or renewing prescriptions or being kept informed about care provided to patients by other health care providers even though you may not be personally seeing them regularly.

Similarly, there are straightforward examples of when physicians are not actively managing care. For example, where a specialist's involvement with a patient has already reached its natural or expected conclusion prior to the practice closure, or episodic care that is being provided in an emergency room or walk-in clinic. In these situations, neither the patient nor the physician is likely to have an expectation of an ongoing physician-patient relationship and so would not be captured by the policy.

However, there are many more examples and case specific scenarios where professional judgment comes into play in determining whether or not notifying patients is required by the policy.

In addition to notifying patients directly, what other steps can physicians take to help ensure patients are aware of the practice closure?

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34 While direct notification is required to ensure that patients are personally informed about a
35 practice closure, direct notification can also be supplemented by the following methods of
36 notification:

37 - Printed notice, posted in the office;
38 - The outgoing voicemail message;
39 - A notice posted on a website; and/or
40 - Newspaper advertisement.

41 ***Who else should I be notifying (in addition to patients, the CPSO and hospitals) about my***
42 ***practice closure?***

43 The policy states that physicians must use their professional judgment to determine whether
44 other health care providers involved in the patient's care would benefit from notification. This
45 could include other physicians, pharmacies or laboratories that patients frequently use. As
46 well, there may be others who would benefit from notice of a practice closure, such as the
47 Ministry of Health and Long-Term Care.

48 **Arranging Ongoing Care**

49 ***How can I help my patients find another physician to take over their care?***

50 The policy requires physicians to take reasonable steps to facilitate ongoing care. Recognizing
51 that what is appropriate will depend on the reason for the practice closure, the needs of the
52 patient, and the risks to them if ongoing care is not arranged, as well as the system resources
53 that are available in the physician's community. For example, what steps are reasonable would
54 look different for a family physician in a well-resourced community compared to an
55 underserviced community or when planning well in advance of an upcoming retirement when
56 compared to an unexpected closure due to an illness.

57 Generally speaking, it's considered best practice for physicians who are retiring or relocating
58 their practice outside their current community to try and arrange for a successor to take over
59 the entire practice or at least a part of the practice. However, the College recognizes that this
60 will not always be possible for a number a different reasons.

61 In those instances where it's not possible to arrange for a successor or where patients opt not
62 to go with the planned successor, physicians can still provide some assistance to patients in
63 finding a new health care provider.

64 For many patients, it will be sufficient to provide them with information about how they can
65 access ongoing care, using the resources listed on the College website. However, patients who

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66 may be categorized as higher-need, marginalized and/or complex[1] may require additional
67 assistance in order to arrange for the ongoing care of these patients.

68 **Records**

69 ***If I am arranging for a successor to take over my practice can I provide them with information***
70 ***about patients in my practice?***

71 The *Personal Health Information Privacy Act, 2004* (*PHIPA*) permits physicians who are
72 custodians of the medical record to disclose patients' personal health information to a potential
73 successor for the purpose of allowing the potential successor to assess and evaluate the
74 physician's practice as long as the potential successor enters into an agreement to keep the
75 information confidential and secure.[2]

76 ***What happens to my patient records if I die?***

77 If a physician dies, the estate trustee of the physician is deemed to be the custodian of the
78 records until custody and control of the records passes to another person who is legally
79 authorized to hold them.[3]

80 Where there is uncertainty about who is responsible for the medical records of a deceased
81 physician, a call to the CMPA or the College's Physician Advisory Service can help. More
82 information about medical records and practice closure can be found in the resources listed
83 below.

84 ***I am relocating my practice, what are my record retention obligations?***

85 When you relocate your practice, you are still responsible for meeting records retention
86 requirements, whether or not you will be providing ongoing health care to your patients. If you
87 are transferring custody of records for patients you can contact the CMPA to ensure that the
88 arrangements you make for record transfer and retention comply with your obligations under
89 the *Medicine Act, 1991* with respect to records and *PHIPA*.

90 It is good practice when you transfer medical records to someone who is legally authorized to
91 hold them, to document record transfer arrangements in a written agreement. An agreement
92 can address the following:

---

[1] These patients include those requiring urgent access to care, those with chronic conditions, an activity-limiting disability, mental illness, or other socio-economic factors.
[2] *PHIPA*, s. 42 (1)
[3] *PHIPA* , s. 3 (12)

- The location of the records;
- The requirement of the receiving physician to notify the transferring physician if the records are moved to a different location or transferred to a different physician;
- The transferring physician's right of access to the records in the event of a civil claim or College complaint;
- The patients' right of access to the records;
- The length of time for which the records must be retained;
- The obligation to protect the confidentiality of the records; and
- The destruction of the records.

Resources

The information below provides additional guidance for physicians with respect to closing a medical practice. Information includes: planning for an unexpected closure (i.e. unexpected death or illness), planning for an expected closure, what to do about patient medical records, sample notification letters to patients, privacy obligations and other office management considerations.

Canadian Medical Protective Association

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 medical office closure issues. However, the CMPA has a number of resources on the issues generally that physicians may find helpful.

For example:

Considerations When Leaving Practice

Winding Down Your Practice

Electronic Records Handbook

Ontario Medical Association

Closing a Practice: A Guide for Physicians (includes sample patient notification letters)

Closing a Practice: When the Unexpected Happens

Information and Privacy Commissioner of Ontario

Succession Planning to Help Prevent Abandoned Records

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122 Avoiding Abandoned Health Records: Guidance for Health Information Custodians Changing
123 Practice

124 Checklist for Health Information Custodians in the Event of a Planned or Unforeseen Change in
125 Practice

126 *Ministry of Health and Long-Term Care*

127 HealthForceOntario: Transition Out of Practice: A Guide for Physicians

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the September 20th meeting of Council, **Dr. Mark Spiller** of Kirkland will receive the Council Award.

BACKGROUND:

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

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

CURRENT STATUS:

Dr. Michael Franklyn will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: August 30, 2019

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: Policy Redesign Implementation – Batch 2

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The Council approves the following revised policies:

(a) “Dispensing Drugs” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(b) “Mandatory and Permissive Reporting” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(c) “Medical Expert: Reports and Testimony” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(d) “Physician Behaviour in the Professional Environment” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(e) “Physicians’ Relationships with Industry: Practice, Education, and Research” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(f) “Physician Treatment of Self, Family Members, or Others Closer to Them” (a copy of which forms Appendix “ ” to the minutes of this meeting);

(g) "Professional Responsibilities in Postgraduate Medical Education" (a copy of which forms Appendix " " to the minutes of this meeting);

(h) "Professional Responsibilities in Undergraduate Medical Education" (a copy of which forms Appendix " " to the minutes of this meeting); and

(i) "Third Party Reports" (a copy of which forms Appendix " " to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: ***Policy Redesign Implementation* – Batch 2**

FOR DECISION

ISSUE:

- At its December 2018 meeting, Council approved a proposal to redesign College policies in order to enhance their utility for physicians. The first batch of redesigned policies was considered and approved by Council in May 2019.

- Council is provided with an overview of the implementation plan put in place to facilitate the redesign process and is presented with the second batch of redesigned policies, along with some proposed housekeeping amendments to one policy. Council is asked whether each redesigned draft policy can be approved as a policy of the College.

BACKGROUND:

- Council approved a proposal to redesign College policies to be clearer, more concise, and user-friendly. Central to the proposal was a commitment to redesign all policies not currently under review *without* triggering the need for a consultation or altering past decisions of Council. As a result, all existing mandatory and permissive expectations were to be retained and not meaningfully altered through the redesign process.

- The redesign process has been overseen by the *Policy Redesign Working Group* which is comprised of Council Members Brenda Copps (Chair), Ellen Mary Mills, Janet van Vlymen, and Medical Advisors Keith Hay and Angela Carol.

- A comprehensive implementation plan was developed in order to redesign policies without losing or meaningfully altering any expectations. As a reminder, this process involved:

    - A line-by-line analysis of each policy to identify content that needed to be retained (i.e., expectations), repurposed into a companion document (e.g., context or rationale), or deleted altogether.

    - Redrafting the policy in line with the redesign approach, streamlining content if possible, and developing a companion advice document if needed.

- A comprehensive audit conducted by a second member of staff, including a line-by-line review of the original policy, redesigned policy, and advice document to ensure the revisions were sound.

- A subsequent line-by-line audit performed by the Manager of Policy and a final line-by-line audit conducted by Legal Counsel.

- During the redesign process, interpretive issues would arise where, for example, older drafting conventions (e.g., “should”, “expect”, etc.) needed to be translated into current conventions (i.e., “must”, “advised”), or where implicit expectations needed to be made explicit or re-framed as to explicitly apply to physicians.

- In each case proposed language would be developed by consulting with the last author of the policy and/or after careful consideration of the spirit or intention of the policy and the purpose and limits of the redesign process. The proposed language was then presented to the *Policy Redesign Working Group* for consideration and approval prior to finalizing.

- The first batch of redesigned policies was approved at the May 2019 meeting of Council and are now online.

CURRENT STATUS:

- As with the first batch of redesigned policies, because the redesign process has not resulted in substantive changes to the existing policies, approval is being sought on the basis of the process that was undertaken and the *Policy Redesign Working Group's* oversight, rather than a detailed review of each policy.

A. Outcomes of the Implementation Plan: Batch 2

- Following the same implementation plan that was used for the first batch of policies, a second batch of nine policies has been redesigned and *Advice to the Profession* companion documents have been developed where needed (see **Appendix A**). The policies are:

1. *Dispensing Drugs*
2. *Mandatory and Permissive Reporting*
3. *Medical Expert: Reports and Testimony*
4. *Physician Behaviour in the Professional Environment*
5. *Physicians' Relationships with Industry: Practice, Education and Research*
6. *Physician Treatment of Self, Family Members, or Others Close to Them*
7. *Professional Responsibilities in Postgraduate Medical Education*
8. *Professional Responsibilities in Undergraduate Medical Education*
9. *Third Party Reports*

- Notably, there were significantly more interpretive issues that arose in the context of the second batch when compared with the first. This is primarily due to the fact that a number of the policies were older or more complex in nature.

- Once again, the policy redesign process led to significant reductions in policy content. The word count of these policies[1] has been reduced by over 30% without losing or altering a single expectation. While not as significant as the first batch, the combined result of the two batches amounts to a total reduction of nearly 40%.

B. Additional Policy Amendments

- The *Mandatory and Permissive Reporting* policy primarily reflects physician's reporting obligations as set out in legislation or regulation.

- Since the policy was last updated, a number of legislative amendments have come into force necessitating that housekeeping amendments be made. Each of the proposed changes have been drafted to align with the legislation and have been vetted by Legal Counsel. Substantive amendments have been highlighted in the appendix.

Child Abuse and Neglect

- The *Child and Family Services Act* has been repealed, and replaced by the *Child, Youth and Family Services Act, 2017*. Minor amendments have been made to capture refinements that were made with respect to reporting obligations (e.g., "sexual molestation" has been changed to "sexual abuse") and to update legislative references.

Impaired Driving

- The *Highway Traffic Act* includes a broad provision to report patients suffering from a condition that may make it dangerous to drive and has been amended to set out specific reportable conditions. The redesigned policy has been updated to capture the list of reportable conditions.

- The amended *Act* also allows for discretionary reporting and so the redesigned policy includes a requirement for physicians to use their judgment to consider whether reports are warranted in instances other than the prescribed conditions.

[1] The *Mandatory and Permissive Reporting* policy was excluded from this count. The need to track the legislation/ regulation and to make significant additions to track recent changes, limited our ability to reduce content.

Communicable Diseases and Diseases of Public Health Significance

- Amendments were made to the *Health Protection and Promotion Act* and the regulations under the Act, amending the conditions that require reporting to the Medical Officer of Health, including adverse reactions to immunizations, and the terminology used to describe these conditions (i.e., from "reportable diseases" to "diseases of public health significance).

- The redesigned policy was updated to reflect these changes and to direct readers to the appropriate regulation for a list of specific reportable conditions.

Reporting Offences, Professional Negligence and Malpractice, Findings by Another Professional Regulatory Body, and Charges and Bail Conditions

- The *Health Professions Procedural Code* (*HPPC*) has been amended and contains new reporting obligations to the College. The redesigned policy now captures all of the reporting obligations under the *HPPC*, including the obligation to self-report offences, findings of professional negligence and malpractice, findings of professional misconduct or incompetence by another regulatory body, and charges, including bail conditions and other restrictions.

NEXT STEPS:

- Should Council approve the second batch of redesigned policies, they will replace the existing policies on the College's website, and notification will be published in *Dialogue* and announced through the College's social media properties emphasizing that expectations have not changed.

DECISION FOR COUNCIL:

1. Does Council approve each redesigned policy as a policy of the College?

Contact: Craig Roxborough, ext. 339
Date: August 30, 2019

Attachments:
Appendix A: Policy Redesign Documents – Batch 2

Dispensing Drugs

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

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

Policy

This policy was drafted in collaboration with the Ontario College of Pharmacists.

1. Physicians who dispense drugs **must** meet the same standards of dispensing that a pharmacist must meet.

2. Physicians who dispense drugs **must** comply with the requirements that are set out in this policy as well those contained in any other relevant College policies[1] and provincial/federal legislation[2].[3]

3. Physicians are permitted to charge a dispensing fee; however, physicians **must not** charge a fee that is excessive.[4]

4. Physicians **must not** profit on the sale of a drug to a patient except in the limited circumstances permitted by legislation.[5]

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[1] Including, but not limited to, the *Prescribing Drugs* policy.
[2] Relevant legislation includes, but is not limited to: the *Controlled Drugs and Substances Act*, the *Narcotics Safety and Awareness Act,* the *Drug and Pharmacies Regulation Act,* the *Drug Interchangeability and Dispensing Fee Act*, and the *Food and Drugs Act*. These pieces of legislation set out the requirements for the sale and dispensing of drugs, including labelling, record keeping and the retention of records.
[3] Guidance for dispensing drug samples is included in the College's *Prescribing Drugs* policy.
[4] It is a ground of professional misconduct to charge an excessive fee for a service (Paragraph 21, Subsection 1(1) Ontario Regulation 856/93 under the *Medicine Act*).
[5] Section 16 (d) Ontario Regulation 114/94 under the *Medicine Act* specifies the circumstances in which physicians are permitted to profit on the sale of a drug to a patient. These circumstances include: where the drug is necessary for the immediate treatment of the patient, in an emergency, or where the services of a pharmacist are not reasonably readily available.

5. Physicians who dispense[6] drugs **must**:

   a. dispense drugs only for their own patients;
   b. use proper methods of procurement[7] in order to be assured of the origin and chain of custody[8] of drugs being dispensed, along with knowledge of:
      i. who had the product;
      ii. when they had the product;
      iii. how long they had the product;
      iv. how the product was stored;
      v. who they bought it from; and
      vi. who they sold it to;
   c. store drugs securely;
   d. have an audit system in place in order to identify possible drug loss;
   e. store drugs appropriately to prevent spoilage (for example, temperature control where necessary);
   f. keep records of the purchase or sale of drugs;
   g. keep records which allow for the retrieval and/or inspection of prescriptions;
   h. provide appropriate packaging[9], labelling, and patient related material for the drugs they dispense;[10] and
   i. dispose of drugs that are unfit to be dispensed (e.g. expired or damaged) safely and securely and in accordance with any environmental requirements.

6. Physicians **must not** dispense drugs that are past their expiry date or that will likely expire before a patient has finished using them.

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[6] It is advisable to have standardized dispensing procedures (including labelling, instructions and documentation) in order to minimize errors.
[7] The Ontario College of Pharmacists suggests that physicians consider procuring drugs from wholesalers who are registered with the Ontario College of Pharmacists.
[8] This includes documentation of each sale or transaction of the product, e.g., a packing slip from the manufacturer or wholesaler registered with the Ontario College of Pharmacists.
[9] This includes using child resistant packaging unless: (a) the person to whom the drug will be dispensed to directs otherwise; (b) in the professional judgment of the physician who is responsible for the dispensing of the drug, it is advisable not to use a child resistant package given the particular circumstances; or (c) a child resistant package is not suitable because of the physical form of the drug (Section 45 Ontario Regulation 58/11 under the *DPRA*).
[10] Under the Food and Drug Regulations, physicians who dispense Class A opioids are required to apply a warning sticker to the prescription bottle, container, or package, and provide a patient information handout to accompany the drug. A sticker or handout is not required if the prescription is being administered under the supervision of a practitioner (for example, a physician or a nurse). For more information about these requirements, and to access digital copies of the materials, please see Health Canada's FAQ.

Mandatory and Permissive Reporting

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.

Physicians have a legal and professional obligation to maintain the confidentiality of patient information. There are circumstances, however, where physicians are either required or permitted to report particular events or clinical conditions to the appropriate government or regulatory agency. This policy sets out circumstances that may require or permit physicians to make a report. The policy does not represent an exhaustive list of physicians’ legal responsibilities, nor is it a substitute for legal advice regarding reporting obligations.

Definitions

Mandatory Reports: Mandatory reports are legally required and considered necessary in the public interest. Depending on the origin of the mandatory reporting duty, physicians are required to include specific information and, at times, professional medical opinions in mandatory reports.

Permissive Reports: Permissive reports are rooted in professional responsibility and ethics. While they may be legally permitted in certain circumstances, the decision to make a permissive report is at the physician’s discretion.

Policy

General

1. Physicians **must** be aware of and comply with the legal, professional and ethical reporting obligations relevant to their practice.[1]

2. In order to support a trusting physician-patient relationship, physicians are **advised** to communicate with patients about their reporting duties, where circumstances make it appropriate to do so.

[1] Generally physicians are protected from legal action when complying, in good faith, with reporting obligations. In some instances, physicians who fail to report their suspicions may be guilty of an offence punishable by fine or subject to disciplinary proceedings.

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30 3. Physicians are **advised** to consult with the Canadian Medical Protective Association (CMPA),
31 the Office of the Information and Privacy Commissioner of Ontario (IPC) and/or the
32 College's Physician and Public Advisory Service (PPAS) where they have questions about any
33 of their reporting obligations.

34 Mandatory Reporting

35 Listed below are the mandatory reporting obligations captured in this policy. Please use the
36 links below to be directed to more information about each obligation [hyperlinks to be added]:

37 • Child Abuse or Neglect
38 • Impaired Driving Ability
39 • Long-Term Care and Retirement Homes
40 • Sexual Abuse of a Patient
41 • Facility Operators: Duty to Report, Incapacity, Incompetence and Sexual Abuse
42 • Terminating or Restricting Employment, Privileges and Partnerships
43 • Births, Still-births and Deaths
44 • Communicable Diseases and Diseases of Public Health Significance
45 • Controlled Drugs and Substances
46 • Community Treatment Plans
47 • Gunshot Wounds
48 • Pilots or Air Traffic Controllers
49 • Maritime Safety
50 • Railway Safety
51 • Occupational Health and Safety
52 • Correctional Facilities
53 • Preferential Access to Health Care
54 • Health Card Fraud
55 • Privacy Breaches
56 • Offences, Professional Negligence and Malpractice, Findings by Another Professional
57 Regulatory Body, and Charges and Bail Conditions

58 Child Abuse or Neglect

59 4. Under the *Child Youth and Family Services Act* (*CYFSA*), a 'child in need of protection'
60 includes a child who has suffered, or is at risk of suffering, physical abuse, sexual abuse,
61 emotional abuse, or neglect.[2,3] Physicians who have reasonable grounds[4] to suspect a child

[2] Section 74(2) of the *Child, Youth and Family Services Act, 2017,* S.O. 2017, c. 14, Sched. 1 (hereinafter *CYFSA*).

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62 is or may be in need of protection **must** immediately report the suspicion, and the
63 information upon which it is based, directly to a children's aid society[5] (CAS).[6]

64 5. Physicians **must** make a report directly to CAS when:

65 a. The child has suffered physical harm, including by way of neglect, or there is a risk
66 that the child is likely to suffer physical harm.[7]
67 b. The child requires treatment to cure, prevent or alleviate physical harm or suffering,
68 and the child's parent or the person responsible for the child does not provide
69 treatment, or access to the treatment, or, where the child is incapable of consenting
70 to the treatment, refuses, or is unavailable or unable to consent to the treatment.[8]
71 c. The child has been or there is at risk that the child is likely to be sexually abused or
72 sexually exploited, by the person responsible for the child, or by another person and
73 the person responsible knows or should know of the possibility of sexual abuse or
74 sexual exploitation and fails to protect the child.[9]
75 d. The child has suffered or there is a risk that the child is likely to suffer emotional
76 harm[10], resulting from the actions, inaction, or pattern of neglect by the child's
77 parent or the person responsible for the child.[11]
78 e. The child has suffered or is at risk of likely suffering emotional harm, and the child's
79 parent, or the person responsible for the child does not provide services or
80 treatment, or access to services or treatment, or where the child is incapable of
81 consenting to treatment, refuses or is unavailable or unable to consent to services or
82 treatment to remedy or alleviate the harm.[12]

[3] As set out in section 125(4) of the *CYFSA* the duty to report does not apply to older children (i.e., 16 and 17 years old); however, physicians may make a report for children 16 or 17 years of age if the described circumstance or condition exists.
[4] The Ontario Ministry of Children and Youth Services, which administers the *CYFSA*, has defined "reasonable grounds" in this context as the information that an average person, using normal and honest judgment, would need in order to decide to report. Government of Ontario, Reporting Child Abuse and Neglect (Ontario: Ministry of Children and Youth Services, 2010).
[5] Children's aid societies are known as "family and children's services" in some communities.
[6] Section 125(1) of the *CFYSA;* Physicians are not obligated to report suspicions of abuse to the police. However, if information provided by the physician to the CAS alleges that a criminal offence has been perpetrated against a child, the CAS will immediately inform the police, and work with the police according to established protocols for investigation (Government of Ontario, Child Protection Standards in Ontario (Ontario: Ministry of Children and Youth Services, 2007)).
[7] *CYFSA* 125(1) paras 1 and 2.
[8] *CFSA* 125(1) para 5.
[9] *CYFSA* 125(1) para 3.
[10] *CYFSA* 125(1) para 6; emotional harm is demonstrated by serious: anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development.
[11] *CYFSA* 125(1) para 8.
[12] *CYFSA* 125(1) paras 7 and 9.

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f. The child suffers from a mental, emotional or developmental condition that, if left untreated could seriously impair the child's development, and the child's parent or the person responsible for the child does not provide the treatment, or access to the treatment, or where the child is incapable of consenting to the treatment, refuses, or is unable or unavailable to consent to treatment to remedy or alleviate the condition.[13]
g. The child's parent has died, or is unavailable to exercise their custodial rights over the child, and has not made adequate provision for the child's care and custody.[14]
h. The child is in a residential placement and the parent refuses, or is unable or unwilling to resume the child's care and custody.[15]
i. The child is under the age of 12 and has killed or seriously injured another person or caused serious damage to another person's property and the child's parent or the person responsible for the child does not provide services or treatment or access to services or treatment, or, where the child is incapable of consenting to treatment, refuses or is unavailable or unable to consent to treatment necessary to prevent a recurrence [16]
j. The child is under the age of 12 and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person responsible for the child or because of that person's failure or inability to supervise the child adequately.[17]

6. Physicians who have reasonable grounds to suspect a child is in need of protection **must** not rely on any other person to report on their behalf.[18]

7. Since the duty to report is ongoing, physicians **must** make a further report to the CAS if there are additional reasonable grounds to suspect that the child is or may be in need of protection.[19]

Impaired Driving Ability

8. Physicians **must** report[20] every individual who is at least 16 years old who attended the physician for an examination or for the provision of medical or other services, who, in the

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[13] *CYFSA* 125(1) para 10.
[14] *CYFSA* 125(1) para 11.
[15] *CYFSA* 125(1) para 11.
[16] *CYFSA* 125(1) para 12.
[17] *CYFSA* 125(1) para 13.
[18] Section 125(3) *CYFSA*.
[19] Section 125(2) *CYFSA*. There is no ongoing duty for a child who is 16 or 17 years old however s. 125(4) of the *CYFSA* provides for permissive reporting for older children.

111 opinion of the physician has or appears to have a prescribed medical condition, functional
112 impairment, or visual impairment, that is not of a distinctly transient or non-recurrent
113 nature,[21] including:[22]

114 a. cognitive impairment,[23]
115 b. sudden incapacitation,[24]
116 c. motor or sensory impairment,[25]
117 d. visual impairment,[26]
118 e. substance use disorder,[27]
119 f. psychiatric illness.[28,29]

120 9. For assistance determining whether a reporting obligation under provision #8 exists,
121 physicians are **advised** to consult the *CCMTA Medical Standards for Drivers* (2017),[30] and

[20] A report by a physician under the *Highway Traffic Act* will not automatically result in the suspension or downgrading of the patient's licence. Upon receipt, the Ministry of Transportation will review information received in accordance with the *Highway Traffic Act* and national medical standards. The national medical standards are those published by the Canadian Council of Motor Transport Administrators (CCMTA), and are referenced in Section 14(2) of *Drivers' Licences,* O. Reg. 340/94 enacted under the *Highway Traffic Act* (hereinafter *Highway Traffic Act*, *Drivers' Licences Regulation*).

[21] Section 203(1) and 203(4) of the *Highway Traffic Act*, R.S.O. 1990, c. H.8 (hereinafter *HTA*) and section 14.1(4) of *Highway Traffic Act*, *Drivers' Licences Regulation*; the Medical Condition Report form is available for physicians to use when reporting a patient and is available on the Ministry of Transportation's website.

[22] Section 14.1(3) of *Highway Traffic Act*, *Drivers' Licences Regulation.*

[23] A disorder resulting in cognitive impairment that,
i. affects attention, judgment and problem solving, planning and sequencing, memory, insight, reaction time or visuospatial perception, and
ii. results in substantial limitation of the person's ability to perform activities of daily living.

[24] A disorder that has a moderate or high risk of sudden incapacitation, or that has resulted in sudden incapacitation and that has a moderate or high risk of recurrence.

[25] A condition or disorder resulting in severe motor impairment that affects co-ordination, muscle strength and control, flexibility, motor planning, touch or positional sense.

[26] A best corrected visual acuity that is below 20/50 with both eyes open and examined together; a visual field that is less than 120 continuous degrees along the horizontal meridian, or less than 15 continuous degrees above and below fixation, or less than 60 degrees to either side of the vertical midline, including hemianopia; Diplopia that is within 40 degrees of fixation point (in all directions) of primary position, that cannot be corrected using prism lenses or patching.

[27] A diagnosis of an uncontrolled substance use disorder, excluding caffeine and nicotine, and the person is non-compliant with treatment recommendations.

[28] A condition or disorder that currently involves acute psychosis or severe abnormalities of perception such as those present in schizophrenia or in other psychotic disorders, bipolar disorders, trauma or stressor-related disorders, dissociative disorders or neurocognitive disorders, or the person has a suicidal plan involving a vehicle or an intent to use a vehicle to harm others.

[29] Physicians are not required to report modest or incremental changes in ability that, in the prescribed person's opinion, are attributable to a process of natural aging, unless the cumulative effect of the changes constitutes a condition or impairment described in provision 8.

[30] This document is published by the Canadian Council of Motor Transport Administrators and available on the Internet through the website of the Canadian Council of Motor Transport Administrators.

122 the Canadian Medical Association's *Determining Medical Fitness to Operate Motor Vehicles,*
123 9th edition (2017)[31].[32]

124 10. If an individual described in provision #8 above does not have or appear to have one of the
125 prescribed conditions, but has or may have another condition or impairment that may make
126 it dangerous for the individual to operate a motor vehicle, physicians **must** use their
127 professional judgement to determine if a report is warranted.[33]

128 11. Physicians **must** send reports to the Registrar of Motor Vehicles in the form and manner
129 specified by the Registrar, and include the following information:

130 a. the name, address, and date of birth of the individual,
131 b. the condition or impairment diagnosed or identified, and a brief description of the
132 condition or impairment, and
133 c. any other information requested by the form.[34]

134 12. While it is not necessary to obtain a patient's consent before making a report under
135 the *Highway Traffic Act*, where appropriate, physicians are **advised** to inform the patient in
136 advance of doing so, or in circumstances where the patient was not informed beforehand,
137 after the report has been made.

138 **Long-Term Care and Retirement Homes**

139 13. Physicians **must** immediately report their suspicion and the information upon which it is
140 based to the Registrar of the Retirement Homes Regulatory Authority, or long-term care
141 home director when they have reasonable grounds to suspect that a resident of a nursing
142 home or retirement home has suffered harm or is at risk of harm due to improper or
143 incompetent treatment or care, unlawful conduct, abuse or neglect.[35]

144 14. Additionally, physicians **must** report suspicions of misuse or misappropriation of a resident's
145 money or of funding provided to a licensee.[36]

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[31] This document is available on the internet through the website of the Canadian Medical Association.
[32] Section 14.1(6) of *Highway Traffic Act*, *Drivers' Licences Regulation*.
[33] Section 203 (2) of *HTA.*
[34] Section 204 (1) of *HTA.*
[35] Sections 24(1) and 24(4)of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8 (hereinafter *Long-Term Care Homes Act*) and Sections 75(1) and 75(3) of the *Retirement Homes Act, 2010*, S.O. 2010, c.11.
[36] Section 24(1) *Long-Term Care Homes Act;* Section 2(1) of the *Long-Term Care Homes Act* defines 'licensee' as the holder of a licence issued under the *Long-Term Care Homes Act*, and includes the municipality or municipalities or board of management that maintains a provincially approved municipal home, joint home or First Nations home.

146 **Sexual Abuse of a Patient**

147 15. When a physician has reasonable grounds, obtained in the course of practising the
148 profession, to believe that another physician or regulated health professional has sexually
149 abused[37] a patient, the physician **must** file a report in writing with the Registrar of the
150 college to which the alleged abuser belongs.[38]

151 16. Where information regarding sexual abuse is obtained from a patient, physicians **must** use
152 their best efforts to advise the patient of the requirement to file the report before doing
153 so.[39]

154 17. Generally, physicians **must** file reports within 30 days after the obligation to report arises.
155 However, where the physician has reasonable grounds to believe that the alleged abuse will
156 continue or that the member will sexually abuse other patients, physicians **must** make the
157 report immediately.[40]

158 18. Physicians **must** include the following information in their reports:

159 a. their name;
160 b. the name of the regulated health professional who is the subject of the report;
161 c. an explanation of the alleged sexual abuse; and
162 d. the name of the patient who may have been sexually abused (if the grounds for
163 reporting are related to a particular patient, and the patient or the patient's
164 representative, has consented in writing).[41]

165 19. Physicians providing psychotherapy to the alleged abuser, who are able to form an opinion
166 as to whether the alleged abuser is likely to sexually abuse patients in the future, **must** also
167 include their opinion in the report.[42]

168 20. If the reporting physician ceases to provide psychotherapy to the alleged abuser, the
169 reporting physician **must** provide an additional report to the same college immediately.[43]

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[37] Section 1(3) of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1001, c.18 (hereinafter *HPPC*), defines sexual abuse of a patient by a member as: (a) sexual intercourse or other forms of physical sexual relations between the member and the patient (b) touching, of a sexual nature, of the patient by the member, or (c) behaviour or remarks of a sexual nature by the member towards the patient.
[38] Section 85.1(1) and 85.3(1) of the *HPPC*. Under section 85.1(2) of the *HPPC* physicians are not required to file a report if the name of the regulated health professional who would be the subject of the report is not known.
[39] Section 85.1(3) of the *HPPC*.
[40] Section 85.3(2) of the *HPPC*.
[41] Sections 85.3 (3) and 85.3(4) of the *HPPC*.
[42] Section 85.3 (5) of the *HPPC*.
[43] Section 85.4(1) and 85.4(2) of the *HPPC*.

170 **Facility Operators: Duty to Report Incapacity, Incompetence and Sexual Abuse**

171 Under the *Health Professions Procedural Code,* physicians or others who operate a
172 facility[44] where one or more regulated health professionals practise, have specific reporting
173 obligations. Physicians acting as facility operators are subject to the additional requirements set
174 out below.

175 21. Physicians who operate a facility (including but not limited to hospitals and long-term care
176 homes) where one or more regulated health professionals practise, who have reasonable
177 grounds to believe that a regulated health professional practising in the facility is
178 incompetent[45], incapacitated[46] or has sexually abused a patient, **must** file a report with the
179 Registrar of the college to which the regulated health professional belongs.[47,48]

180 22. Generally, when a reporting obligation arises, physicians **must** make reports within 30 days
181 after the obligation to report arises. However, physicians **must** report immediately when
182 there are reasonable grounds to believe that:

183 a. the regulated health professional will continue to sexually abuse the patient or will
184 sexually abuse other patients; or
185 b. the incompetence or incapacity of the regulated health professional is likely to
186 expose a patient to harm or injury and there is urgent need for intervention.[49]

187 23. Physicians **must** include the following in their reports:

188 a. their name,
189 b. the name of the regulated health professional who is the subject of the report,
190 c. an explanation of the alleged sexual abuse, incompetence, or incapacity, and
191 d. if concerns relate to a specific patient, the name of that patient.[50]

[44] The terms ‘facility’ and ‘facility operator’ are not defined in the *RHPA* or the *HPPC*. For the purposes of providing guidance to the profession, the CPSO relies on the definition of “health facility” contained in the *Independent Health Facilities Act*, R.S.O. 1990, c.I.3, as a working definition. The *Independent Health Facilities Act* (*IHFA*) defines “health facility” as a place in which one or more members of the public receive health services and includes an independent health facility (s.1(1) *IHFA*).
[45] Section 52(1) of the *HPPC* states that a panel shall find a member to be incompetent if the member’s professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member’s practice should be restricted.
[46] Section 1(1) of the *HPPC* states that “incapacitated” means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member’s certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practise.
[47] Section 85.2(1) and 85.3(1) of the *HPPC*.
[48] Under section 85.2(3) of the *HPPC* facility operators are not required to file a report if the name of the regulated health professional who would be the subject of the report is not known.
[49] Section 85.3(2) of the *HPPC*.

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192 24. In reports of alleged sexual abuse, physicians **must** only include patient names with the
193 written consent of the patient or representative.[51]

194 **Terminating or Restricting Employment, Privileges and Partnerships**

195 ***Employers and Affiliates***[52]

196 25. Physicians who employ or offer privileges to regulated health professionals or who
197 associate in partnership with such professionals ("employers and affiliates") **must** report to
198 the relevant college when they terminate the employment of a regulated health
199 professional, or revoke, suspend or restrict their privileges, or dissolve their partnership,
200 health profession corporation or association for reasons of:

201 a. professional misconduct,[53]
202 b. incompetence,[54] or
203 c. incapacity[55].[56]

204 26. Physicians who are "employers and affiliates" **must** make a report when a regulated health
205 professional resigns, or voluntarily relinquishes or restricts their privileges, if:

206 a. they have reasonable grounds to believe that the resignation, relinquishment or
207 restriction of the regulated health professional is related to that member's
208 professional misconduct, incompetence or incapacity;[57] or
209 b. the resignation, relinquishment or restriction takes place during or as a result of an
210 investigation, conducted by or on behalf of the employer or affiliate, into allegations
211 related to that member's professional misconduct, incompetence or incapacity.[58]

[50] Sections 85.3(3) of the *HPPC*.
[51] Sections 85.3(4) of the *HPPC*.
[52] As set out in Section 85.5(3) of the *HPPC*, this section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services.
[53] Section 51(1) of the *HPPC* states that a panel shall find that a member has committed an act of professional misconduct if:
(a) the member has been found guilty of an offence that is relevant to the member's suitability to practise;
(b) the governing body of a health profession in a jurisdiction other than Ontario has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct as defined in the regulations;
(b.0.1) the member has failed to co-operate with the Quality Assurance Committee or any assessor appointed by that committee;
(b.1) the member has sexually abused a patient; or
(c) the member has committed an act of professional misconduct as defined in the regulations.
[54] Please see footnote 45 for the definition of incompetence.
[55] Please see footnote 46 for the definition of incapacity.
[56] Section 85.5(1) of the *HPPC*
[57] Section 85.5(2) paragraph 1 of the *HPPC*.

212 27. Physicians **must** include the following details of the event in their reports:

213 a. the reasons for the event or intended event,
214 b. the grounds upon which their belief is based, or
215 c. the nature of the allegations being investigated.[59]

216 28. Physicians **must** make all reports in writing and send them to the Registrar of the
217 appropriate college within 30 days after the obligation to report arises.[60]

218 ***Public Hospitals***

219 29. Physicians acting as hospital administrators **must** provide a detailed report to the College of
220 Physicians and Surgeons of Ontario (CPSO) in the following circumstances:[61]

221 a. A physician's application for appointment or reappointment to the medical staff of a
222 hospital is rejected, or the physician's privileges are restricted or cancelled, due to
223 the physician's incompetence, negligence, or misconduct;[62]
224 b. A physician resigns from the medical staff of a hospital or restricts his or her
225 practice within a hospital and there are reasonable grounds to believe that the
226 resignation or restriction is related to the physician's competence, negligence or
227 conduct;[63]
228 c. A physician resigns from the medical staff of a hospital or restricts his or her
229 practice within a hospital during or as a result of an investigation into the
230 physician's competence, negligence or conduct.[64]

231 **Births, Still-births and Deaths**

232 ***Live Births***

233 30. Physicians attending the birth of a child **must** give notice of the birth to the Registrar
234 General, in the form approved by the Registrar General, within two business days.[65]

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[58] Section 85.5(2), paragraph 2 of the *HPPC*.
[59] Section 85.5(1), 85.5(2), paragraph 1, and 85.5(2), paragraph 2 of the *HPPC*.
[60] Section 85.5(1) and 85.5(2) of the *HPPC*.
[61] Section 33 of the *Public Hospitals Act*, R.S.O. 1990, c. P. 40 (hereinafter *Public Hospitals Act*).
[62] Section 33(a) and 33(b) of the *Public Hospitals Act*.
[63] Section 33(c) of the *Public Hospitals Act*.
[64] Section 33(d) of the *Public Hospitals Act*.
[65] Section 8 of the *Vital Statistics Act*, R.S.O. 1990, c. V.4 (hereinafter *Vital Statistics Act*); Section 1(2) and (3) of *General*, R.R.O. 1990, Regulation 1094 enacted under the *Vital Statistics Act* (hereinafter *Vital Statistics Act, General Regulation*).

235 ***Still-births***

236 31. Physicians attending a still-birth **must** give notice of the still-birth to the Registrar General,
237 within two business days.[66]

238 32. Physicians **must** also complete a medical certificate of still-birth setting out the cause of the
239 still-birth, and deliver the medical certificate of still-birth to the funeral director in charge of
240 the body for the purpose of burial, cremation or other disposition.[67]

241 33. Physicians **must** provide both the notice of still-birth and medical certificate of still-birth in
242 the form approved by the Registrar General.[68]

243 34. If there is no physician in attendance at the still-birth, or there is reason to believe the still-
244 birth has occurred as a result of negligence, malpractice, misconduct or under
245 circumstances that require investigation, physicians who are appointed as coroners **must**
246 complete the medical certificate.[69]

247 ***Deaths***[70]

248 35. A physician who has been in attendance during the last illness of a deceased person, or who
249 has sufficient knowledge of the last illness, **must** complete and sign a medical certificate of
250 death in the form approved by the Registrar General.

251 36. Physicians **must:**

252 a. State the cause of death according to the *International Statistical Classification of*
253 *Diseases and Related Health Problems*, as published by the World Health
254 Organization, in the certificate; and
255 b. Deliver the certificate to the funeral director immediately.[71]

256 ***Notification of Coroner***

257 37. Physicians **must** immediately notify a coroner or police officer if there is reason to believe
258 that an individual has died:

259 a. as a result of violence, misadventure, negligence, misconduct or malpractice;
260 b. by unfair means;

[66] Section 19(3), paragraph (a) of the *Vital Statistics Act, General Regulation*.
[67] Section 20 of the *Vital Statistics Act, General Regulation*.
[68] Section 9.1 of the *Vital Statistics Act*; Sections 19(2) and 20 (1) of the *Vital Statistics Act, General Regulation*.
[69] Section 20(1), paragraphs 2 and 3 of the *Vital Statistics Act, General Regulation*.
[70] For guidance related to reporting deaths resulting from medical assistance in dying to the Coroner, please refer to the College's *Medical Assistance in Dying* policy.
[71] Section 21 of the *Vital Statistics Act*; Sections 35(2) and 70 of the *Vital Statistics Act, General Regulation*.

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261 c. during pregnancy or following pregnancy in circumstances that might be reasonably
262 attributed to the pregnancy;
263 d. suddenly and unexpectedly;
264 e. from disease or sickness for which he or she was not treated by a legally qualified
265 medical practitioner;
266 f. from any cause other than disease; or
267 g. under circumstances that may require investigation.[72]

268 38. Physicians **must** include the facts and circumstances relating to the death in their
269 notifications.[73]

270 39. Physicians who are appointed as coroners are **advised** to consult the *Coroners Act* to
271 understand their obligations.

272 **Communicable Diseases and Diseases of Public Health Significance**

273 40. Physicians **must** report to the Medical Officer of Health of the health unit in which the
274 professional services were provided, as soon as possible[74] when, in the course of providing
275 professional services, they have formed the opinion that an individual:

276 a. has or may have a disease of public health significance[75] and is not a patient in or an
277 out-patient of a hospital;[76]
278 b. is or may be infected with an agent of a communicable disease;[77]
279 c. is under the care and treatment of the physician for a communicable disease, but
280 refuses treatment, or neglects to continue treatment in a manner and to a degree
281 that is satisfactory to the physician.[78]

282 41. Where reports are made in relation to communicable diseases or diseases of public health
283 significance, physicians **must** include the following information about the individual
284 involved:

[72] Section 10(1) of the *Coroners Act*, R.S.O. 1990, c. C. 37 (hereinafter *Coroners Act*).
[73] Section 10(1) of the *Coroners Act*.
[74] Section 25(1), 26, 27(1), and 34(1) of the *Health Protection and Promotion Act, R.S.O. 1990, c. H.7 (hereinafter HPPA)*.
[75] A list of diseases of public health significance is contained in the *Designation of Diseases*, O. Reg 135/18 enacted under the *HPPA* (hereinafter *HPPA, Designation of Diseases Regulation*). A copy of this list can be obtained from the local Medical Officer of Health.
[76] Section 25(1) of *HPPA*; under section 27(1) of *HPPA* the reporting duty of hospital administrators arises if an entry in 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 may be infected with an agent of a communicable disease.
[77] A list of communicable diseases is contained in the *Designation of Diseases Regulation*. A copy of this list can be obtained from the local Medical Officer of Health.
[78] Section 34(1) of the *HPPA*.

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285 a. name and address in full, and if available, any other contact information;[79]
286 b. date of birth in full;
287 c. sex; and
288 d. date of onset of symptoms.[80]

289 42. For reports regarding the refusal of treatment for a communicable disease, or the neglect to
290 continue with treatment for a communicable disease to the satisfaction of the physician,
291 physicians **must** include the name and address of the individual.

292 43. Some diseases require additional information in the report. Physicians are **advised** to
293 consult the *Reports Regulation* for more information about their specific reporting
294 obligations.[81]

295 44. If the Medical Officer of Health requires additional information, physicians **must** provide the
296 information upon request.[82]

297 ***Duty to Report Death Due to a Disease of Public Health Significance***

298 45. Any physician who signs a death certificate indicating that the cause of death of an
299 individual was a disease of public health significance, or that a disease of public health
300 significance was a contributing cause of death, **must** report this to the Medical Officer of
301 Health for the health unit in which the death occurred.[83]

302 46. Physicians **must** make the report as soon as possible after signing the certificate.[84]

303 ***Eyes of New-Born***

304 47. When a physician attends the birth of a child and is aware that an eye of the new-born child
305 has become reddened, inflamed or swollen, the physician **must** make a written report to
306 the Medical Officer of Health within two weeks of the child's birth and include the following
307 information in their report:

308 a. the name, age, and home address of the child;

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[79] An exception exists to the requirement to include a patient's name and address. Section 5.1(2) of *Reports, R.R.O. 1990, Reg. 569, enacted under the HPPA (hereinafter HPPA, Reports Regulation*)sets out that when patients infected with an agent of AIDS receive testing in a designated clinic and are provided with counselling about preventing transmission, the patient's name and address are not required in the report. Schedule 1 of the *HPPA, Reports Regulation* sets out 50 clinics across the province where anonymous HIV testing is offered.
[80] Section 1(1) of the *HPPA*, *Reports Regulation*.
[81] For a list of diseases and their specific reporting requirements please see *HPPA, Reports Regulation*.
[82] Section 1(2) of the *HPPA, Reports Regulation*.
[83] Section 30 of the *HPPA*.
[84] Section 30 of the *HPPA*; Physicians are advised to consult the *HPPA*, *Reports Regulation* for information regarding the specific contents of these reports.

309 b. the whereabouts of the child (if not at home); and
310 c. the conditions of the eye that the physician has observed.[85]

311 ***Rabies***

312 48. Physicians who have information about an animal bite or animal contact that may result in
313 rabies in persons, **must** notify the Medical Officer of Health as soon as possible and provide
314 the Medical Officer of Health with the required information.[86]

315 ***Reactions to Immunizations***

316 49. If any of the following events occurs as a result of administering an immunizing agent[87], and
317 the physician is of the opinion that the event may be related to the immunization,
318 physicians **must** make a report to the Medical Officer of Health of the health unit in which
319 the professional services were provided within seven days of the event:[88]

320 a. persistent crying or screaming, anaphylaxis or anaphylactic shock occurring within
321 48 hours of being immunized;
322 b. shock-like collapse, high fever or convulsions occurring within three days of being
323 immunized;
324 c. arthritis occurring within 42 days of being immunized;
325 d. generalized urticarial, residual seizure disorder, encephalopathy, encephalitis, or
326 any other significant occurrence occurring within 15 days of being immunized; or
327 e. death occurring at any time and following upon a symptom as described above.

328 **Controlled Drugs and Substances**

329 50. When a physician discovers or is informed that a controlled substance (including a targeted
330 substance,[89] a narcotic,[90] or a controlled drug[91]) has been lost or stolen from their office,

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[85] Section 33(1) of the *HPPA*; Section 1, paragraph 2 of *Communicable Diseases – General*, R.S.O. 1990, Regulation 557 enacted under the *HPPA* (hereinafter *HPPA*, *Communicable Diseases – General Regulation*).
[86] Section 2(1) of the *HPPA, Communicable Diseases – General Regulation*.
[87] Section 38(1) of the *HPPA* defines an "immunizing agent" as a vaccine or combination of vaccines administered for immunization against any disease specified in this Act or the regulations; see *HPPA, Designation of Diseases Regulation* for a list of diseases against which immunizing agents are used.
[88] Sections 38(1) and 38(3) of the *HPPA*.
[89] A list of targeted substances is contained in Schedule 2 of the *Benzodiazepines and Other Targeted Substances Regulations*, SOR/2000-217, enacted under the *Controlled Drugs and Substances Act*, S.C. 1996, c.19.
[90] A list of narcotics is contained in the *Schedule to the Narcotic Control Regulations*, C.R.C., c. 1041, enacted under the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19.
[91] A list of controlled drugs is contained in the Schedule G to Part G of the *Food and Drug Regulations*, C.R.C., c. 870, enacted under *the Food and Drugs Act*, R.S.C., 1985, c. F-27.

331 the physician **must** report the loss or theft to the Office of Controlled Substances, Federal
332 Minister of Health, within 10 days.[92]

333 **Community Treatment Plans**

334 51. Physicians involved in the care of mentally ill patients who are following community
335 treatment plans, have specific reporting duties under the *Mental Health Act*, and its
336 regulations.[93] Where a physician issues an order for examination,[94] the physician **must**
337 ensure the police**:**

338 a. have complete and up-to-date contact information of the physician responsible for
339 completing the examination (including name, address and telephone number),
340 b. are provided with any information that has changed, and
341 c. are informed immediately if the patient attends the examination or if the order is
342 revoked for any other reason before it expires.[95]

343 **Gunshot Wounds**

344 The *Mandatory Gunshot Wounds Reporting Act, 2005* requires every facility[96] that treats a
345 person for a gunshot wound to report to police, as soon as is practical, the fact that a person is
346 being treated for a gunshot wound, the person's name, if known, and the name and location of
347 the facility.[97]

348 52. Physicians working in designated facilities **must** comply with any policies and procedures of
349 the facility to enable the reporting obligations to be met.

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[92] Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, enacted under the *Controlled Drugs and Substances Act*; Section 55(g) of the *Narcotic Control Regulations*, enacted under the *Controlled Drugs and Substances Act*.
[93] *Mental Health Act*, R.S.O. 1990, c. M.7 (hereinafter *Mental Health Act); General* R.R.O. 1990, Reg. 741, enacted under the *Mental Health Act*, R.S.O. 1990, c. M.7 (hereinafter *Mental Health Act Regulations*).
[94] Sections 33.3(1), 33.3(2) and 33.4(3) of the *Mental Health Act* provide that physicians may issue an order for examination if they have reason to believe that the patient is not attending appointments, or is otherwise failing to comply with his or her treatment plan, or the patient (or substitute decision maker) withdraws consent for the treatment plan and refuses to allow the physician to review his or her condition. Section 33.5 of the *Mental Health* Act provides that physicians who issue or renew a community treatment order are responsible for the general supervision and management of the order.
[95] Section 7.4 of the *Mental Health Act Regulations*.
[96] Facilities charged with this obligation are public hospitals, and prescribed organizations or institutions that provide health care services. This reporting obligation may be extended to clinics and medical doctors' offices by regulation, however no regulations were in place as of September 2019.
[97] Section 2(1) of the *Mandatory Gunshot Wounds Reporting Act*, *2005*, S.O. 2005, c.9. The disclosure must be made orally, and as soon as it is reasonably practical to do so, without interfering with the person's treatment or disrupting the regular activities of the facility.

Pilots or Air Traffic Controllers

53. Under the *Aeronautics Act,* physicians **must** report patients they believe, on reasonable grounds, to be a flight crew member, an air traffic controller, or to hold a Canadian aviation document that imposes standards of medical or optometric fitness, where the physician is of the opinion that the patient has a medical or optometric condition that is likely to constitute a hazard to aviation safety.[98]

54. Physicians **must** make the report to a medical advisor designated by the federal Ministry of Transportation, or to a medical advisor designated by the federal Minister of National Defence, if the report relates to a matter of defence[99] and provide the following information:

    a. the physician's opinion regarding the patient's condition, and
    b. the information upon which the opinion is based. [100]

Maritime Safety

55. Under the *Canada Shipping Act,* physicians **must** inform the Ministry of Transportation without delay if they believe on reasonable grounds that the holder of a certificate issued under the *Act* has a medical or optometric condition that is likely to constitute a hazard to maritime safety.

56. Physicians **must** provide the following information in the report:

    a. the physician's opinion regarding the patient's condition, and
    b. the information upon which the opinion is based.[101]

Railway Safety

57. Under the *Railway Safety Act,* physicians **must** notify the railway company's Chief Medical Officer when they believe on reasonable grounds that a patient, occupying a position that is

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[98] Sections 3 and 6.5(1) of the *Aeronautics Act*, R.S.C. 1985, c. A.2 (hereinafter *Aeronautics Act*); further information on medical conditions of interest and reporting procedures can be found on the Transport Canada website, or by contacting the local Civil Aviation Medicine office.

[99] Section 6.5(1) of the *Aeronautics Act*; Under Section 3 of *Aeronautics Act*, a matter relating to defence includes any matter relating to military personnel or a military aircraft, military aerodrome, or military facility of Canada or a foreign state.

[100] Section 6.5(1) of the *Aeronautics Act*.

[101] Section 90(1) of the *Canada Shipping Act, 2001*, S.C. 2001, c.26 (hereinafter *Canada Shipping Act*); visit the Transport Canada website, or contact the Marine Medicine office by phone for additional information on medical conditions of interest and reporting procedures.

374 critical to railway safety,[102] has a condition that is likely to pose a threat to safe railway
375 operations.[103]

376 58. Physicians **must** first take reasonable steps to notify the patient, prior to sending a notice to
377 the railway company's Chief Medical Officer.

378 59. In relation to the notification, physicians **must:**

379 a. make notifications without delay,
380 b. indicate the physician's opinion regarding the condition, and the information upon
381 which the opinion is based;
382 c. provide the patient with a copy of the notice.[104]

383 **Occupational Health and Safety**

384 60. Under the *Occupational Health and Safety Act* physicians who conduct medical
385 examinations on individuals in relation to employment conditions or hazards have a number
386 of reporting requirements[105]and are **advised** to consult the legislation to understand their
387 obligations.

388 **Correctional Facilities**

389 61. Physicians who are treating or attending to inmates at a provincial correctional facility **must**
390 immediately provide a written report to the Superintendent of the facility when an inmate
391 is seriously ill, injured, or unable to work due to illness or disability[106]and include the nature
392 of the injury and the treatment provided.

393 62. Where reports relate to illness or disability, physicians **must** also include whether the
394 inmate is unfit to work or the work should be changed, if applicable.[107]

395 63. Physicians who are of the opinion that a detainee is infected or may be infected with an
396 agent of a communicable disease, **must** immediately notify the Medical Officer of Health of
397 the health unit in which the institution is located.[108]

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[102] Under Section 35(3) of the *Railway Safety Act*, R.S.C. 1985, c. 32 (hereinafter *Railway Safety Act*), at the time of any examination, patients must inform the physician if they hold a safety critical position.
[103] Section 35(2) of the *Railway Safety Act*; Transport Canada has published a document titled *Railway Medical Rules*. This document, which is available on the Transport Canada website, provides guidance for physicians who examine patients in positions that are critical to railway safety.
[104] Section 35(2) of the *Railway Safety Act*.
[105] *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1.
[106] Section 4(3) of the *General* R.R.O. 1990, Regulation 778, enacted under the *Ministry of Correctional Services Act*, R.S.O. 1990, c. M.22 (hereinafter *MCSA*, *General Regulation*).
[107] Section 4(4)(c) and 4(5) of the *MCSA*, *General Regulation*.

64. Where physicians are required, by court order, to report the results of a medical and/or psychological assessment of a young person to the court, physicians are **advised** to consult the *Youth Criminal Justice Act*[109] for further details.

Preferential Access to Health Care

65. When, in the course of professional duties, a physician has reason to believe that a person (either another physician or an individual) or entity has paid or conferred a benefit, or charged or accepted payment of a benefit in exchange for improved access to an insured health service, the physician **must** report the matter to the General Manager of the Ontario Health Insurance Plan.[110]

Health Card Fraud

66. Under the *Health Insurance Act*, physicians **must** promptly report instances of health card fraud to the General Manager of OHIP, including the following situations:

    a. An ineligible person[111] receives or attempts to receive an insured service as if they were an insured person.
    b. An ineligible person obtains or attempts to obtain reimbursement by the Ontario Health Insurance Plan (OHIP) for money paid for an insured service as if he or she were an insured person.
    c. An ineligible person, in an application, return or statement made to OHIP or the General Manager, gives false information about his or her residency.[112, 113]

Privacy Breaches

Privacy breach refers to any unauthorized collection, use, disclosure, retention or disposal of personal health information[114]. The *Personal Health Information Protection Act*, *2004* (*PHIPA*)

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[108] Section 37(1) of the *HPPA*.
[109] *Youth Criminal Justice Act*, S.C. 2002, c.1, including sections 34(1) and 34(14).
[110] Sections 17(1) and 17(2) of the *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c.5; Section 7(1) of *General Regulations*, O. Reg. 288/04, enacted under the *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c.5.
[111] Section 43.1(3) of the *Health Insurance Act*, R.S.O. 1990, c. H.6 (hereinafter *Health Insurance Act*), defines an "ineligible person" as a person who is neither an insured person nor entitled to become one.
[112] Sections 43.1(1) and (2) of the *Health Insurance Act*; Section 1(1), paragraph 1 of the *Health Fraud Regulation*, O. Reg. 173/98, enacted under the *Health Insurance Act*.
[113] Section 43.1(1) of the *Health Insurance Act*; Sections 43.1(5) and 43.1(6) of the *Health Insurance Act* provide that physicians may also make a voluntary report relating to the administration of the *Act* even if the information reported is confidential or privileged and despite any *Act*, regulation or other law prohibiting disclosure of the information.

420 requires reporting of privacy breaches in a number of instances. Those duties pertinent to
421 physicians are set out below.

422 ***Reporting to Affected Individuals***

423 67. Where personal health information is stolen, lost or used or disclosed without authority,
424 physicians acting as health information custodians (custodians) must notify individuals
425 about the breach and their entitlement to make a complaint to the Information and Privacy
426 Commissioner (IPC), at the first reasonable opportunity.[115, 116]

427 68. As part of the notification, physicians **must** disclose the following to affected individuals:[117]

428 a. details of the breach, including the extent of the breach and what personal health
429 information was involved;
430 b. the steps the physician has taken to address the breach, including if the breach has
431 been reported to the IPC; and
432 c. contact information for someone within the organization who can provide
433 additional information, assistance and answer questions.

434 69. When determining the most appropriate form of notification (i.e., by telephone, in writing,
435 or in person at the next appointment) physicians **must** consider factors such as the
436 sensitivity of the personal health information.[118]

437 70. For more information about obligations related to a privacy breach, physicians are **advised**
438 to contact the IPC directly and/or refer to the IPC's guidance documents.[119]

439 ***Reporting to Regulatory Colleges***

440 71. Physicians acting as custodians, who employ, extend privileges to, or are otherwise
441 affiliated with physicians or other regulated health professionals[120] **must** to notify the
442 relevant regulatory body (such as the CPSO) if any of the following events occur:

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[114] The definition of personal health information is set out in Section 4(1) of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (hereinafter *PHIPA*) as well as in the *College's* *Confidentiality of Personal Health Information* policy.
[115] Section 12(2)(a) and 12(2)(b) of *PHIPA*.
[116] Section 12(4) of *PHIPA* provides for an exception to the notification requirement if the custodian is a researcher and specific conditions are met. Further exceptions may be established by regulation, however no such regulations are in force as of September, 2019.
[117] IPC's Privacy Breach Protocol.
[118] IPC's Privacy Breach Protocol.
[119] For example: *Privacy Breach Protocol*, *What to do when faced with a privacy breach: Guidelines for the health sector*, and *Reporting a Privacy Breach to the Commissioner*.

443 a. The regulated health professional's employment is terminated or suspended, or the
444 regulated health professional is subject to disciplinary action, as a result of a privacy
445 breach by the regulated health professional;[121]
446 b. The regulated health professional resigns, and the custodian has reasonable grounds
447 to believe that the resignation is related to an investigation or other action by the
448 custodian with respect to an alleged privacy breach by the regulated health
449 professional;[122]
450 c. The regulated health professional's privileges or affiliation with the custodian are
451 revoked, suspended or restricted as a result of a privacy breach by the regulated
452 health professional;[123]
453 d. The regulated health professional relinquishes or voluntarily restricts his or her
454 privileges or affiliation with the custodian, and the custodian has reasonable
455 grounds to believe that the relinquishment or restriction is related to an
456 investigation or other action by the custodian with respect to an alleged privacy
457 breach by the regulated health professional.[124, 125]

458 72. Physicians acting as custodians **must** give written notice of any of the events described
459 above to the appropriate college within 30 days of the event occurring.[126]

460 ***Reporting to Information and Privacy Commissioner***

461 73. Physicians acting as custodians **must** notify the IPC if at least one of the following situations
462 occurs where an individual's personal health information is stolen, lost or used or disclosed
463 without authority:[127]

464 a. The custodian has reasonable grounds to believe that personal health information in
465 their custody or control was used or disclosed without authority by a person who
466 knew or ought to have known that they did not have authority to use or disclose the
467 information.[128]

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[120] The obligations described in this section also arise if the employee is a member of the Ontario College of Social Workers and Social Service Workers.
[121] Section 17.1(2) para. 1 of *PHIPA.*
[122] Section 17.1(2) para. 2 of *PHIPA.*
[123] Section 17.1(5) para. 1 of *PHIPA.*
[124] Section 17.1(5) para. 2 of *PHIPA.*
[125] A custodian who is a medical officer of health has specific reporting obligations in respect of its agents. See Section 17.1(3)(4) of *PHIPA.*
[126] Section 17.1(2) and 17.1(5) of *PHIPA*.
[127] Section 12(3) of *PHIPA*.
[128] Section 6.3(1)1 of *General Regulations*, O. Reg. 224/17, s. 1, enacted under *PHIPA* (*hereinafter PHIPA, General Regulation)*.

468 b. The custodian has reasonable grounds to believe that personal health information in
469 their custody or control was stolen.[129]
470 c. The custodian has reasonable grounds to believe that, after an initial loss or
471 unauthorized use or disclosure of personal health information in their custody or
472 control, the personal health information was or will be further used or disclosed
473 without authority.[130]
474 d. The loss or unauthorized use or disclosure of personal health information is part of a
475 pattern of similar losses or unauthorized uses or disclosures of personal health
476 information in the custody or control of the custodian.[131]
477 e. The custodian is required to notify a college regarding the employment, privileges or
478 affiliation of a regulated health professional (as outlined above), in circumstances
479 involving the loss or unauthorized use or disclosure of personal health
480 information.[132]
481 f. The custodian would be required to notify a college regarding the employment,
482 privileges or affiliation of an agent (a person who acts for or on behalf of the
483 custodian)[133] if the agent were a regulated health professional, in circumstances
484 involving the loss or unauthorized use or disclosure of personal health
485 information.[134]
486 g. The custodian determines that the loss or unauthorized use or disclosure of personal
487 health information is significant.[135] When determining whether a breach is
488 significant, consideration must be given to all relevant circumstances, including the
489 following:

490 i. Whether the personal health information that was lost or used or disclosed
491 without authority is sensitive;[136]
492 ii. Whether the loss or unauthorized use or disclosure involved a large volume of
493 personal health information;[137]
494 iii. Whether the loss or unauthorized use or disclosure involved many individuals'
495 personal health information;[138] and

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[129] Section 6.3(1)2 of *PHIPA*, *General Regulation*.
[130] Section 6.3(1)3 of *PHIPA*, *General Regulation*.
[131] Section 6.3(1)4 of *PHIPA*, *General Regulation*.
[132] Section 6.3(1)5 of *PHIPA*, *General Regulation*.
[133] The full definition of "agent" is set out in Section 2 of *PHIPA*.
[134] Section 6.3(1)6 of *PHIPA*, *General Regulation*.
[135] Section 6.3(1)7 of *PHIPA*, *General Regulation*.
[136] Section 6.3(1)7i of *PHIPA*, *General Regulation*.
[137] Section 6.3(1)7ii of *PHIPA*, *General Regulation*.
[138] Section 6.3(1)7iii of *PHIPA*, *General Regulation*.

496 iv. Whether more than one health information custodian or agent was responsible
497 for the loss or unauthorized use or disclosure of the personal health
498 information.[139]

499 ***Tracking Breaches and Annual Reports***

500 74. Physicians acting as custodians **must** provide the IPC with an annual report setting out the
501 number of times in the previous calendar year that personal health information in the
502 custodian's custody or control was stolen, lost, or used or disclosed without authority.[140]

503 75. Physicians **must** submit reports to the IPC electronically by March 1st each year, in the
504 format determined by the Commissioner.[141, 142]

505 **Reporting Offences, Professional Negligence and Malpractice, Findings by Another**
506 **Professional Regulatory Body, and Charges and Bail Conditions**

507 76. Physicians **must** provide a written report to the Registrar of the CPSO as soon as reasonably
508 practicable in the following circumstances:

509 a. They have been found guilty of an offence;[143]
510 b. A finding of professional negligence or malpractice has been made against them;[144]
511 c. A finding of professional misconduct or incompetence has been made against them
512 by another professional regulatory body, inside or outside of Ontario;[145]
513 d. They have been charged with an offence. The report must include information
514 about every bail condition or other restriction imposed on, or agreed to, by the
515 physician in connection with the charge.[146]

516 77. Physicians **must** submit the report as soon as reasonably practicable after they receive
517 notice of the finding or of the charge, bail condition or restriction.[147]

518 78. For reports related to offences, physicians **must** include:

519 a. their name;

[139] Section 6.3(1)7iv of *PHIPA*, *General Regulation*.
[140] Section 6.4(1) of *PHIPA*, *General Regulation*.
[141] Section 6.4(2) of *PHIPA*, *General Regulation*.
[142] For additional information please see the IPC's *Reporting a Privacy Breach to the Commissioner: Guidelines for the Health Sector.*
[143] Section 85.6.1 (1) of the *HPPC*.
[144] Section 85.6.2 (1) of the *HPPC*.
[145] Section 85.6.3 (2) of the *HPPC*; section 85.6.3 (1) of the *HPPC* requires physicians to also advise the Registrar in writing if they are a member of another professional regulatory body, inside or outside of Ontario.
[146] Section 85.6.4 (1) of the *HPPC.*
[147] Section 85.6.1 (2), 85.6.2 (2), 85.6.3 (3), 85.6.4 (2) of the *HPPC*.

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520 b. the nature of, and a description of the offence;
521 c. the date they were found guilty of the offence;
522 d. the name and location of the court that found them guilty of the offence; and
523 e. the status of any appeal initiated respecting the finding of guilt.[148]

524 79. For reports related to findings of professional negligence and malpractice, physicians **must**
525 include:

526 a. their name;
527 b. the nature of, and a description of the finding;
528 c. the date that the finding was made against them;
529 d. the name and location of the court that made the finding against them; and
530 e. the status of any appeal initiated respecting the finding made against them.[149]

531 80. For reports related to findings of professional misconduct or incompetence by another
532 professional regulatory body, physicians **must** include:

533 a. their name;
534 b. the nature of, and a description of the finding;
535 c. the date the finding was made against them;
536 d. the name and location of the body that made the finding against them; and
537 e. the status of any appeal initiated respecting the finding made against them.[150]

538 81. For reports related to charges and bail condition or other restrictions, physicians **must**
539 include:

540 a. their name;
541 b. the nature of, and a description of, the charge;
542 c. the date the charge was laid against them;
543 d. the name and location of the court in which the charge was laid or in which the bail
544 condition or restriction was imposed on or agreed to by the physician;
545 e. every bail condition imposed on the physician as a result of the charge;
546 f. any other restriction imposed on or agreed to by the physician relating to the
547 charge; and
548 g. the status of any proceedings with respect to the charge.[151]

[148] Section 85.6.1 (3) of the *HPPC*.
[149] Section 85.6.2 (3) of the *HPPC*.
[150] Section 85.6.3 (4) of the *HPPC*.
[151] Section 85.6.4 (3) of the *HPPC*.

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549 82. Physicians **must not** include any information that violates a publication ban in their
550 report.[152]

551 83. If there is a change in status of the finding that results from an appeal, or a change in status
552 of the charge or bail conditions, physicians **must** submit an additional report to the
553 Registrar.[153]

554 ## Permissive Reports

555 There are circumstances where the disclosure of personal information is permitted by law or
556 based in professionalism and ethics. Listed below are two instances in particular where reports
557 by physicians are permissible.[154,155]

558 ***Disclosure to Prevent Harm***

559 84. Under *PHIPA*, physicians are permitted to disclose personal health information about an
560 individual if they have reasonable grounds to believe disclosure is necessary to eliminate or
561 reduce significant risk of serious bodily harm to a person or group of persons.[156] Physicians
562 **must** use their professional judgment to determine whether a report is necessary to reduce
563 or eliminate risk of harm, considering factors such as the following:
564
565 a. there is a clear risk to an identifiable person or a group of persons;
566 b. there is a risk of serious bodily harm or death; and
567 c. the danger is imminent.[157]

568 85. Where disclosure of confidential information is necessary to reduce or eliminate risk of
569 harm, physicians **must** only include the information necessary to prevent the harm.

570 ***Physician Incapacity and Incompetence***

571 The College's expectations with respect to physician incapacity and incompetence are based in
572 professionalism and ethics. They are distinct from the legal obligation contained in the *Health*

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[152] Section 85.6.1 (4), 85.6.2 (4), 85.6.3 (5) and 85.6.4 (4) of the *HPPC*.
[153] Section 85.6.1 (6), 85.6.2 (6), 85.6.3 (7) and 85.6.4 (6) of the *HPPC*.
[154] For details on additional permissible disclosures available under *PHIPA* physicians are encouraged to review the College's *Confidentiality of Personal Health Information* policy.
[155] In keeping with provision #3 in this policy, physicians are advised to contact the CMPA or the IPC if they are uncertain whether disclosure is appropriate.
[156] Section 40(1) of *PHIPA*. There are no restrictions on the types of persons to whom the information may be disclosed.
[157] The courts have set out circumstances in which concern for public safety may warrant the disclosure of confidential information to reduce or eliminate risk of harm. Smith v. Jones, [1999] S.C.J. No. 15 (S.C.C.).

573 *Professions Procedural Code*, which requires health facility operators to report incapacity and
574 incompetence.

575 86. Physicians **must** take appropriate and timely action when they have reasonable grounds to
576 believe that another physician or health-care professional is incapacitated[158] or
577 incompetent[159], including circumstances where a colleague's pattern of care, health or
578 behaviour poses a risk to patient safety. Depending on the circumstances, appropriate
579 action may include:

580 a. Contacting the Physician Health Program at the Ontario Medical Association,
581 b. Contacting the College's Physician Advisory Service,
582 c. Contacting the individual's friends and family and/or employer, and
583 d. Notifying the individual to whom the physician is accountable (e.g., in a clinic or
584 hospital setting).

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[158] Please see footnote 46 for the definition of incapacity.
[159] Please see footnote 45 for the definition of incompetence.

Medical Expert: Reports and Testimony

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

Medical Expert[1]: medical experts assist those involved in a legal proceeding to understand the medical evidence. A medical expert is typically requested to interpret and/or provide his or her opinion on clinical, scientific or technical issues that normally lie outside the knowledge and experience of the average person. Physicians acting as experts are different from witnesses of fact (testifying about events that they themselves have observed). Acting as a medical expert may involve providing a written and/or oral expert opinion.

Policy[2]

1. When acting as medical experts, physicians **must** provide objective and impartial opinions on matters that fall within their scope of expertise

2. Physicians are **advised** to obtain legal advice if they are unsure of their obligations in specific circumstances.

Accepting a Request to Act as a Medical Expert

Obligation to Act as a Medical Expert

3. Physicians do not have an obligation to act as medical experts. Before agreeing to act as an expert, physicians must consider, among other things, whether they have the requisite

[1] "Expert witness" is another term commonly used to describe a physician who acts as an expert.

[2] This policy is not an exhaustive catalogue of the totality of requirements that may apply to experts who write reports and/or provide testimony. Specific requirements can include, but are not limited to, those found in the *Rules of Civil Procedure* or specific rules for various legal contexts or in the principles of solicitor-client and litigation privilege.

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expertise the matter requires, and whether any actual or potential conflicts of interest exist between them and the parties involved. [3]

4. Where physicians have any doubt as to whether acting as a medical expert is prudent, they are **advised** to obtain legal advice before proceeding.

Potential Conflicts of Interest

5. To manage conflicts of interest effectively, physicians are **advised** to disclose the existence of the potential conflict before accepting requests to act as medical experts.

6. When disclosing potential conflicts of interest involving a patient or former patient, physicians **must not** disclose any personal health information about that patient without their consent, unless permitted or required by law.

Communication Regarding the Physician's Role

7. Where the physician finds it necessary to interact directly with the individual[4] who is the subject of the legal proceeding, they **must** be clear about the nature of their role as medical expert.

8. Physicians **must** explain that their role is not to treat the individual, but to provide objective and impartial opinions to assist the adjudicative body (e.g., court) involved in the legal proceeding and that:

    a. their role may involve obtaining, using and disclosing personal health information about the individual to the person instructing them (e.g., lawyer), in the context of providing an expert opinion;
    b. this information or expert opinion may also be shared with others involved in the legal proceeding, if the lawyer decides to use it in the proceedings; and
    c. where required, consent for obtaining, using and disclosing personal health information will be obtained.

9. Physicians are also **advised** to convey that the final outcome of the legal proceeding is not determined by them, but rather by the adjudicative body involved in the legal proceeding.

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[3]For more information on potential conflicts of interest, please see the Advice document.
[4] For the purposes of the provisions of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18, concerning sexual abuse of a patient, the College will consider individuals to be patients.

57 *Consent*[5]

58 10. Where physicians are asked to review the personal health information of a specific
59 individual, they **must** ensure that proper consent has been obtained to use to use and
60 disclose that information in their report and/or testimony, unless they are permitted or
61 required by law to use and disclose that information.[6]
62
63 11. If physicians are asked to conduct a medical examination on a specific individual, consent
64 for the examination **must** be obtained.
65
66 12. Physicians are **advised** to err on the side of caution and obtain legal advice if they are
67 uncertain about their consent obligations for any reason.

68 *Fees*

69 13. Physicians **must** discuss fees for acting as medical experts with those who are instructing
70 them.
71
72 14. Physicians **must** only charge fees that are reasonable for acting as medical experts.[7,8]

73 *Presence of Observers and Audio/ Video Recording*

74 *15.* If physicians are conducting a medical examination for the purposes of a legal proceeding
75 and one or more parties wish to have an observer present and/or record the examination,

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[5] For more information on consent obligations, see the Advice document.
[6] Where personal health information is reviewed or obtained, physicians may only collect, use and disclose personal health information with the consent of the individual to whom the personal health information relates, or as permitted or required by law. Consent requirements for the disclosure of personal health information are contained in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Schedule A (hereinafter *PHIPA*), and/or the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c.5
[7] In addition to any attendance fees that may be set for specific proceedings, (for example, if a physician has been summoned to testify in court as a witness/medical expert, the daily attendance is set in the rules that regulate the procedures of that particular trial or hearing. This can include the *Rules of Civil Procedure*, the *Family Law Rules*, etc.) some organizations (e.g., the CMPA) have set fees for physicians who are retained as medical experts by that organization. Physicians can refer to the Ontario Medical Association *Physician's Guide to Uninsured Services* for guidelines, and/or other guidelines prepared by relevant organizations (e.g., Canadian Society of Medical Evaluators), as appropriate. For more information on fees see the Advice document.
[8] Under Sections 1(1), paragraph 21 and 1(1), paragraph 22 of *Professional Misconduct*, O. Reg., 856/93, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30, it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided, and to charge more than the current recommended fees in the Ontario Medical Association Guide without first notifying the patient of the excess amount that will be charged.

76 physicians are **advised** to discuss the matter with the person instructing them, as specific
77 rules may apply.[9]

78 *Instructions*

79 16. Before providing expert opinions, physicians **must** ensure that they understand what they
80 are being asked to do, and specifically, what questions they are being asked to answer.
81
82 17. If the instructions are unclear, inadequate or conflicting, physicians **must** seek clarification
83 from those instructing them.

84 ***Acting as a Medical Expert***
85
86 *Objectivity & Impartiality*
87
88 When physicians provide expert opinions, their duty to the adjudicative body prevails over any
89 obligation to the person who is instructing or paying them.

90 18. Physicians acting as medical experts **must**:
91 d. assist the adjudicative body by providing objective and impartial opinions;[10]
92 e. be honest, objective and impartial;
93 f. provide opinions that are reasonable, fair, balanced, and substantiated by fact,
94 scientific evidence[11] or experience, and sound clinical judgment;
95 g. **not** advocate for any party involved in the legal proceeding;
96 h. **not** allow personal bias to prejudice the expert opinions they give;
97 i. **not** provide comments that are unrelated to the expert opinion; and
98 j. **not** make any unprofessional comments or criticisms regarding the other experts or
99 individuals involved in the legal proceeding.[12]

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[9] For example, for court-ordered examinations, *Rules of Civil Procedure*, O. Reg., 438/08, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43 (hereinafter *Courts of Justice Act, Rules of Civil Procedure*). Rule 33.05 states: "No person other than the person being examined, the examining health practitioner and such assistants as the practitioner requires for the purpose of the examination shall be present at the examination unless the court orders otherwise."

[10] See for example the duties of experts set out in Section 4.1.01 of the *Courts of Justice Act, Rules of Civil Procedure*.

[11] Scientific evidence includes scientific theory and technique. The trier of fact (i.e., judge, jury, etc.) must determine the reliability of the scientific evidence that the expert's opinion relies upon.

[12] For additional information on professionalism, refer to the College's Practice Guide.

100 *Scope of Expertise*

101 19. Physicians **must** accurately represent their scope of expertise and restrict their statements
102 to areas in which they have expertise.
103
104 20. If a particular question or issue falls outside the physician's area of expertise, the physician
105 **must** clearly state this and decline to answer. [13]

106 *Comprehensiveness & Accuracy*

107 21. Physicians **must** provide expert opinions that are comprehensive and accurate.[14]
108
109 22. Physicians **must** ensure that all relevant information has been considered,[15] and that the
110 information they rely on to form their expert opinions is accurate. [16]
111
112 23. Physicians **must** clearly express when they do not have enough information to arrive at a
113 conclusion on a particular point, or where their opinions are otherwise qualified.
114
115 24. If physicians change their opinions, they **must** communicate this to the person instructing
116 them in a timely manner.

117 *Transparency*

118 25. Physicians **must:**
119 k. be transparent about the instructions they have been given, the process they use to
120 form their opinions, and the information they rely upon in doing so[17];
121 l. be clear about what has been requested of them (e.g., the questions they were
122 asked to answer);
123 m. have a clear and comprehensible reasoning process, from the underlying data to the
124 ultimate opinion; and
125 n. state all factual assumptions on which the expert opinions are based, and describe
126 any research they conducted and any documents or records they relied upon in
127 forming their opinions.

[13] Canadian Medical Protective Association, *Effective Testifying* (CMPA, 2008).
[14] Section 1(1), paragraph 18 of the *Medicine Act, Professional Misconduct Regulation*.
[15] As articulated in the College's Third Party Reports policy, physicians must ensure that they have obtained and reviewed all available information that could impact their findings, opinion and/or recommendation.
[16] As articulated in the Third Party Reports policy, if physicians rely on information which they cannot substantiate independently, physicians must note the source of the information and the fact that it has not been independently confirmed.
[17] See for example Section 53.03(2.1) of the *Courts of Justice Act, Rules of Civil Procedure*.

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128 *Clarity*

129 26. To allow for optimal clarity, physicians **must** use language and terminology that will be
130 readily understood by lay persons. As part of this, physicians **must** explain any abbreviations
131 and medical or other technical terminology used.

132 *Timeliness*

133 27. Physicians **must** provide written reports and/or testimony without unreasonable delay.[18]

134 ***Final Considerations***

135

136 *Suspicious Findings*

137

138 When examining an individual or reviewing the personal health information of an individual
139 whom they are not treating, a physician may become aware of a suspicious finding where it is
140 unclear whether it has been previously identified, including an unexpected significant clinical
141 finding or condition that raises serious concerns or may require essential intervention.[19] Given
142 that the physician is conducting the examination or review in their role as medical expert, and
143 not as treating physician, they may have different responsibilities concerning the disclosure of
144 the suspicious finding to the individual, as specific legal obligations may apply.

145 28. In general, physicians who become aware of a suspicious finding **must** use their professional
146 judgment to determine whether to seek legal advice, based on the circumstances of the
147 particular case.

148

149 a. Where the suspicious finding does not suggest that the individual is at immediate
150 risk of harm and that urgent medical intervention is required, physicians **must** seek
151 independent legal advice regarding the disclosure of the suspicious finding to the
152 individual.

153 b. Where the suspicious finding suggests the individual is at imminent risk of significant
154 harm and immediate medical care is required, physicians **must** exercise their
155 professional judgment to determine whether the patient's current clinical status is
156 urgent enough to warrant immediate disclosure to the individual.

157 i. When physicians notify an individual of suspicious findings, physicians are
158 **advised** to emphasize the importance of obtaining timely medical attention

[18] Section 1(1), paragraph 17 of the *Medicine Act, Professional Misconduct Regulation*.

[19] This includes, but is not limited to, undiagnosed conditions and conditions for which immediate diagnostic intervention is required.

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159 and to seek the individual's consent to share these findings with his or her
160 primary care provider.
161 ii. When consent is obtained, physicians are **advised** to convey the findings in
162 written form to the primary care provider to facilitate appropriate medical
163 follow-up.
164
165 29. If the suspicious finding is disclosed, physicians **must** only provide clinical information that is
166 directly relevant to the finding.

167 *Records Retention & Access*

168 Generally speaking, physicians are required to retain records[20] and provide access to that
169 information with appropriate consent, where applicable.[21] However, when acting as medical
170 experts, their obligations may depend on the rules governing the legal proceeding and the
171 specific circumstances of the case.

172 30. Physicians are **advised** to familiarize themselves with the legal requirements applicable to
173 the specific context in which they are providing their expert opinions and/or obtain
174 independent legal advice regarding their obligations to retain records and/or provide access
175 to the information.

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[20] Sections 18 and 19 of the *General*, O. Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30.
[21] For information on medical record-keeping requirements, refer to the College's Medical Records policy. For more information on the disclosure of personal health information, see *PHIPA*.

Advice to the Profession: Medical Expert: Reports and Testimony

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.

At times, physicians may be asked to participate in legal proceedings as medical experts. A medical expert's role is to assist those involved in the legal proceeding to understand the medical evidence. A medical expert's opinion is relied upon to make important decisions that have a significant impact on all parties involved in the legal proceeding.

As such, there are important considerations for any physician acting as a medical expert. This document is intended to help physicians understand the role and responsibilities of a medical expert and how to discharge them, in line with their professional expectations set out in the *Medical Expert: Reports and Testimony* policy.

What is the role of a medical expert?

Medical experts may provide opinions in writing (i.e., a report) and/or orally (i.e., testimony). Physicians may provide opinions about an individual, or opine on broader topics, such as an area of medical practice, or a medical condition, provided that they have the expertise the matter requires. When physicians are asked to provide expert opinions about an individual, they may review personal health information provided to them about the individual, or information they obtain themselves (e.g., during a medical examination), to formulate their opinions.[1]

Who can be a medical expert?

Any physician (treating or non-treating) could be a medical expert by virtue of his or her knowledge and experience as a physician, provided that the issue falls within his or her area of expertise and he or she has no actual or potential conflicts of interest. It is not only leading specialists that are qualified to act as experts.[2]

What kind of situations would constitute a potential conflict of interest?

Examples of situations where physicians could have a conflict of interest include: the physician acted as the opposing party's treating physician, the physician had previously discussed the

[1] Where personal health information is reviewed or obtained, physicians may only collect, use and disclose personal health information with the consent of the individual to whom the personal health information relates, or as permitted or required by law.
[2] Canadian Medical Protective Association, A Medico-Legal Handbook for Physicians in Canada (CMPA, 2010)

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31 case with another party, or the physician had a personal or professional relationship with any of
32 the parties involved.

33 ***What is the difference between a witness of fact and a medical expert?***

34 A witness of fact is typically asked or required to provide information about a patient, in his or
35 her capacity as a treating physician. Physicians may be asked to provide information regarding
36 what the patient stated, what symptoms were reported, what examination was undertaken,
37 what the diagnosis was, and what advice or treatment was offered. A medical expert is
38 expected to provide an opinion. Expert opinions are given in situations where someone with a
39 layperson's knowledge or experience is unlikely to reach the correct inference from the facts
40 alone.[3]

41 ***How does a physician become a medical expert?***

42 Physicians are asked to be medical experts. For example, physicians can be asked by a lawyer to
43 provide expert opinions. Before a medical expert's report and/or testimony are considered by
44 the adjudicative body, the adjudicative body must qualify the physician as an "expert".
45 Typically, physicians are required to provide their curriculum vitae and the adjudicative body
46 uses the criteria in *R v. Mohan*[4] to determine the admissibility of expert evidence.

47 ***What types of legal proceedings may require a medical expert opinion?***

48 There are many different types of legal proceedings which may require a medical expert
49 opinion. Some examples include proceedings before the following adjudicative bodies: a federal
50 or provincial court (e.g. medico-legal litigation cases, criminal trials), a tribunal established
51 under an Act of Parliament or under an Act of the Legislature of Ontario (e.g. a hearing before
52 the College of Physicians and Surgeons of Ontario's Discipline Committee or Fitness to Practise
53 Committee), a commission or board appointed under an Act of Parliament or under an Act of
54 the Legislature of Ontario (e.g. workplace safety and insurance board), or an arbitrator, etc.

55 ***If I am asked to provide an expert opinion about a specific individual, what information would***
56 ***I review?***

57 When physicians are asked to provide expert opinions about an individual, they may review
58 personal health information provided to them about the individual (e.g. their medical records),
59 or information they obtain themselves (e.g. during a medical examination), to formulate their

[3] Frank Iacobucci & Graeme Hamilton, "The Goudge Inquiry and the Role of Medical Expert Witnesses" (2010) 182 (1) CMAJ 53.
[4] R. v. Mohan, [1994] 2 S.C.R. 9.

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60 opinions. Those instructing the physician will explain what information he or she is expected to
61 review/obtain.

62 ***Are reports written by medical experts considered third party reports, and does the Third***
63 ***Party Reports policy apply?***

64 Yes, the reports medical experts write are considered 'third party reports' because they are
65 being prepared for a third party process (e.g. legal proceeding), instead of for the purpose of
66 the provision of health care. The report requirements contained in the *Third Party Reports*
67 policy are consistent with those found in the *Medical Expert* policy. However, the *Third Party*
68 *Reports* policy does not contain professional expectations regarding the unique role physicians
69 must fulfill when acting as medical experts. Therefore, the *Medical Expert* policy contains the
70 professional expectations that apply to physicians who write reports and/or provide testimony
71 as medical experts.

72 ***When will consent for obtaining, using or disclosing personal health information be required?***

73 Obligations with respect to consent will differ depending on whether physicians are asked to
74 provide opinions about a specific individual, or whether physicians have been asked to
75 comment on more general matters, such as a specific area of medicine, or a medical condition.

76 Where physicians are providing opinions on more general matters and no information about a
77 specific individual has been obtained or will be disclosed, consent is likely not required. Where
78 information does not identify an individual or where it is not reasonably foreseeable in the
79 circumstances that the information could be utilized, either alone or with other information, to
80 identify an individual, consent is not required to collect, use or disclose the information.

81 As the policy outlines, where you are asked to:

82 - review the personal health information of a specific individual, or
83 - conduct a medical examination on a specific individual

84 you must obtain proper consent to use and disclose that information, unless you are permitted
85 or required to do so by law

86 ***Who am I providing the expert opinion for?***

87 Even though physicians may be asked to be medical experts by a party involved in the legal
88 proceeding (i.e. Crown prosecutor in a criminal case), medical experts are not advocates for
89 either side. Their duty is solely to the adjudicative body. A medical expert's role is to assist the
90 adjudicative body by providing an objective and impartial opinion.

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91 ***How much can I charge for providing an expert report and/or testimony?***

92 Providing expert reports and/or testimony is an uninsured service. As with any uninsured
93 service, physicians are able to charge a reasonable fee for the services they perform.[5] As the
94 policy states, physicians must discuss fees for acting as medical experts with those who are
95 instructing them. In some instances, financial arrangements for witnesses are established in
96 law. If a physician has been summoned to testify in court as a witness/medical expert, the daily
97 attendance is set in the rules that regulate the procedures of that particular trial or hearing.
98 This can include the *Rules of Civil Procedure*, the *Family Law Rules*, etc.

99 In addition to any attendance fees that may be set for specific proceedings, some organizations
100 (e.g. the CMPA) have set fees for physicians who are retained as medical experts by that
101 organization. Physicians can also refer to the Ontario Medical Association *Physician's Guide to*
102 *Uninsured Services* for guidelines and/or other guidelines prepared by relevant organizations
103 (e.g. Canadian Society of Medical Evaluators), as appropriate.

104 ***Where can I find out more information about being a medical expert?***

105 There are a number of different resources to assist physicians who act as medical experts.
106 Please see the following resources for more information:

107 Canadian Medical Protective Association, *Preparing medico-legal reports: suggestions*
108 *for physicians* (CMPA, 2008).
109
110 Canadian Medical Protective Association, *Avoid pitfalls when preparing medico-legal*
111 *reports* (CMPA, 2008).
112
113 Canadian Medical Protective Association, *Expectations for experts' reports are changing*
114 (CMPA, 2011).
115
116 Canadian Medical Protective Association, *Testifying: what it involves and how to do it*
117 *effectively* (CMPA, 2018).
118
119 Medico-Legal Society of Toronto, *Medico-Legal Report* (MLST, 2008).

[5] Section 1(1), paragraph 21 of Professional Misconduct, O. Reg., 856/93, enacted under the Medicine Act, 1991, S.O. 1991, c. 30.

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Physician Behaviour in the Professional Environment

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

Disruptive behaviour: inappropriate words, actions, or inactions by a physician that interfere with (or may interfere with) the physician's ability to collaborate, the delivery of quality health care, or the safety or perceived safety of others. Disruptive behaviour may be demonstrated through a single act, but will more commonly be identified through a pattern of events.

Policy

General

1. Physicians **must** take responsibility for their behaviour and meet the obligations and expectations set out in this policy, other College policies,[1] the *Practice Guide,* and applicable legislation,[2] along with the expectations set out in institutional Codes of Conduct, policies, or by-laws. Specifically:

    a. Physicians **must** uphold the standards of medical professionalism, conduct themselves in a professional manner, and not engage in disruptive behaviours.
    b. Physicians **must** act in a respectful, courteous, and civil manner towards their patients,[3] colleagues,[4] and others involved in the provision of health care.

2. If a physician is unable to control their behaviour on their own, they are **advised** to seek appropriate assistance to do so.

[1] These include *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* (regarding sexual abuse and misconduct) and *Professional Obligations and Human Rights* (regarding discriminatory behaviour).
[2] For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 (hereinafter "*OHSA*").
[3] This includes the family and friends of patients.
[4] Colleagues are considered all those who work with the physician, whether members of a health regulatory college or not. This includes other physicians, nurses, trainees, non-clinical staff, volunteers, and all other individuals who contribute to health-care delivery.

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28 3. In addition to whatever resources may be available through their local setting (medical
29 school, hospital, or other work environment), physicians and their colleagues are **advised** to
30 contact the Ontario Medical Association's Physician Health Program to explore the
31 resources available for obtaining assistance.[5]

32 ***Responsibilities to Patients***

33 4. Physicians **must** act in the best interests of the individual patient.[6] This includes acting
34 respectfully toward patients, their families, friends or visitors, and prospective patients,
35 even under stressful situations.
36
37 5. Advocacy for patients, both individually and collectively, is an important component of the
38 physician's role. While advocacy may sometimes lead to disagreement or conflict with
39 colleagues or the administration of the institution within which they work, physicians **must**
40 meet the expectation for professional behaviour even in these contexts.[7]

41 ***Responsibilities to Other Health-Care Professionals***

42 6. To ensure the safe and effective delivery of health care and a healthy working
43 environment,[8] physicians **must** work respectfully and collaboratively with other members of
44 the health-care team, including all who are involved in the provision of health care.[9]

45 ***Responsibilities to the Profession***

46 7. Physicians **must** uphold the standards of the medical profession by modelling appropriate
47 behaviour for other members of the health-care team, in particular trainees, and fostering a
48 culture of respect within their practice setting or workplace.

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[5] More information on the Physician Health Program can be found here.

[6] Specifically, *The Practice Guide: Medical Professionalism and College Policies* notes that, "when providing care to a patient, a physician should always put that patient first."

[7] For further information regarding physicians' responsibility to advocate on behalf of patients, see *The Practice Guide* at pg. 8.

[8] Literature shows that unprofessional and/or disruptive behaviour can negatively impact both the delivery of quality health care and patient safety and outcomes by eroding the effective communication and collaboration that underpin good medical practice (Leape, L.L., Shore, M.F., Dienstag, J.L. et. al. (2012). Perspective: a culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. *Academic Medicine*, 87(7), 845-852; Sanchez, L.T. (2014). Disruptive behaviors among physicians. *Journal of the American Medical Association*, 312(21), 2209-2210; Leape, L.L. & Fromson, J.A. (2006). Problem doctors: is there a system-level solution? *Annals of Internal Medicine*, 144(2), 107-115).

[9] Physicians may have other obligations under *OHSA* in regard to their own behaviour in the workplace, as well as specific obligations if they are employers as defined by *OHSA*.

49 ***Disruptive Behaviour***

50 Disruptive behaviour poses a threat to patients and outcomes by inhibiting the collegiality and
51 collaboration essential to teamwork, impeding communication, undermining morale, and
52 inhibiting compliance with and implementation of new practices.

53 8. Physicians **must not** engage in disruptive behaviours, because they undermine
54 professionalism and a culture of safety. Disruptive behaviours may include, but are not
55 limited to, the following:
56
57 a. Rude, profane, disrespectful, insulting, demeaning, threatening, bullying, or abusive
58 language, tone, innuendos, and behaviour;
59 b. Arguments[10] or outbursts of anger including throwing or breaking things;
60 c. Use, attempted use, or threat of violence or physical force with patients, colleagues,
61 and others involved in the provision of health care;[11]
62 d. Comments or actions that may be perceived as harassing or may contribute to a
63 poisoned professional environment;
64 e. Mocking, shaming, disparaging or censuring patients, colleagues, and others
65 involved in the provision of health care;
66 f. Repeated failure to promptly respond to calls or requests for information or
67 assistance when on call or when expected to be available; and
68 g. Failure to work collaboratively or cooperatively with others.
69
70 9. While there may be a myriad of reasons for disruptive behaviour – whether personal,
71 professional, or situational – physicians **must** nevertheless demonstrate professional
72 behaviour at all times.

73 ***Guidebook for Managing Disruptive Physician Behaviour***

74 The *Guidebook for Managing Disruptive Physician Behaviour*, developed in association with the
75 Ontario Hospital Association, may provide general helpful advice and tools for creating
76 environments that foster medical professionalism, identifying disruptive behaviour, and
77 effectively addressing disruptive behaviour.

[10] Respectful discussions, in which disagreement is expressed, are not arguments.
[11] The policy does not intend to capture circumstances where, for instance, force may be necessary to restrain a patient who poses a threat to themselves or those providing them with care.

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1 # Physician Treatment of Self, Family Members, or Others Close to
2 # Them

3 Policies of the College of Physicians and Surgeons of Ontario (the “College”) set out
4 expectations for the professional conduct of physicians practising in Ontario. Together with the
5 Practice Guide and relevant legislation and case law, they will be used by the College and its
6 Committees when considering physician practice or conduct.
7
8 Within policies, the terms ‘must’ and ‘advised’ are used to articulate the College’s expectations.
9 When ‘advised’ is used, it indicates that physicians can use reasonable discretion when applying
10 this expectation to practice.

11 ## Definitions

12 **Family member:** An individual with whom the physician has a familial connection **and** with
13 whom the physician has a personal or close relationship, where the relationship is of such a
14 nature that it would *reasonably affect* the physician’s professional judgment. This includes, but
15 is not limited to: the physician’s spouse or partner, parent, child, sibling, members of the
16 physician’s extended family, or those of the physician’s spouse or partner (for example: in-
17 laws).

18 **Others close to them:** *Any other* individuals who have a personal or close relationship with the
19 physician, whether familial or not, where the relationship is of such a nature that it would
20 *reasonably affect* the physician’s professional judgment. This may include, but is not limited to,
21 friends, colleagues, and staff.[1]

22 **Treatment:** Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic
23 or other health-related purpose. This includes: the performance of any controlled act;[2] ordering
24 and performing tests (including blood tests and diagnostic imaging); providing a course of
25 treatment, plan of treatment, or community treatment plan.[3]

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[1] Physicians are advised to contact the College’s Physician Advisory Services or the Canadian Medical Protective Association (CMPA) for further guidance as to which individuals may be included in this term.
[2] Controlled acts for physicians, as set out in s. 4 of the *Medicine Act,* S.O. 1991, c. 30.
[3] The definition of “treatment” has been adapted, and modified, from the definition of “treatment” as set out in the *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Schedule A, at Section 2(1); the exceptions to “treatment” under the *Health Care Consent Act* do not apply to this policy.

26 **Minor condition**: A non-urgent, non-serious condition that requires only short-term, episodic,
27 routine care and is not likely to be an indication of, or lead to, a more serious condition, or a
28 condition which requires ongoing clinical care or monitoring.[4]

29 **Emergency:** an "emergency" exists where an individual is apparently experiencing severe
30 suffering or is at risk of sustaining serious bodily harm if medical intervention is not promptly
31 provided.

32 Policy

33 1. In order to meet their professional obligations to practise medicine safely and effectively,
34 physicians **must** only provide treatment for themselves and family members in limited
35 circumstances, as set out in this policy.

36 **Providing Treatment**

37 2. Physicians **must not** provide treatment for themselves or family members except:
38 a) For a minor condition, or in emergency situations;
39 **and**
40 b) When another qualified health-care professional is not readily available.
41
42 3. Physicians **must not** provide recurring episodic treatment to themselves or family members
43 for the same disease or condition, or provide ongoing management of a disease or
44 condition, even where the disease or condition is minor.
45
46 4. As the same risks of compromised objectivity and meeting the standard of care may arise
47 when providing care to *others close to them*, physicians are **advised** to carefully consider
48 whether it would be appropriate to provide treatment in these instances.
49
50 a. Where the relationship would *reasonably affect* the physician's professional
51 judgement, physicians **must not** provide treatment to an individual close to them,
52 except in accordance with the circumstance set out in provision 2 of this policy.
53
54 5. When the nature of the relationship with family members or others close to them has
55 changed, physicians **must** re-evaluate the nature of their relationship to determine whether
56 they can still be objective.
57

[4] 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.

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58 a. If the physician's professional judgment has been *reasonably affected* by changes in
59 the relationship, physicians **must** transfer care of the individual to another qualified
60 health-care professional as soon as is practical.

61 **Scope of Treatment and Transfer of Care**

62 6. Physicians **must** always act within the limits of their knowledge, skill and judgment.[5]
63
64 7. Providing treatment in accordance with this policy is limited to addressing the immediate
65 medical needs associated with treating a minor condition or emergency. Where additional
66 or ongoing care is necessary, physicians **must** transfer care of the individual to another
67 qualified health-care professional as soon as is practical.

68 **Expectations about Documenting Care and Maintaining Confidentiality**

69 8. Physicians **must** advise the individual receiving care to notify their primary health-care
70 professional of the treatment that the physician has provided.
71
72 9. Where the individual does not have a primary health-care professional, physicians are
73 **advised** to explain to the individual the importance of informing their next health-care
74 professional, where practical, of the treatment received from the physician.
75
76 10. Where it is impractical for the individual receiving treatment to inform their own primary
77 health-care professional of the treatment the individual received (e.g., children), physicians
78 are **advised** to inform the individual's primary health-care professional, with the individual's
79 consent, of the treatment they provided.
80
81 11. Physicians **must** maintain the confidentiality of the personal health information of any
82 individual they treat.[6]

83 **Spouses or Sexual/ Romantic Partners**

84 12. Physicians **must** be mindful that providing treatment to a spouse, partner, or anyone else
85 with whom they are sexually or romantically involved may give rise to a physician-patient
86 relationship and that providing treatment that exceeds the circumstances set out in this

[5] Sections 2(1)(c), 2(5), O. Reg. 865/93 (Registration), enacted under the Medicine Act, 1991, S.O 1001., c.30.
[6] Physicians must abide by their legal obligations under the Ontario *Personal Health Information Protection Act, 2004,* S.O. 2004, c. 3 Sched. A *(PHIPA),* as well as the expectations set out in the College's *Confidentiality of Personal Health Information* policy.

87 policy may give rise to a physician-patient relationship[7] such that the sexual abuse
88 provisions[8] of the *Regulated Health Professions Act, 1991* would apply.
89
90 13. Physicians **must not** provide treatment to a spouse, partner, or anyone else with whom
91 they are sexually or romantically involved, beyond the circumstances of a minor condition
92 or emergency, and where no other qualified health-care professional is readily available.

93 **Prescribing or Administering Drugs**
94
95 14. If prescribing drugs is required as part of providing care in accordance with this policy,
96 physicians **must** comply with the College's *Prescribing Drugs* policy.
97
98 15. Physicians **must not** prescribe or administer the following for themselves, family members,
99 or others close to them:
100 a. narcotics[9, 10],
101 b. controlled drugs or substances[11,12],
102 c. monitored drugs[13],
103 d. cannabis for medical purposes[14], or

[7] Patient criteria, O. Reg. 260/18, under subsection 1(6) of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act*, 1991, S.O. 1991, c.18 (hereinafter *HPPC*). For more information, see the College's *Maintaining Boundaries and Preventing Sexual Abuse* policy section "Determining Whether a Physician-Patient Relationship Exists".
[8] Legislative provisions relating to sexual abuse are set out in Sections 1(3) to (6) and Sections 51(1) to (3) and (4.1) to (9) of the *HPPC.* This includes the amendments to the HPPC contained in Bill 87 (Protecting Patients Act, 2017) in force as of May 1, 2018. It does not include any other requirements that may be developed in regulation. Physicians are advised that the passing of Bill 70, the Regulated Health Professions Amendment Act (Spousal Exception), 2013, has not changed the law with respect to physicians, as the College has not opted to exempt physicians who treat their spouses from the sexual abuse provisions. For more information, see the College's *Maintaining Boundaries and Preventing Sexual Abuse* policy.
[9] 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.
[10] While these drugs or substances may be a legitimate treatment, 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*. There are no exceptions under the *CDSA* for prescribing or administering these drugs or substances to non-patients, even in emergencies. 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*.
[11] 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.
[12] Please see footnote 10.
[13] The Ontario Ministry of Health and Long-Term Care (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 http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx. See also s. 2 of the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 for a definition of 'monitored drug'.
[14] See the College's *Cannabis for Medical Purposes* policy for more information.

104 e. any drugs or substances that are addicting or habituating.

105

106 16. Physicians **must not** prescribe or administer the drugs or substances set out in provision 15
107 even when another health-care professional is in charge of managing the treatment of the
108 disease or condition.

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1 # Advice to the Profession: Physician Treatment of Self, Family
2 # Members, or Others Close to Them

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

7 Physicians may find themselves in circumstances where they must decide whether it would be
8 appropriate to provide treatment for themselves, family members, or others close to them.
9 While physicians may have the best of intentions and a genuine desire to deliver the best
10 possible care when providing treatment for themselves, family members, or others close to
11 them, the literature suggests that a physician's ability to maintain the necessary amount of
12 emotional and clinical objectivity may be compromised. Physicians may then have difficulty
13 meeting the standard of care. Consequently, the individual may not receive the best quality
14 treatment, despite the physician's best intentions.

15 This document is intended to help physicians interpret the expectations as set out in the
16 *Physician Treatment of Self, Family Members or Others Close to Them* policy and provide
17 guidance around how these obligations may be effectively discharged.

18 **How can objectivity and professional judgment be compromised when providing treatment**
19 **for oneself, family members or others close to you?**

20 A physician's ability to maintain the necessary amount of emotional and clinical objectivity
21 required for professional judgment can be compromised when treating themselves, family
22 members, or those close to them. The physician may unconsciously hold preconceived notions
23 about the individual's health and behaviour, or make assumptions about the individual's
24 medical history or personal circumstances. Similarly, the physician may assume that they are
25 privy to all the relevant information about the individual and therefore taking a full history or
26 conducting a medically indicated examination is unnecessary. For example, a physician
27 providing treatment for their child may assume the child has not engaged in sexual activity or
28 high-risk behaviour, and therefore may not consider all of the possible clinical indications for
29 treatment.

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30 **How can compromised objectivity and/or professional judgement impact quality of care?**

31 The literature[1] suggests that physicians who provide treatment for individuals when their
32 emotional and clinical objectivity is compromised may have difficulty meeting the standard of
33 care. This can occur in a number of ways, including, but not limited to:

34 - Physician discomfort in discussing sensitive issues or taking medical histories.
35 - Discomfort amongst family members and others close to the physician in discussing
36 sensitive issues with the physician. This can be especially true with children receiving
37 treatment, and particularly with respect to sexual health and behaviour, drug use,
38 mental health issues, or issues of abuse or neglect.
39 - Physicians may feel obligated or pressure to treat problems that are beyond the
40 physician's expertise or training, or to prescribe drugs that are addicting/habituating,
41 including narcotics or controlled substances, for family members or those close to them.
42 - Difficulty for the physician to recognize the need to obtain informed consent in this
43 context and to respect the individual's decision-making autonomy.
44 - Difficulty for the physician to recognize that the duty of confidentiality applies in this
45 context, just as it would for a patient. The physician may also experience difficulty in
46 appreciating that the individual's information must be kept confidential, even if other
47 family members or others close to the physician insist on knowing 'what is going on' in
48 relation to the individual's health.
49 - Physician reluctance to make a mandatory report (e.g. an impairment affecting the
50 individual's ability to drive, or a suspicion of child abuse).

51 When the standard of care has been adversely impacted, this can result in poorer quality health
52 care for the individual receiving the treatment.

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[1] See for example:
- Katherine J. Gold, et al. "No Appointment Necessary? Ethical Challenges in Treating Friends and Family" (2014) N Engl J Med 2014; 371:1254-1258.
- Carolyne Krupa, "The limits of treating loved ones" Amednews.com (6 February, 2012), online: Amednews.com.
- F. Chen et al., "Role conflicts of physicians and their family members: rules but no rulebook" (2001) 75(4) West. J. Med. 236–239.
- American Academy of Pediatrics Committee on Bioethics, "Pediatrician-Family-Patient-Relationships: Managing the Boundaries" (2009) Pediatrics Vol. 124 No. 6, 1685 -1688.
- Kathy Oxtoby, "Doctors' Self Prescribing" BMJ Careers (10 January 2012), online: BMJ Careers.
- Ruth Chambers & John Belcher, "Self-reported health care over the past 10 years: a survey of general practitioners" (1992) 42 British J. Gen. Practice 153-156.
- Richard C. Wasserman et al., "Health Care of Physicians' Children" (1989) 83 Pediatrics 319.
- Edward J. Krall, "Doctors Who Doctor Self, Family, and Colleagues" (2008) 107 Wisconsin Med. J., No. 6, 279-284.

The Canadian Medical Association (CMA) advises physicians to "limit treatment of yourself or members of your immediate family to minor or emergency services, and only when another physician is not readily available; there should be no fee for such treatment."[2]

Which family members can I treat within the scope of this policy?

Many of us have family members with whom we are very close, and others with whom we may not maintain as close a relationship, or have no relationship at all. The risks associated with physicians providing treatment to family members arise where the nature of the relationship is personal or close enough that the physician's feelings toward that individual (positive or negative) could *reasonably affect* their emotional and clinical objectivity and impair their professional judgment.

Which members of a physician's family this will include will vary with every physician. They may include members of the physician's immediate or extended family, in-laws, or members of a non-traditional family unit. Some examples include, but are not limited to: the physician's spouse or partner; ex-spouse or ex-partner; parent; step-parent; child; step-child; adopted or foster child; sibling or half-sibling; step-sibling; grandparent or grandchild; aunt; uncle; niece or nephew; or those of the physician's spouse or partner.

What types of non-familial relationships may impact objectivity?

Personal or close relationships with other individuals, who are not family members, could also compromise the physician's emotional and clinical objectivity in the same way. These individuals can include friends, colleagues, and staff, among others. Not every relationship the physician has would necessarily impair the physician's objectivity. However, when a physician's relationship with an individual is of such a nature that the physician's professional judgment could *reasonably be affected*, that individual would fall under the scope of the policy as defined by the term 'others close to them'.

How can I effectively evaluate the nature of the relationship?

When evaluating the nature of a relationship with an individual, if you can answer "yes" to any of the questions below, the individual probably falls within the scope of having a personal or close relationship with you, and your objectivity may be reasonably affected in providing treatment to that individual.

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[2] Canadian Medical Association (CMA), *Code of Ethics*, Section 20.

82 **1. Would I be uncomfortable asking the questions necessary to take a full history,**
83 **performing a medically indicated examination, or making a proper diagnosis,**
84 **particularly on sensitive topics?**
85 Relationships with family members or others close to the physician can give rise to the
86 physician unconsciously holding preconceived notions about the individual's health and
87 behaviour, or making assumptions about the individual's medical history or personal
88 circumstances. Consequently, the physician may not ask questions or seek information
89 that could inform the diagnosis or subsequent care. Similarly, physicians may feel
90 uncomfortable taking a comprehensive medical history, or assume that they are privy to
91 all the relevant information about the individual and that therefore taking a full history
92 or conducting a medically indicated examination is unnecessary. This in turn
93 compromises the physician's ability to meet the standard of care.
94
95 **2. Would this individual be uncomfortable discussing sensitive topics or disclosing high**
96 **risk behaviours with me?**
97 Family members and others close to the physician may feel uncomfortable discussing
98 these issues with a physician with whom they have a personal or close relationship.
99 They may also fear judgment or other consequences in the relationship. This can be
100 particularly true with respect to the individual's sexual health and behaviour, drug use,
101 mental health issues, or issues of abuse or neglect; especially if the individual is a child.
102 Consequently, the individual may withhold information which is vital to a diagnosis or
103 the management of a condition.
104
105 **3. Would I have difficulty allowing this individual to make a decision about his/her own**
106 **care with which I disagree?**
107 Respect for an individual's autonomy is central to the provision of ethically sound health
108 care. Individuals must be able to make free and informed decisions about their health
109 care, as well as question or refuse treatment options. Family members and others close
110 to the physician, particularly children, may be unduly influenced by the physician's
111 opinions, or feel unable to refuse treatment or seek alternative opinions. For more
112 information please see the College's *Consent to Medical Treatment* policy.
113
114 **4. Could the personal or close relationship with this individual make it more difficult for**
115 **me to maintain confidentiality or make a mandatory report?**
116 Confidentiality may be harder to maintain and may be at greater risk of being breached,
117 such as when other family members or others close to the physician insist on knowing
118 'what is going on' in relation to the individual's health. Conversely, a physician may be
119 more reluctant to make a mandatory report (e.g. an impairment affecting the

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individual's ability to drive, or a suspicion of child abuse) where a personal or close relationship exists.

If I treat someone with whom I am sexually or romantically involved, is a physician-patient relationship established?

Providing care to an individual with whom you are sexually or romantically involved may lead to the establishment of a physician-patient relationship and, as a result, the sexual abuse provisions of the *Regulated Health Professions Act, 1991* (*RHPA*) would then apply.

As prescribed in regulation, an individual is **not** a physician's patient if all the following conditions are met:

- There is a sexual relationship between the individual and the physician at the time the health care service is provided to the individual;
- The health care service provided by the physician to the individual was done in an emergency circumstance or the service was minor in nature; and,
- The physician has taken reasonable steps to transfer the individual's care, or there is no reasonable opportunity to transfer care.

However, if these above criteria are not met and any of the following criteria are met then a physician-patient relationship would be established:

- 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.

Providing care to a romantic/sexual partner with any of the four criteria present would trigger the application of the sexual abuse provisions in the RHPA.

For more information, please consult the *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy.

Why does the policy set out expectations for communicating the care provided to other health-care providers involved in the individual's care?

Documentation of medical treatment is essential to safe, quality health care. Complete and accurate medical records facilitate and enhance communication in collaborative care models,

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152 are essential to continuity of care, and identify problems or patterns that may help determine
153 the course of health care.

154 When physicians provide treatment for themselves, family members, or others close to them,
155 there is a risk that the individual receiving the care will not have a complete and accurate
156 medical record. Communicating the treatment provided to the individual's primary care
157 provider helps to ensure that the individual has a complete and accurate medical record.

158 **Does this policy apply in rural or isolated communities?**

159 Yes, the expectations set out in this policy apply in rural and isolated[3] communities. While the
160 College recognizes that physicians in these communities often have relationships with many or
161 all of the individuals seeking treatment, the risks associated with compromised objectivity and
162 professional judgment apply in rural and isolated settings just as they do in other settings.

163 In keeping with the policy, the care that the physician can provide to an individual will be
164 dependent on the nature of the personal relationship between the physician and the individual.
165 Where the nature of the relationship with that family member or other individual close to the
166 physician could *reasonably affect* the physician's professional judgment, then the physician is
167 limited to providing treatment only within the context of a minor condition or emergency, and
168 where no other qualified health-care professional is readily available, as set out in this policy.

169 If the personal relationship between the physician and the individual is not close, and therefore
170 does not fit either the definition of "family member" or "others close to them", the physician
171 will be able to act as that individual's treating physician.

172 **Can I refill a prescription for myself, my family members or others close to me?**

173 Regardless of whether physicians are prescribing a drug for the first time or whether they are
174 refilling an existing prescription, physicians are still prescribing. Consequently, when providing
175 treatment for a minor condition or emergency necessitates a refill for a drug, physicians are
176 expected to comply with the College's *Prescribing Drugs* policy. Physicians are reminded that
177 they are prohibited from prescribing for themselves, family members, or others close to them,
178 any of the following: narcotics; controlled drugs or substances; monitored drugs; cannabis for
179 medical purposes; or any drugs or substances that have the potential to be addicting or
180 habituating, regardless of whether the prescription is a new prescription or a refill.

[3] Isolation could be based on geography, culture, language, etc.

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181 **Does this policy apply to referrals?**

182 Yes, referrals for yourself, family members, or others close to you would be captured by this
183 policy.

184 Making a referral requires the referring physician to assess the individual, which may include
185 taking a history, conducting an appropriate examination and/or arranging investigations, to
186 identify a clinical indication for a referral. The steps involved would exceed the scope of care
187 that the policy permits physicians to undertake in relation to themselves, family members or
188 others close to them.

189 For the purposes of this policy, referrals are considered to be distinct from making informal
190 recommendations to family members or others close to you about a specific physician they
191 might consider seeing, and from facilitating contact between the individual and that physician.
192 To ensure continuity of care, physicians must advise the individual to discuss any
193 recommendations with his/her primary health-care professional.

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Physicians' Relationships with Industry: Practice, Education, and Research

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

Industry: In this policy, industry refers to the full range of commercial enterprises associated with health care. These include, but are not restricted to, the pharmaceutical industry, the biotechnology industry, the medical device industry, and commercial providers of services related to clinical practice, research, and education.

Conflict of interest: A conflict of interest is created any time a reasonable person could perceive that a physician's personal interest or relationship with industry is at odds with their professional responsibilities.[1] In this policy, the term "conflict of interest" is defined broadly and in accordance with the definition above. While sections 15-17 of Ontario Regulation 114/94 under the Medicine Act, 1991 describe some specific situations that constitute conflicts of interest, this policy is not limited in its scope to those specific situations.

Policy

1. Physicians **must** safeguard their clinical objectivity and professional independence when interacting with industry.[2]

2. Physicians **must** avoid or recognize and appropriately manage conflicts of interest arising from their professional duties.

Industry gifts

Research demonstrates that accepting gifts or inducements from industry influences and likely undermines a physician's independent clinical judgment, even where the physician believes otherwise.[3]

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[1] A conflict of interest can exist even if the physician is confident that their professional judgment is not actually being influenced by the conflicting interest or relationship.
[2] For more information, please see the College's accompanying *Advice to the Profession: Physicians' Relationships with Industry: Practice, Education and Research*.

39 3. Physicians **must not** request or accept a fee or equivalent compensation from industry in
40 exchange for seeing industry representatives in a promotional or similar capacity.
41
42 4. Physicians **must not** accept personal gifts of any value from industry or industry
43 representatives.
44
45 5. If accepting items from industry that advance disease/treatment education (e.g. patient
46 teaching aids), physicians **must** only accept items that:
47
48 a. primarily entail a benefit to patients, and
49 b. do not have value to the physician outside of their professional responsibilities.
50
51 **Product detailing**
52
53 6. Where industry representatives are providing information about products or services,
54 physicians are permitted to accept meals for themselves and appropriate staff, however,
55 physicians **must** only accept meals that are of a modest value.[4]
56
57 a. Physicians are **advised** to consider the reasonable expectations of their patients in
58 assessing whether a meal is "modest".
59
60 7. Physicians **must** critically evaluate any information provided by industry representatives
61 and not solely rely on this information when making clinical decisions regarding patient
62 care.
63
64 8. Physicians **must** ensure that industry-produced patient-education materials (e.g.
65 pamphlets) are accurate, balanced, and complete, before providing them to patients.
66
67 **Drugs samples**
68
69 9. Physicians who accept drug samples from industry **must** comply with the expectations for
70 drug samples that are set out in the *Prescribing Drugs* policy.
71 a. Physicians **must not** take samples for personal use or the use of their family
72 members.[5]

[3] Key evidence from the literature can be found in the following articles:

- Katz, Dana, Caplan, Arthur, & Merz, Jon. (2003, June 1). All Gifts Large and Small: Toward an Understanding of Pharmaceutical Gift Giving. *University of Pennsylvania Scholarly Commons – Center for Bioethics Papers*.
- Fugh-Berman, A, & Ahari, S. Following the Script: How Drug Reps Make Friends and Influence Doctors. (2007). *PLoS Med*. 4(4), e150.
- Spurling, GK, et al. Information from Pharmaceutical Companies and the Quality, Quantity, and Cost of Physicians' Prescribing: A Systematic Review. (2010). *PLoS Med*. 7(10), e1000352.

[4] Physicians are reminded that it is an act of professional misconduct to receive a benefit from a supplier contrary to s. 16(a) of O. Reg. 114/94 under the Medicine Act, 1991.

73 ## Continuing medical education/Continuing professional development (CME/CPD)
74
75 ***Physician organizers of CME/CPD events***
76
77 10. Physicians who organize CME/CPD events **must** ensure that:
78
79 a. final decisions regarding the content, faculty, educational methods, and materials
80 are made without influence from industry sponsors;
81 b. CME/CPD activities are scientifically valid, objective, and contain balanced
82 information relevant to the topic or focus of the event;
83 c. all funds from industry are in the form of an independent educational grant payable
84 to the institution or organization sponsoring the CME/CPD activity;
85 d. educational materials and presentations refer to generic names in addition to trade
86 names where a generic name exists;
87 e. physician presenters are paid an amount that is at fair market value and
88 commensurate with the services provided[6];
89 f. physician presenters are paid through the meeting organizers and not the industry
90 sponsor;
91 g. negotiations for space or for types of promotional displays at CME/CPD functions
92 are not influenced by industry sponsorship;
93 h. promotional displays from industry are not in the same room as the educational
94 event;
95 i. presenters, attendees, and their personal guests pay for the full cost of any pre or
96 post meeting social events;
97 j. there is a mechanism to manage all identified conflicts of interest; and
98 k. industry sponsorship of the event is fully disclosed (this includes making the
99 disclosure publicly accessible prior to the meeting).
100
101 11. Physicians who organize CME/CPD events **must** only accept payments that are at fair
102 market value and commensurate with the services provided.[7]

103 12. Where a CME/CPD activity does not have a formal organizing committee, and where a
104 physician is directly engaged by industry to organize the event,[8] physician organizers **must**
105 continue to comply with the expectations set out above with the following exception:
106
107 a. funding for the event, including payments to presenters, may be provided directly by
108 industry and need not be in the form of an independent educational grant.
109
110

[5] Limited exceptions are set out in the *Physician Treatment of Self, Family Members, or Others Close to Them* policy.
[6] Payments may include reimbursements for reasonable travel, lodging, and meal expenses.
[7] Payments may include reimbursements for reasonable travel, lodging, and meal expenses.
[8] Example of such an event: "industry dinner".

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111 ***Physician presenters, session chairs, and/or panel members***
112
113 13. Physicians who prepare and present a substantive educational session at a CME/CPD event
114 (or who act as Session Chairs and/or Panel Members) **must**:
115
116 a. ensure the scientific validity, objectivity, and completeness of the information they
117 present;
118 b. provide a balanced presentation of the prevailing body of scientific information
119 when mentioning specific products or services, and if reasonable, alternative
120 products or services;
121 c. disclose where any presentation materials, including presentation slides, have been
122 developed by industry;
123 d. refer to generic names in addition to trade names (where a generic name exists);
124 e. only accept payments that are at fair market value and commensurate with the
125 services provided; and
126 f. only accept payments that are made through the meeting organizers and not the
127 industry sponsor.[9]
128
129 14. Where a CME/CPD activity does not have a formal organizing committee, physicians who
130 present at a CME/CPD event **must** continue to comply with the expectations set out above
131 with the following exception:
132
133 a. payment may be accepted directly from the industry sponsor provided it is at fair
134 market value and commensurate with the services provided.[10]
135
136 ***Disclosure of industry relationships at CME/CPD events***
137
138 15. Physicians who organize and/or present at CME/CPD events **must** disclose to attendees at
139 the event all conflicts of interest arising from their relationships with industry, including
140 (but not limited to):
141
142 a. current or past relationships with manufacturers of products mentioned at the event
143 or with manufacturers of competing products;
144 b. any direct financial payments from industry;
145 c. investments in industry (excluding mutual funds);
146 d. membership on advisory boards;
147 e. grants or clinical trials funded by industry; and
148 f. any other significant (paid or unpaid) relationships with industry.

[9] Payments may also include reimbursements for reasonable travel, lodging, and meal expenses.
[10] Payments may include reimbursements for reasonable travel, lodging, and meal expenses.

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149 ***Physicians who attend CME/CPD events***
150
151 16. Physicians who attend CME/CPD events **must not** accept payment or reimbursement for
152 travel, lodging, or meal expenses from industry; however, physicians may accept meals
153 provided at a CME/CPD event where the meal is of modest value.[11]
154
155 a. Physicians are **advised** to consider the reasonable expectations of their patients in
156 assessing whether a meal is "modest".
157
158 17. Physicians **must** only dispense scholarships or other funds from industry to undergraduate
159 medical students or postgraduate trainees (including fellows) to attend CME/CPD events
160 where the selection of recipients is made by their academic institutions.
161
162 18. Physicians who attend a CME/CPD event **must** model ethical behaviour by acting in
163 accordance with this policy.

164 ## Consultation or advisory board/investigator meetings
165
166 19. Physicians who are asked by industry to sit on advisory or consultation boards, or to serve
167 as individual advisors or consultants, **must**:
168
169 a. enter into a written agreement setting out the details of the arrangement;
170 b. only agree to impart specialized medical knowledge that could not otherwise be
171 acquired by the hiring company;
172 c. not engage in promotional activities on behalf of the company while in this position;
173 d. disclose their relationship with industry when providing educational activities on
174 behalf of the company, and ensure that all information presented is accurate,
175 complete, and balanced;
176 e. only accept remuneration at fair market value and commensurate with the services
177 provided; and
178 f. only attend meetings that are held in the physician's geographic locale or which
179 form part of a meeting that the physician would normally attend (when these
180 arrangements are not feasible, reasonable travel and accommodation expenses may
181 be reimbursed).
182
183 20. Physician researchers who attend Investigator Meetings (where researchers meet for the
184 purpose of developing research protocols or discussing research results) **must**:
185
186 a. only accept remuneration at fair market value and commensurate with the services
187 provided; and

[11] Physicians are reminded that it is an act of professional misconduct to receive a benefit from a supplier contrary to s. 16(a) of O. Reg. 114/94 under the Medicine Act, 1991.

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188 b. only attend meetings in the physician's geographic locale or as part of a meeting
189 that the physician would normally attend (when these arrangements are not
190 feasible, reasonable travel and accommodation expenses may be reimbursed).
191

192 Industry-sponsored research

193
194 21. Physicians **must** only participate in industry-sponsored research that is ethically defensible,
195 scientifically valid, and that complies with relevant national guidelines, including the Tri-
196 Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS-2).[12,13]
197
198 22. Physicians **must** only participate in research involving human participants, including post-
199 marketing surveillance studies (phase IV clinical research), that has the approval of a
200 research ethics board (REB). This applies equally to research that only involves the use of
201 personal health information [PHI].[14]
202
203 23. Physicians **must** only participate in clinical trials that have been registered prior to the
204 enrolment of the first participant in a web-accessible research registry.
205

206 *Patient consent for the use or disclosure of personal health information*

207
208 24. Physicians **must** comply with their legal obligations under the *Personal Health Information*
209 *Protection Act, 2004 (PHIPA)* when collecting, using, or disclosing personal health
210 information in relation to all research initiatives, including those sponsored by industry.[15]
211
212 25. Physicians **must** only use or disclose patient information if they have the patient's consent,
213 or if the provisions under Personal Health Information Protection Act (PHIPA)[16] which
214 permit the use or disclosure of information for research purposes without consent have
215 been satisfied.[17]
216

[12] View the statement here: http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf.
[13] Physician must adhere to the Tri-Council Policy Statement: Ethic Conduct for Research Involving Humans (TCPS-2) regardless of whether they are receiving funding from one of Canada's three federal research agencies: the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council of Canada (NSERC), or the Social Sciences and Humanities Research Council of Canada (SSHRC).
[14] For the definition of "personal health information", see s. 4 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A (*PHIPA*).
[15] Grant-funded research would be subject to the same privacy and consent requirements as set out in this section, as would marketing and market research. Physicians should be aware that funding agencies may also stipulate requirements with respect to consent and privacy.
[16] *PHIPA, 2004.*
[17] S. 37(1)(j) and 37(3) of *PHIPA* provide that physicians who do not have patient express consent may use their patients' personal health information only if they comply with the provisions of *PHIPA* at s. 44(2) – (4) and 44(6)(a) –(f), which require the submission of a research plan for research ethics board approval. Additional requirements for research plans are set out in s. 16 of the Ontario Regulation 329/04 under *PHIPA*. Similar obligations apply to the collection of patient personal health information for research purposes, as set out in s. 29(a) and s. 36(1) (a) and (d) of *PHIPA*.

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217 26. Physicians **must not** use PHI for research purposes if other information will serve the
218 purpose, and physicians **must not** use more PHI than is reasonably necessary for the
219 purpose.[18]
220
221 27. Physicians **must** comply with any requirements of the research ethics board with respect to
222 the documentation of consent for the use or disclosure of PHI.
223
224 ***What information must be disclosed to patients participating in industry-sponsored research?***
225
226 28. Whenever engaging in research involving human participants, physicians **must** inform the
227 potential participant about the relative probability of harms and benefits of participating as
228 a research participant and **must** disclose all risks, even those which are rare or remote,
229 especially if they entail serious consequences.[19]
230
231 29. Physicians **must** advise prospective participants that they have the right to decline to
232 participate or to withdraw from the study at any time, without prejudice to their ongoing
233 care.
234
235 30. Physicians **must** inform their patients of the nature of the benefit the physician will receive
236 for recruiting the patient for participation in the research study.[20] Physicians **must** also
237 disclose any affiliations (e.g., with the pharmaceutical company or researcher) that may
238 impact on the patient's decision to provide consent.
239
240 ***Compensation***
241
242 31. Physicians **must** only accept compensation for participation in industry research at fair
243 market value, commensurate with services provided.
244
245 32. Physicians **must** only accept compensation for recruiting patients into a research study
246 (including post-marketing surveillance studies) if:
247
248 a. recruiting patients requires the physician to undertake activities beyond their
249 normal practice, including, but not limited to, meeting with patients, discussing the
250 study, and obtaining informed consent for the disclosure of patient information; and
251 b. compensation is at fair market value and commensurate with the services provided.
252

[18] S. 30 (1) and (2) of *PHIPA*.
[19] Halushka v. University of Saskatchewan (1965), 53 D.L.R. (2d) 436 (Sask. C.A.) Weiss v. Solomon (1998), 48 C.C.L.T. 280 (Qc. Sup. Ct.).
[20] Informing patients of the "nature" of the benefit involves disclosing the type of benefit that may be received. It also includes disclosing the amount of any compensation the physician will receive.

253 33. Physicians **must** not accept “finder’s fees”, whereby the sole activity performed by the
254 physician is to disclose the names of potential research participants.
255
256 ***Publication of research findings***
257
258 34. Physicians **must** only be included as an author of a published article reporting the results of
259 industry-sponsored research if they have contributed substantively to the study or the
260 composition of the article.[21]
261
262 35. Physicians **must not** agree to publish as author any article written in whole or part by the
263 employees or agents of industry (“ghostwriting”) unless contributions are clearly disclosed
264 by authorship or acknowledgment.
265
266 36. When submitting industry-sponsored research to medical journals or for public
267 consumption, physicians **must** fully comply with the disclosure requirements of the
268 receiving publication.
269
270 37. Physicians **must** clearly disclose any relationship they have to industry where it has
271 provided funding or other support for the studies or where it makes the products that are
272 the subject of the study, whether or not the publications require such disclosure.
273
274 38. Physicians **must** seek to publish negative as well as positive results in the spirit of good
275 science, and in the interest of contributing to the existing body of knowledge.
276
277 39. Physicians **must not** enter into agreements that would limit their right to submit research
278 results for publication, disclose the results of a study, or report adverse events.
279
280 40. Physicians **must not** knowingly be involved in concealing research results or presenting
281 them in a misleading fashion.

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[21] The criteria for authorship that must be met are those set out by the International Committee of Medical Journal Editors (http://www.icmje.org/).

Advice to the Profession: Physicians' Relationships with Industry: Practice, Education and Research

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 practice of medicine often involves interaction between physicians and industry, including pharmaceutical, medical device, and technology companies. These interactions have the potential to benefit both physicians and patients by advancing medical knowledge and improving patient care.

While industry has a valuable and legitimate role to play in the practice of medicine, its interests and responsibilities may diverge from the professional and legal obligations of physicians. As a result, physicians may sometimes find themselves facing ethical dilemmas or conflicts of interest stemming from their relationships with industry. A growing body of empirical evidence demonstrates that patient trust and clinical care can be adversely affected by these conflicts.

The *Physicians' Relationships with Industry: Practice, Education and Research* policy does not discourage appropriate physician-industry interactions, but instead aims to assist physicians in understanding and managing their relationships with industry appropriately.

This document is intended to help physicians interpret their obligations as set out in the *Physicians' Relationships with Industry: Practice, Education, and Research* [hyperlink] policy, and provide guidance for how these obligations can be effectively discharged.

Accepting gifts or inducements of any value can undermine a physician's clinical judgment

While many physicians are convinced of their own clinical independence when interacting with industry, a large body of empirical evidence strongly demonstrates that accepting gifts or inducements of *any* value can influence and undermine a physician's independent clinical judgment, even when the physician believes otherwise.[1] The expectations contained in the *Physician's Relationships with Industry* policy are rooted in this research.

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[1] For examples, please see the following articles:

- Katz, Dana, Caplan, Arthur, & Merz, Jon. (2003, June 1). All Gifts Large and Small: Toward an Understanding of Pharmaceutical Gift Giving. *University of Pennsylvania Scholarly Commons – Center for Bioethics Papers*.
- Fugh-Berman, A, & Ahari, S. Following the Script: How Drug Reps Make Friends and Influence Doctors. (2007). *PLoS Med*. 4(4), e150.
- Spurling, GK, et al. Information from Pharmaceutical Companies and the Quality, Quantity, and Cost of Physicians' Prescribing: A Systematic Review. (2010). *PLoS Med*. 7(10), e1000352.

Industry branding on patient teaching aids

While the College recognizes that what may be included in or on teaching aids is not necessarily in the control of physicians, it is preferable that they:

- include (at most) the logo of the donor company, and
- do not refer to specific therapeutic agents, services, or other products.

Accepting "modest" meals from industry

The policy permits physicians to accept meals from industry in the following situations:

- when industry representatives are providing information about products or services (e.g. "product detailing"), and
- when attending CME/CPD events

In both cases, the policy requires physicians to accept meals of "modest" value.

Physicians can exercise individual judgments when determining whether a meal is of "modest" value. While the College is unable to provide a specific dollar value, physicians are advised to consider the reasonable expectations of their patients in assessing whether a meal is "modest".

Mechanisms to manage conflicts of interest at CME/CPD events

The policy requires physicians who organize CME/CPD events to ensure that there is a mechanism in place to manage all identified conflicts of interest (for example, conflicts of interest arising from the relationship between an event speaker and an event sponsor).

Examples of these types of mechanisms include (but are not limited to):

1. Disclosing the conflicts of interest of physician organizers or excluding them from planning activity content in which they have a conflict of interest.

2. Requiring physician presenters to:

    - disclose their conflict of interest,
    - attest that they have divested themselves of their financial relationships,
    - refrain from making recommendations regarding products or services, or
    - recommend an alternative presenter for the planning committee's consideration.

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74 ***Industry-sponsored research: requirements for obtaining patient consent for the use or***
75 ***disclosure of personal health information***
76
77 Physicians who participate in industry-sponsored research must comply with their legal
78 obligations under the *Personal Health Information Protection Act, 2004 (PHIPA)* when
79 collecting, using, or disclosing personal health information.[2]
80
81 To assist physicians in understanding their legal obligations with respect to consent, an
82 overview of the relevant legal requirements are outlined below. Should physicians require
83 guidance with respect to specific circumstances, or have questions about their obligations, they
84 are advised to contact their legal counsel, the Canadian Medical Protective Association (CMPA),
85 or the Information and Privacy Commissioner of Ontario (IPC) for further direction.
86
87 **A) What are the elements of consent?**
88
89 *PHIPA* requires that consent to the use or disclosure of personal health information for research
90 purposes must:[3]
91
92 - be the consent of the individual[4] to whom the information relates,
93 - be knowledgeable[5],
94 - relate to the information,
95 - not be obtained through deception or coercion, and
96 - be obtained from an individual with the capacity to consent. [6]

97
98 **B) Obtaining consent**
99
100 As stated in the policy (and required by legislation), physicians must "only use patient
101 information if they have the patient's consent, or if the provisions under *PHIPA* which permit
102 the use of information for research purposes without consent have been satisfied."[7] Physicians

[2] Grant-funded research would be subject to the same privacy and consent requirements as set out in this section, as would marketing and market research. Physicians should be aware that funding agencies may also stipulate requirements with respect to consent and privacy.
[3] S. 18 (1)(a-d) of *PHIPA*.
[4] If an individual is incapable of consenting to the collection, use or disclosure of information, *PHIPA* sets out the persons who can consent on behalf of the individual. *PHIPA* S. 23 (1) 3.
[5] Consent is considered to be knowledgeable if it is reasonable in the circumstances to believe that the individual knows the purposes of the collection, use, or disclosure of the information, and that the individual knows that they may either give or withhold consent (S. 21 and 23 of *PHIPA*.) .
[6] S. 21 and 23 of *PHIPA*.
[7] S. 37(1)(j) and 37(3) of *PHIPA* provide that physicians who do not have patient express consent may use their patients' personal health information only if they comply with the provisions of *PHIPA* at s. 44(2) – (4) and 44(6)(a) –(f), which require the submission of a research plan for research ethics board approval. Additional requirements for research plans are set out in s. 16 of the Ontario Regulation 329/04 under *PHIPA*. Similar obligations apply to the collection of patient personal health information for research purposes, as set out in s. 29(a) and s. 36(1) (a) and (d) of *PHIPA*.

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103 are reminded that using patient information for research without the patient's consent is only
104 permissible in the following limited circumstances: where research ethics board approval has
105 been granted for the research and the board has found that it is impractical to obtain a
106 patient's consent.[8]
107
108 Even when consent has been obtained, legislation only permits physicians to disclose personal
109 health information where no other information will do, and requires physicians to disclose as
110 little personal health information as possible to meet the research needs.[9]
111
112 **C) Industry requests to contact patients directly**
113
114 Physicians are reminded that legislation prohibits third party researchers from contacting the
115 physician's patients, either directly or indirectly, unless the physician has obtained the patient's
116 consent to be contacted by the researcher.[10]

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[8] S. 44 (3)(d) of *PHIPA*.
[9] S. 30 (1) and (2) of *PHIPA*.
[10] S. 44 (6)(e) of *PHIPA*.

Professional Responsibilities in Postgraduate Medical Education

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.

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Definitions

Postgraduate Trainees ("trainees")[1]: Physicians who hold a degree in medicine and are continuing in postgraduate medical education. Regardless of the class of certificate of registration held, postgraduate trainees cannot practice independently within the confines of the training program.

Most Responsible Physician ("MRP"): The physician who has final accountability for the medical care of a patient when the trainee is providing care.

Supervisors: Physicians who have taken on the responsibility by their respective training programs to guide, observe and assess the educational activities of trainees. The supervisor of a trainee involved in the care of a patient may or may not be the most responsible physician for that patient. Residents or fellows often serve in the role of supervisors, but do not act as the most responsible physician for patient care.

Policy

1. While this policy focuses on professional responsibilities in the postgraduate environment, supervisors and trainees **must** be familiar with other applicable CPSO policies including, but not limited to *Delegation of Controlled Acts*, *Mandatory Reporting*, *Consent to Treatment*,

[1] The majority of trainees in Ontario hold a certificate of registration authorizing postgraduate education, and are commonly referred to as "residents" or "fellows" in most teaching sites. However, a trainee may have a different class of registration depending on his/her individual circumstances: 1) pre-entry assessment program certificate of registration – commonly issued to international medical graduates (IMGs) for an initial "assessment phase"; this would include completing a "pre-entry assessment program" or "assessment verification period"; 2) restricted certificate of registration – trainees who have qualified under the *Residents Working Additional Hours for Pay* policy; 3) certificates of registration authorizing independent practice – trainees who have completed their residency program and qualified for full registration, but who continue to do fellowship training.

25 *Disclosure of Harm*, *Medical Records*, and *Physician Behaviour in the Professional*
26 *Environment*.

27 ***Supervision and Training***

28 2. The MRP and/or supervisor physician **must** provide appropriate supervision to the trainee.
29 This includes:

30 a. being familiar with program objectives;
31 b. making the patient or substitute decision-maker aware of the identity of the MRP, and
32 the fact that the MRP is ultimately accountable for the patient's care;
33 c. making the patient or substitute decision-maker aware of the identity of trainee(s)
34 who are members of the treatment team, their stage in the postgraduate program, as
35 well as their degree of involvement in patient care;
36 d. being willing and available to see patients when required or when requested;
37 e. regularly evaluating a trainee's clinical competence and learning needs, and assigning
38 graduated responsibility accordingly;
39 f. making reasonable efforts to determine that the trainee has the necessary
40 competence (knowledge, skill and judgment) to participate in a patient's care and does
41 not compromise that care;
42 g. ensuring that all relevant clinical information is made available to the trainee, and
43 directly assessing the patient as appropriate; and
44 h. communicating regularly with the trainee to discuss and review the trainee's patient
45 assessments, management, and documentation of patient care in the medical record.

46 3. The trainee **must**:

47 a. participate in the care of patients as appropriate to their competencies, and specific
48 circumstances, as well as to meet identified educational needs;
49 b. make the patient or substitute decision-maker aware of their name, role, stage in the
50 postgraduate program, and degree of involvement in patient care;
51 c. make the patient or substitute decision-maker aware of the name and role of the MRP,
52 and the fact that the MRP is ultimately accountable for the patient's care;
53 d. communicate with the supervisor and/or MRP:
54 i. in accordance with guidelines of the postgraduate program and/or clinical
55 placement setting,
56 ii. about patient assessments performed by the trainee,
57 iii. when there is a significant change in a patient's condition,

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iv. when the 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 substitute decision-maker and family expresses significant concerns, or
vii. in any emergency situation or when there is significant risk to the patient's well-being;

e. document their clinical findings and treatment plans and discuss these with the MRP and/or the supervisor.

Professional Relationships

4. The MRP, supervisor and trainee **must** demonstrate professional behaviour in their interactions with each other, as well as with patients, other trainees, colleagues and support staff. This includes avoiding "disruptive behaviour" which is any form of behaviour that interferes with, or is likely to interfere with quality health-care delivery or quality medical education. For example, the use of inappropriate words, actions or inactions that interfere with the ability to function well with others.[2]

5. Positive role-modeling[3] is of the utmost importance and MRPs and/or supervisors **must** demonstrate a model of ethical and compassionate care.

6. The MRP and/or supervisor **must** be mindful of the power differential in their relationship with the trainee and **must** not allow any personal relationships to interfere with their supervision and evaluation of the trainee.

7. In order for the appropriate faculty member to decide whether alternate arrangements for supervision and evaluation of the trainee are warranted, the MRP and/or supervisor **must** disclose any personal relationship, which pre-dates or develops during the training phase between the MRP and/or supervisor, and the trainee, e.g., family, dating, business, friendship, etc., to the appropriate responsible member of faculty (such as department or division head or postgraduate program director).

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[2] For more information, see the College's *Physician Behaviour in the Professional Environment* policy as well as the Guidebook for Managing Disruptive Physician Behaviour.
[3] Students often gain knowledge and develop attitudes about professionalism through role-modeling.

88 ***Patient Care within the Postgraduate Educational Environment***

89 8. In the postgraduate environment, the MRP, the supervisor or the trainee **must** ensure that
90 patients are informed that care involves a collaborative, team-based approach and that
91 trainees are integral members of the health-care team.[4]
92
93 9. Trainees **must** only take on clinical responsibility in a graduated manner in step with their
94 demonstrated growing competency, although never completely independent of
95 appropriate supervision.

96 10. While physicians **must** obtain patient consent[5] for treatment or a proposed change in
97 treatment in any setting, there are circumstances unique to the postgraduate environment,
98 which require additional consideration:

99 a. When a significant component, or all, of a medical procedure is to be performed by a
100 trainee without direct supervision, the MRP, supervisor or trainee **must** ensure that the
101 patient is made aware of this fact and where possible, **must** obtain express consent[6].
102 b. When an examination is performed solely for educational purposes[7], the MRP and/or
103 supervisor, **must**:
104 i. provide an explanation of the educational purpose behind the proposed
105 examination or clinical demonstration to the patient and obtain their express
106 consent. This **must** occur whether or not the patient will be conscious during the
107 examination.
108 ii. **not** allow the examination to be performed by the trainee if express consent
109 cannot be obtained, e.g., the patient is unconscious.
110 iii. be confident that the proposed examination or clinical demonstration will not be
111 detrimental to the patient, either physically or psychologically.

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[4] Typically, hospitals and other clinical settings would have signage notifying patients that they are in teaching institutions. However, physicians in private offices and clinics must explicitly communicate this information.
[5] Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. For more information, please refer to the College's *Consent to Treatment* policy and also, the *Health Care Consent Act*, 1996, c.2. Sched. A.
[6] Express consent is directly given, either orally or in writing.
[7] An examination is defined as solely "educational" when it is unrelated to or unnecessary for patient care or treatment.

Professional Responsibilities in Undergraduate Medical Education

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

Undergraduate medical students ("medical students"): Students enrolled in an undergraduate medical education program in any jurisdiction. They are not members of the College of Physicians and Surgeons of Ontario.[1]

Most responsible physician ("MRP"): The physician who has final accountability for the medical care of the patient, regardless of whether a student is involved in the clinical encounter.

Supervisors: Physicians who have taken on the responsibility to guide, observe, and assess the educational activities of medical students.[2] The supervisor of a medical student involved in the care of a patient may or may not be the most responsible physician for that patient. Residents or fellows often serve in the role of supervisors but do not act as the most responsible physician for patient care.

Policy

1. While this policy focuses on professional responsibilities in the undergraduate environment, supervisors **must** be familiar with other applicable College policies

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[1] Students are able to participate in the delivery of health care through a provision in the *Regulated Health Professions Act, 1991*, which permits them to carry out controlled acts "under the supervision or direction of a member of the profession," i.e., a clinical teacher or supervisor. Medical students are not independent practitioners or specialists. They are pursuing both program and individual objectives in a graded fashion under the supervision of the undergraduate medical education program. While some students hold "Affiliate Status" with the College, they are not licensed to practise medicine in Ontario, and are not members of the College.

[2] Supervision may include, but is not limited to the guidance, teaching, observation, and assessment of undergraduate medical students.

23 including, but not limited to *Delegation of Controlled Acts*, *Mandatory Reporting*, *Consent*
24 *to Treatment*, *Disclosure of Harm*, and *Medical Records*.[3]
25 a. Supervisors **are advised** to encourage medical students to become familiar with the
26 above-named policies, this policy, as well as any applicable medical school policies,
27 guidelines and statements relevant to undergraduate medical education.

28 ***Designation of Most Responsible Physician***

29 2. Patient care is often provided by multiple health-care professionals, with one individual
30 designated as the most responsible physician; therefore, the MRP and/or the supervisor
31 **must** ensure that patients are given the name of the MRP, along with an explanation that
32 the MRP is responsible for directing and managing their care.

33 ***Identification of Medical Students and their Role in the Health-care Team***

34 3. The MRP and/or supervisor **must** ensure that patients are made aware that patient care
35 in teaching hospitals and other affiliated sites where education occurs relies on a team-
36 based approach, i.e., care is provided by multiple health-care professionals, including
37 students.[4]
38
39 4. The MRP and/or supervisor **must** ensure that the educational status of medical students
40 and nature of their role on the team are made clear to the patient, the patient's family,
41 and members of the health-care team as early as possible during the educational process.
42 In particular, the MRP and/or supervisor **must** ensure that it is made clear to patients that
43 medical students are not physicians. [5]
44
45 a. Unless appropriate for the medical student to do so themselves, the MRP and/or
46 supervisor **must** ensure that students are introduced as medical students.

47 ***Supervision and Education of Medical Students***

48 5. The MRP and/or supervisor **must** provide appropriate supervision. This includes:
49

[3] There are MD program requirements set out in the "Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree" prepared by the Liaison Committee on Medical Education, as well as university and hospital policies and procedures relating to professionalism, e.g. Codes of Conduct.
[4] Typically, a hospital would have signage notifying patients that it is a teaching institution. However, physicians in private offices and clinics need to explicitly communicate this information.
[5] An explanation could be provided that team-based approach forms an important part of their undergraduate medical education program.

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50 a. determining the medical student's willingness and competency or capacity to
51 participate in the clinical care of patients, as a learning experience;
52 b. closely observing interactions between the medical student and the patient to
53 assess:
54 i. the medical student's performance, capabilities and educational needs;
55 ii. whether the medical student has the requisite competence (knowledge, skill
56 and judgment) to safely participate in a patient's care without compromising
57 that care; and
58 iii. whether the medical student demonstrates the necessary competencies and
59 expertise to interact with patients without the supervisor being present in
60 the room;
61 c. meeting at appropriate intervals with the medical student to discuss their
62 assessments;
63 d. ensuring that the medical student only engages in acts based on previously agreed-
64 upon arrangements with the MRP;
65 e. reviewing, providing feedback and countersigning documentation by a medical
66 student of a patient's history, physical examination, diagnosis, and progress notes as
67 soon as possible;
68 f. managing and documenting patient care, regardless of the level of involvement of
69 medical students; and
70 g. counter-signing all orders concerning investigation or treatment of a patient, written
71 under the supervision or direction of a physician.[6]

72 6. The MRP and the supervisor, if different, **must** ensure that there is clear communication
73 between them in order to ensure the best possible care for the patient.

74 ***Professional Relationships***

75 7. Physicians **must** demonstrate professional behaviour in their interactions with each other,
76 as well as with students, patients, other trainees, colleagues from other health
77 professions, and support staff. This includes refraining from "disruptive behaviour" which
78 is any form of behaviour that interferes with, or is likely to interfere with quality health-
79 care delivery or quality medical education. For example, the use of inappropriate words,
80 actions, or inactions that interfere with a physician's ability to function well with others.[7]

[6] Prescriptions, telephone or other transmitted orders may be transcribed by the medical student, but must be countersigned.

[7] For more information, please refer to the College policy on *Physician Behaviour in the Professional Environment*, as well as the Guidebook for Managing Disruptive Physician Behaviour.

81 a. Positive role-modeling[8] is of the utmost importance and MRPs and/or supervisors
82 **must** demonstrate a model of compassionate and ethical care.
83
84 8. The MRP and supervisor **must** be mindful of the power differential in their relationship
85 with the student and **must not** allow any personal relationships to interfere with the
86 student's education, supervision, or evaluation.
87
88 9. In order for the appropriate faculty member to decide whether alternate arrangements
89 for supervision and evaluation of the student are warranted, the MRP or supervisor **must**
90 disclose any relationship which pre-dates or develops during the educational phase
91 between the MRP or supervisor and the medical student (e.g., family, clinical care, dating,
92 business, friendship, etc.), to the appropriate responsible member of faculty (such as the
93 department or division head or undergraduate program director).
94
95 10. Physicians are **advised** to be aware of university policies and procedures on these issues.

96 ***Reporting Responsibilities***

97 11. Physicians involved in the education of medical students **must** report to the medical
98 school and, if applicable, to the health-care institution when:
99
100 a. a medical student exhibits behaviours that would suggest incompetence, incapacity,
101 or abuse of a patient;
102 b. a medical student fails to behave professionally and ethically in interactions with
103 patients, supervisors or colleagues; or
104 c. otherwise engages in inappropriate behaviour.[9]
105
106 12. Physicians who are involved in medical school administration **must** ensure**:**
107 a. A safe, supportive environment is provided that allows medical students to make a
108 report if they believe their supervisor and/or the MRP:
109 i. exhibits any behaviours that would suggest incompetence, incapacity, or abuse of
110 a patient;
111 ii. fails to behave professionally and ethically in interactions with patients,
112 supervisors or colleagues; or
113 iii. otherwise engages in inappropriate behaviour; and

[8] Students 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 those principles of professionalism taught to students during the undergraduate didactic curriculum.
[9] This obligation equally extends to physicians who supervise medical students from other jurisdictions.

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114 b. Students will not face intimidation or academic penalties for reporting such
115 behaviours.

116 ***Consent and the Educational Nature of the Undergraduate Environment***

117 13. While physicians **must** obtain patient consent[10] for treatment in any setting, there are
118 circumstances unique to the undergraduate environment, which require additional
119 consideration:
120
121 a. In the rare situation where a significant component, or all, of a medical procedure is to
122 be performed by a student and the MRP and/or supervisor is not physically present in
123 the room, the MRP and/or supervisor **must** ensure the patient is made aware of this fact
124 and, where possible, express consent[11] **must** be obtained.
125 b. Where an investigation and/or procedure is performed solely for educational
126 purposes[12], the MRP and/or supervisor **must:**
127 i. Provide an explanation of the educational purpose behind the proposed
128 investigation or procedure to the patient and obtain their express consent[13].
129 This **must** occur whether or not the patient will be conscious during the
130 examination.
131 ii. Ensure the examination is not performed if express consent cannot be
132 obtained, e.g., the patient is unconscious.
133 iii. Be confident that the proposed examination or clinical demonstration will not
134 be detrimental to the patient, either physically or psychologically.[14]
135
136 ***Supervision of Medical Students for Educational Experiences not Part of an Ontario***
137 ***Undergraduate Medical Education Program***

138 14. In addition to fulfilling the obligations set out elsewhere in this policy, physicians who
139 choose to supervise medical students for educational experiences not part of an Ontario
140 undergraduate medical education program **must** also:

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[10] Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. For more information, please refer to the College's *Consent to Treatment* policy and also, the *Health Care Consent Act, 1996*, c. 2, Sched. A.

[11] Express consent is directly given, either orally or in writing.
[12] An investigation or procedure is defined as solely "educational" when it is unrelated to or unnecessary for patient care or treatment.
[13] See footnote 11.
[14] For more information, please refer to the joint policy statement "Pelvic Examinations by Medical Students" dated September 2010 prepared by the Society of Obstetricians and Gynaecologists of Canada (SOGC) Ethics Committee and the Association of Professors of Obstetrics and Gynaecology of Canada (APOG).

141

142 a. be familiar with the *Delegation of Controlled Acts* policy,[15]

143 b. obtain evidence that the student is enrolled in and in good standing at an

144 undergraduate medical education program at an acceptable medical school,[16]

145 c. ensure that the student has liability protection that provides coverage for the

146 educational experience,

147 d. ensure that the student has personal health coverage in Ontario,

148 e. ensure that they have liability protection for that student to be in the office, and

149 f. ensure that the student has up-to-date immunizations.[17]

150

151 15. Where physicians do not have experience supervising medical students or are unable to

152 fulfill the expectations outlined above they **must** limit the activities of the medical student

153 to the observation of clinical care only.

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[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.

[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 either the World Health Organization's Directory of Medical Schools: http://www.who.int/hrh/wdms/en/, or the Foundation of Advancement of International Medical Education and Research's (FAIMER's) International Medical Education Directory (IMED): https://imed.faimer.org/

[17] Please refer to the Council of Ontario Faculties of Medicine's Immunization policy which is available on the websites of the Ontario medical schools, for more information.

Third Party Reports

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

Third party reports: Forms, letters or reports physicians are asked to complete or prepare in relation to a third party process that are not for the purpose of the provision of health care; for example, for insurance benefits, or in respect of workplace issues, attendance in educational programs, or legal proceedings. Third party reports may:

- relate to a physician's patient or to individuals with whom physicians do not have a treating relationship; and
- be requested by the physician's patient directly or an external party, such as a representative from an insurance company or a lawyer.

Treating physician: A physician who provides a third party report about their own patients, with whom the physician has a treating relationship.

Independent medical examiner: A physician who provides a third party report about an individual with whom the physician does not have a treating relationship.

Independent medical examination: An examination which is conducted strictly for the purpose of a third party report. It is distinct from a regular physician-patient encounter and, as such, it does not obligate the independent medical examiner to treat, or to provide health care to the examinee.

Examinee: An individual who is the subject of a report, but who is not in a treating relationship with the reporting physician.[1]

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[1] For the purposes of the provisions of the *Health Professions Procedural Code* (*Regulated Health Professions Act, 1991*, S.O. 1991, c.18., Sched. A. *Patient criteria*, O. Reg. 260/18) concerning sexual abuse of a patient, the College will consider examinees to be patients. As outlined in 1(6) of the *Health Professions Procedural Code*, the physician-patient relationship continues for a minimum of 1 year after the date upon which the individual, in this case the examinee, ceases to be the physician's patient. A physician who engages in sexual relations with an examinee before the minimum 1 year timeframe will have sexually abused a patient and be subject to mandatory revocation provisions.

28 ## Policy

29 1. This policy does not provide an exhaustive catalogue of every requirement that may apply
30 to specific third party reports requests.[2] As such, physicians[3] are **advised** to keep informed
31 of any additional requirements[4] that may be applicable in their particular circumstances,
32 including those set out in statute or regulation so they can ensure that they have complied
33 with their obligations.
34
35 2. Physicians **must** act with the same high level of integrity and professionalism when
36 preparing a third party report, or conducting an examination for a third party report, as they
37 would when delivering health care.

38 ## Before a Third Party Report is Prepared

39 ***Obligation to Provide a Report***

40 3. Treating physicians **must** provide reports about their own patients when proper consent is
41 provided.[5]
42
43 4. Independent medical examiners are not obligated to provide reports about examinees or
44 about former patients. When asked to provide a report about a former patient, physicians
45 are **advised** to disclose the existence of the previous treating relationship before accepting
46 the request in order to allow all parties to consider whether objectivity will be a concern in
47 the specific circumstances and to evaluate whether the report should be provided by
48 another independent medical examiner.

49 ***Communication***

50 5. To avoid misunderstanding, physicians **must** communicate clearly the nature of their role in
51 providing a third party report.[6]
52
53 6. In discussing their role, physicians **must** explain to patients that:

[2] Policy expectations specific to the role of medical experts are provided in the College's *Medical Expert: Reports and Testimony* policy.
[3] Unless otherwise noted, any references in this policy to a physician or physicians apply to both treating physicians, and independent medical examiners.
[4] These include, but are not limited to solicitor client and litigation privilege and requirements contained in the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43.
[5] The obligation to provide reports about patients may also be contained in statute. For example, see the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c.16, Sched. A., ss.37(1), 37(3).
[6] In particular, patients may be more apt to confuse the encounter with a typical appointment for health care when it is their own treating physician that is providing the report.

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   a. while the specifics of the information provided will depend on the circumstances of each case, they are obliged to disclose relevant and accurate information in the third party report; and
   b. where required, consent will be obtained and documented.

7. Physicians are also **advised** to convey that the final outcome (for instance, decisions regarding eligibility for benefits) are not made by the physician but rather by the relevant decision makers in the third party process.

Fees

8. Physicians **must** discuss any requirements or arrangements with respect to fees (including cancellation fees for missed appointments) with the requesting party before proceeding.

9. Physicians **must** comply with any legal obligations they may have in relation to fees for third party reports.[7]

10. Where there are no legal requirements with respect to fees, physicians **must** consider the recommendations set out in the Ontario Medical Association's *Physician's Guide to Uninsured Services* and **must** notify the requesting party if fees in excess of these recommendations are to be charged.[8]

11. While it is generally permissible for physicians to request receipt of payment in advance for reports and examinations, physicians are **advised** to refrain from doing so on compassionate grounds, when the patient or examinee is responsible for payment directly, and the report relates to basic income and health benefits.

Consent for Disclosure of Information

12. Physicians **must** obtain appropriate consent[9] for disclosing personal health information to the third party.[10]

13. The consent process will vary depending on the circumstances of each case; however, at minimum, physicians **must** ensure the following points are conveyed:

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[7] For instance, see *Workplace Safety and Insurance Act, 1997*, S.O. 1997 c. 16, Sched. A., s.37(5). The Professional Misconduct regulation (Section 1(1), paragraph 21 of O.Reg. 856/93 *Professional Misconduct*, enacted under the *Medicine Act, 1991* S.O. 1991. C.30.) also specifies that it is an act of professional misconduct to charge a fee that is excessive in relation to the services performed.
[8] Section 1(1) paragraph 22 of the *Professional Misconduct Regulation*.
[9] Appropriate consent may be obtained from the patient or examinee, or from a substitute decision maker.
[10] *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched A., and/or *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c.5.

   a. consent can be withdrawn at any time; however, this will prevent the physician from completing and submitting the report;
   b. limits may be placed on the information that physicians can disclose in a report; however, such limitations may prevent physicians from proceeding with the reports process; and
   c. physicians have obligations to be truthful and accurate when detailing information in the report, and when forming a professional opinion about the patient’s or the examinee’s condition or functional abilities.

14. Physicians are strongly **advised** to document that consent has been obtained.

15. Physicians are **advised** to seek independent legal advice where they are uncertain about the specific information that should be conveyed through the consent process.

Consent for Medical Examination

16. Physicians **must** obtain appropriate consent for conducting a medical examination.

17. Physicians **must** ensure it is understood that the examination is being conducted to prepare the report.

18. Physicians **must** outline what the examination will entail. This includes:

   a. an indication of what areas of the body will be examined,
   b. what functional capabilities the physician will be testing, and
   c. what types of questions the physician may have to ask.

19. Physicians are strongly **advised** to document that consent has been obtained.

20. Physicians **must** be satisfied of the following, if relying on a pre-signed consent form:

   a. the form meets the criteria of a valid, informed consent; and
   b. the consent form applies to, and authorizes the full spectrum of acts they will conduct in order to prepare the third party report[11].

21. If physicians have any doubts about the validity of the consent provided, or if limits have been imposed on the consent that will prevent physicians from completing the report, they **must** discuss the matter with the requesting party before proceeding.

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[11] For example, if physicians will need to conduct a medical examination, the signed form must contain consent for an examination.

Presence of Observers & Audio/Video Recording

22. If physicians are conducting an examination for the purposes of a legal proceeding and one or more parties wish to have an observer present, they are **advised** to discuss the matter with the lawyer involved, as specific rules may apply.[12,13]

23. Physicians **must** ensure any arrangements with respect to observers or recording are mutually agreeable to the parties involved.

24. Should the parties disagree over whether the examination will be recorded, or will be conducted in the presence of an observer, physicians are **advised** to postpone the examination until these matters can be discussed and a resolution reached.

Proceeding with the Request for a Third Party Report

Comprehensiveness

25. Physicians **must** take steps to obtain and review all available clinical notes, records and opinions relating to the patient or examinee that could impact the findings of the report, including the physician's final opinion and/or recommendations.

26. If physicians have not been provided with all available information despite reasonable requests, they **must** explicitly note this fact in the report, and clearly indicate that the findings made were based on the information available to them.

Accuracy

27. Physicians **must** ensure that the information contained in the third party report is accurate.

28. If physicians rely on information which they cannot substantiate independently, such as employment history or previous medical history, physicians **must** note in the report the source of the information and the fact that it has not been independently confirmed.

Objectivity

29. Physicians **must** state any findings or opinions contained in a report in a way that is objective and free from personal bias.

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[12] For example, for court-ordered examinations, the *Rules of Civil Procedure* R.R.O. 1990, Reg. 194, enacted under the *Courts of Justice Act*, R.S.O. 1990, c. C.43. Rule 33.05 states that observers shall not be present during examinations unless the court orders otherwise.
[13] If the matter is not related to a legal proceeding, physicians are not obligated to conduct an examination in the presence of an observer or to record an examination, but they are permitted to do so if they wish.

149 30. Physicians **must not** include comments unrelated to the physician's professional opinion, or
150 that are extraneous to the requesting party's stated objectives.

151 ***Clarity***

152 31. To allow for optimal clarity, physicians are **advised** to outline the basis for their professional
153 opinion, and the information or observations on which they have relied in forming that
154 opinion.
155
156 32. Physicians **must** use language and terminology in the report that is appropriate for the
157 intended audience.
158
159 33. Physicians are **advised** to avoid using medical short forms or jargon. Where this is not
160 possible, physicians **must** include, in addition to technical medical terminology, more
161 colloquial terms or explanations to ensure the reader understands the report's contents.

162 ***Relevance***

163 34. Physicians **must** only include information in the third party reports which they deem
164 necessary and relevant.

165 ***Timeliness***

166 35. In some instances, timelines for providing reports will be set out in legislation.[14] Absent a
167 specific legal requirement, physicians **must** complete and submit third party reports within
168 60 days.
169
170 36. If, in rare circumstances, physicians are not able to comply with this timeframe, either due
171 to the complexity of the report, or for another appropriate reason, physicians **must** discuss
172 the matter with the requesting party and reach an agreement for a reasonable extension.[15]

173 ***Scope of Expertise & Knowledge***

174 37. In situations where a physician is asked to answer questions, or provide an opinion that is
175 beyond their expertise or experience, or which requires access to information they do not
176 have, physicians are **advised** to discuss the matter with the requesting party, and explain
177 that they may not be able to answer every question asked, or provide the opinion sought.

[14] For example, see sections 32 and 42 of the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, O.Reg. 403/96, enacted under the *Insurance Act*, R.S.O. 1990, c. I.8.

[15] Under the *Professional Misconduct* regulations (section 1(1), paragraph 17 of O.Reg. 856/93,*Professional Misconduct*, enacted under the *Medicine Act, 1991*, S.O. 1991, c.30) it is an act of professional misconduct to fail, without reasonable cause, to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate.

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178 a. If the party will not amend their request, or is otherwise unresponsive to the
179 concerns expressed, physicians **must:**
180 i. restrict their statements to matters that are within their area(s) of expertise
181 and about which they have sufficient information, and
182 ii. indicate clearly the reasons for which they are unable to fulfill all the
183 elements of the third party's request.

184 ***Independent Medical Examinations: Suspicious Findings***

185 38. If, in the context of an examination, the independent medical examiner discovers a
186 suspicious finding where it is unclear whether it has been previously identified, such as an
187 unexpected significant clinical finding, a condition which raises serious concern or a
188 symptom or condition which requires essential intervention,[16] they **must** advise the
189 examinee or their substitute decision maker of this fact to enable timely medical attention.
190
191 39. Independent medical examiners are **advised** to seek consent to share the results with the
192 examinee's treating physician.
193
194 40. Independent medical examiners are **advised** to convey the findings in written form as soon
195 as possible to that treating physician, and not to merely send the treating physician a copy
196 of the third party report.[17]
197
198 41. If the independent medical examiner is conducting the examination in the context of a legal
199 proceeding, they **must** use their professional judgment to determine whether to seek
200 independent legal advice based on the circumstances of the particular case, before
201 disclosing the findings to the examinee.

202 **After the Report is Prepared**

203 ***Retention of Reports, Notes and Documents***

204 42. Physicians **must** retain third party reports and related documents in accordance with their
205 legal obligations.[18]

[16] This includes but is not limited to undiagnosed conditions and conditions for which immediate diagnostic intervention is required.
[17] Sending a letter will enable both the treating physician and the independent medical examiner to have a record of the finding and its disclosure. Independent medical examiners are advised to not merely send the third party report for two reasons: first, the consent may not extend to disclosure of the entire report, and second, provision of the entire report will not give the treating physician specific information about the unexpected finding, and therefore the treating physician may not obtain the information necessary to intervene or follow up in the requisite manner.
[18] Requirements relating to the retention of reports, notes and documents will vary depending on the context in which a physician has provided a third party report and may be specified in legislation. For instance, requirements with respect to the length of retention periods are contained in O.Reg.114/94 *General*, enacted under the *Medicine Act, 1991*, S.O. 1990, c. 30., Part V, Records ss.18, 19, and the regulations under the *Occupational*

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206 a. Physicians are **advised** to familiarize themselves with the specific obligations that
207 are applicable to their circumstances and seek independent legal advice where
208 necessary.
209
210 43. In circumstances where there are no applicable legal obligations with respect to the
211 information that needs to be retained, physicians are **advised** to retain the following:
212
213 a. consent obtained;
214 b. contract with the third party, outlining scope, purpose, timelines and fee
215 arrangements;
216 c. audio or video recording of the examination, where applicable, if the recording was
217 made by the physician;
218 d. documents, or information not created by the physician, which the physician relied
219 upon when preparing the report; and
220 e. a list of sources of ancillary information, and any audio or visual information
221 recorded by another person.
222
223 44. In the absence of a specific statutory retention requirement, physicians may be inclined to
224 return or destroy ancillary information but are **advised** to take these steps only if they are
225 satisfied that this information will be retained by others, and will be available for their own
226 review should they be required to discuss the third party report in the future.
227
228 a. As an alternative, physicians are **advised** to consider options to address storage
229 concerns such as retaining information electronically.

230 ***Access to Reports***

231 45. Where, after the report has been submitted, patients or examinees contact physicians
232 directly to request copies of the report, notes or documents relied upon when preparing
233 the report, physicians **must** comply with any statutory obligations they may have to provide
234 access to reports, documents or notes.[19]
235
236 a. Physicians are **advised** to seek independent legal advice where they are uncertain
237 how to respond to a request for access, or what obligations they may have.

Health and Safety Act, R.S.O. 1990, c.O.1 also contain requirements for retention of records. Requirements with respect to the type of information that must be retained are included in O.Reg. 114/94, General, enacted under the Medicine Act, 1991, S.O. 1991, c.30., Part V., Records, s.18 which requires that the information retained include a record of assessments, including notes of examinations and investigations, and written reports provided by other physicians or other health-care professionals.

[19] This includes but is not limited to applicable obligations under Ontario and Canadian privacy legislation.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: ***Planning for and Providing Quality End-of-Life Care* – Policy Changes**

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The Council approves the revised "Planning for and Providing Quality End-of-Life Care", (a copy of which forms Appendix " " to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: ***Planning for and Providing Quality End-of-Life Care* – Policy Changes**

FOR DECISION

ISSUE:

- In May 2019 Council considered proposed revisions to the *Planning for and Providing Quality End-of-Life Care* policy as part of the policy redesign process. The revisions were developed in response to recent stakeholder feedback regarding the policy expectations in relation to "no-CPR" orders. At the time, Council felt that the revisions were substantive enough to warrant additional consideration at a future meeting.

- Since that time, a significant Court decision has been released clarifying physicians' obligations with respect to the writing of no-CPR orders and the provision of CPR. As a result, revisions are now being proposed that address *both* the stakeholder feedback received and the Court decision.

- Council is provided with an overview of the history and evolution of this issue and is presented with proposed revisions for consideration. Council is asked whether the redesigned policy incorporating the proposed revisions can be approved as a policy of the College.

BACKGROUND:

A. Policy Review History

- The policy was last reviewed in 2013-2015 and was overseen by a Working Group chaired by Dr. Carol Leet and comprised of Council Members and Non-Council physicians[1] with relevant expertise.

- Expectations regarding "no-CPR" orders were the most challenging element of the file.

---

[1] Debbie Giampietri, Emile Therien, Dr. Ron Wexler, along with Dr. Scott Wooder (who at the time was Past President, Ontario Medical Association), Dr. Adam Rapoport (Medical Director, Paediatric Advanced Care Team, Hospital for Sick Children), and Dr. Camilla Zimmermann (Head, Palliative Care, University Health Network).

- Initially the Working Group developed and Council approved a draft version of the policy for external consultation that required consent to be obtained prior to writing a no-CPR order.
- This position was drafted, in part, due to a Health Professions Appeal and Review Board (HPARB) return[2] where the College was directed to update the policy at the time to require consent for a no-CPR order. HPARB based this direction on an interpretation and application of the Supreme Court of Canada's reasoning in *Rasouli*. At the time, this interpretation of *Rasouli* had not yet been tested in the Courts and was the subject of significant debate.
- During the consultation process, this draft expectation received significant negative feedback, primarily from the critical care and palliative care physicians. In order to explore their concerns, these stakeholders were included in teleconferences with relevant staff and a presentation to the Working Group was given by Dr. James Downar[3] on behalf of the Ontario Medical Association Section on Critical Care.
- In light of the legal uncertainty regarding the consent requirements for no-CPR orders and in response to the significant feedback received, the Working Group revised its position by removing the consent requirement. It did, however, continue to prohibit unilateral decision-making regarding the writing of no-CPR orders and felt it was necessary to require that CPR be provided while conflict resolution was underway to preserve this prohibition.
- This change was not considered sufficient by many in the critical care specialty, and they submitted proposed policy revisions directly to the Working Group and Council. Their proposal retained key elements of the Working Group's version, but would have permitted physicians to make bedside determinations as to whether or not to provide CPR while conflict resolution was underway, depending on whether or not CPR was within the standard of care.
- Council considered, but ultimately did not accept this proposal. At the time Council felt it was contrary to the spirit of the policy, undermined the intention of conflict resolution, and departed significantly from the expectations of the public. Council approved the Working Group's version of the policy instead, which came into effect September 2015.
- In January 2016, two critical care physicians contacted the College expressing support for the policy but offering an amendment to clarify the expectations regarding CPR. More specifically, that the policy be amended to clarify that CPR need not be provided if the patient's condition would prevent the intended physiologic goals of CPR from being achieved.
- Council considered and accepted this proposal as an amendment to the policy in May 2016.

---

[2] The case involved a physician who wrote a no-CPR order prior to communication with the patient's substitute decision-maker. The substitute decision-maker witnessed her father arrest while the health-care team refused to provide CPR. This process was consistent with the hospital's policy and arguably the College's policy at the time.
[3] Dr. Downar is currently the Head of the Division of Palliative Care at the Ottawa General Hospital.

B. Stakeholder Engagement

- While the 2016 revisions were viewed favourably by some, the expectations continued to garner significant negative feedback and stakeholder activity intensified in late 2018.

  - A *Healthy Debate* opinion article exploring the emotional challenges critical care physicians experience as they try to provide appropriate and high quality care while navigating patient and family expectations prompted social media chatter about the College's policy (including tweets from Dr. Downar: here & here) and an interest in mounting opposition ahead of the next scheduled policy review in 2020 (see here).

  - Another *Healthy Debate* opinion article mistakenly described the College's position as requiring "permission" for no-CPR orders and expressed concern about how CPR has become a default, irrespective of the lack of benefit and harm that often accompanies it.

  - Staff engaged with a critical care physician and clinical ethicist from an academic hospital to discuss their concerns with the policy. These discussions helped to identify areas of the policy that are being misinterpreted or misapplied by physicians (e.g., as requiring consent), as well as a general sense that physicians are providing care beyond what is intended by the policy (e.g., providing CPR in instances the policy does not require) for fear of reprisal from the College.

  - In his role as Chair of the Ethics Committee for the Canadian Critical Care Society, Dr. Downar met with Dr. Whitmore to express this group's continued concerns with the policy and to reiterate their position as submitted to Council in 2015.

C. Policy Resign and Proposed Revisions in Response to Stakeholder Feedback

- The policy was redesigned in accordance with the policy redesign process and the implementation plan as articulated in the *Policy Redesign Implementation – Batch 2* briefing note included in the September Council Materials. A companion *Advice to the Profession* document was also developed to repurpose important contextual information and to answer frequently asked questions.

- As the intention of the policy redesign process was to improve the clarity and utility of policies, this process afforded the opportunity to explore additional revisions in order to address areas of misinterpretation and misapplication and to update the tone of the policy to be more reflective of physicians' expertise in this area.

- The proposed changes were identified and outlined within the context of the first batch of redesigned policies and considered by Council at its May 2019 meeting. Council ultimately felt these changes were too substantive to approve without additional consideration and moved that the policy return as a standalone item at a subsequent meeting.

CURRENT STATUS:

A. Legal Developments

- The case at the center of the HPARB return, noted above and which initially prompted the Working Group to develop a consent requirement, was recently heard by the Court in the context of a civil suit against the subject physicians.

- In late August the Court released a comprehensive decision, dismissing the suit.

    - Importantly, the decision specifically addressed the issue of whether or not consent is required prior to writing a no-CPR order and what physicians' obligations are with respect to providing CPR in general.

    - Additionally, the Court specifically engaged with the *Rasouli* decision to determine whether the analysis and conclusions presented there apply in the context of withholding CPR as well.

- Ultimately the Court determined that the withholding of CPR, including the writing of a no-CPR order, is different than the withdrawal of life-sustaining treatment. In particular, it noted that while consent is required for the latter, which was at issue in *Rasouli*, the reasoning and conclusion of that case does not apply in the context of withholding CPR and consent is not required.

- Instead, the Court found that physicians are only obliged to provide CPR when doing so is within the standard of care and that the writing of a no-CPR order is effectively a process requirement (not a treatment) that is needed in order to respond to a hospital policy that CPR be provided as a default treatment option.

    - Notably, while the Court acknowledged that the subject physicians could have improved their communication practices regarding the writing of a no-CPR order, it ultimately determined advance communication with the patient or substitute decision-maker regarding the writing of a no-CPR order was not necessarily required by the standards of the profession at that time.[4]

B. Proposed Revisions

- With legal uncertainty during the last policy review process, there was a need for the College to develop a reasonable and balanced position that provided guidance to the profession while recognizing that the law could evolve to either require or not require

[4] The court was adjudicating consent requirement and practices as they existed and would be assessed in 2008, the date of the incident in question.

consent for a no-CPR order. As a result of the above Court decision, this uncertainty no longer exists as there is now a post-*Rasouli* Court decision addressing the issue of withholding CPR.[5]

- Given that there is significant confusion among physicians regarding the policy expectations and that legal clarity has now been provided by the Court, revisions are being proposed in order to remove any impression that the College requires consent to be obtained prior to writing a no-CPR order and that the College requires physicians to provide CPR in instances where doing so is not in accordance with the standard of care.

- Importantly, although revisions are being proposed, core elements of the current position are being retained. In particular, the proposed revisions continue to:

    - prohibit unilateral decision-making regarding the writing of a no-CPR order;
    - require that patients and/or substitute decision-makers be informed prior to a no-CPR order being written;
    - require a robust conflict resolution process to be undertaken when there is disagreement; and
    - prohibit the writing of a no-CPR order while conflict resolution is underway.

- While the Court was more permissive regarding communication requirements,[6] given the central role that communication holds in medical professionalism and previous support that was provided for these elements of the policy by members of the critical care specialty, these expectations have been retained.

- The most substantive changes being proposed relate to physicians' obligations to provide CPR while conflict resolution regarding the writing of a no-CPR order is underway. While substantive in nature, these revisions are being proposed as they are needed to align with the Court's decision.

- The proposed changes and their rationale are outlined in detail in **Appendix A**, along with a comparison to the current language. The proposed changes are reflected in the revised draft policy and companion *Advice* document which are attached as **Appendix B** and **C**, respectively (substantive revisions are highlighted in grey). These changes address three general issues, as outlined below.

Clarifying that consent is not required

- Revisions are proposed in order to clarify that physicians are only required to *inform* patients and/or substitute decision-makers that a no-CPR order will be written and the

[5] At the time of the Council Submission deadline (August 30, 2019), it is not known whether the decision will be appealed.
[6] As noted above, the Court was adjudicating the case on the basis of practices as they existed at the time of the incident.

reasons why, and that physicians are not required to seek consent prior to writing the order.

- The proposed revisions aim to address areas of misinterpretation and reflect physicians' legal obligations in light of the Court's decision. The specific language being proposed has been informed by stakeholder feedback which helped to identify how the current language was being misinterpreted and is consistent with the Working Group's intention to set an expectation that was meaningfully different than proposing that a no-CPR order be written and seeking consent to do so.

Updating the expectations regarding the provision of CPR during conflict resolution

- Currently the policy requires physicians to provide CPR while conflict resolution regarding the writing of a no-CPR order is underway, unless the physiologic goals of CPR cannot be achieved.

- Given the clarity that has now been provided by the Court, namely that physicians are only obliged to provide CPR in accordance with the standard of care, substantive revisions are proposed. More specifically, revisions are proposed that would allow for a bedside determination to be made, while conflict resolution is underway, regarding the resuscitative measures that are warranted in accordance with the standard of care.

    - Importantly, the prohibition on the unilateral writing of a no-CPR order and engagement in a conflict resolution process continues to be preserved, but this amendment allows physicians to make appropriate in-the-moment treatment decisions.

    - Notably, these revisions are also consistent with the language originally proposed by members of the Critical Care specialty in 2015.

Updating the tone of the policy to support the use of professional judgment

- Minor revisions are proposed to update the tone of the policy in order to minimize the feeling among physicians that they cannot rely on their professional judgment or that the College does not value or trust this judgment.

    - The language of the policy, as currently written, can be read as implying that the College believes physicians may enter these discussions or make clinical assessments in bad faith and has had a "chill effect" on physicians exercising their judgment. The proposed changes will update the tone of the policy and are aligned with the emphasis the Court has placed on the role of physician judgment.

NEXT STEPS:

- Should Council approve the redesigned policy, it will replace the existing policy on the College's website.
- Notification of the redesigned policy will be published in *Dialogue* and announced through the College's social media properties, and will emphasize that the majority of the expectations have not changed, while highlighting the proposed revisions as addressing the Court's recent decision.

DECISIONS FOR COUNCIL:

1. Does Council approve the revised *Planning for and Providing Quality End-of-Life Care* policy as a policy of the College?

Contact: Craig Roxborough, Ext. 339
Date: August 30, 2019

Attachments:
Appendix A: Proposed Revisions and Rationale
Appendix B: *Planning for and Providing Quality End-of-Life Care* – Redesigned Policy
Appendix C: *Advice to the Profession: Planning for and Providing Quality End-of-Life Care*

"No-CPR Orders" – Proposed Revisions and Rationale

The table below captures the current and proposed language for each passage within the policy, along with a rationale for the change.

Current	Proposed	Rationale
A decision regarding a no-CPR order cannot be made unilaterally by the physician.	15. Physicians **must not** unilaterally make a decision regarding a no-CPR order.	No change in the expectation. Only minor revisions have been made in accordance with the policy redesign process.
Where a physician is of the opinion that CPR should not be provided for a patient and that a no-CPR order should be written in the patient's record, the College requires physicians to discuss this with the patient and/or substitute decision-maker at the earliest and most appropriate opportunity, and to explain why CPR is not being proposed. This discussion must occur before a no-CPR order can be written.	a. Before writing a no-CPR order in the patient's record, physicians **must** inform the patient and/or substitute decision-maker that the order will be written and the reasons why.	The language has been simplified and revised to be clear that the obligation is to *inform*, not to make a recommendation or proposal. This addresses stakeholder feedback and aligns with the Court's determination that a no-CPR order is not being proposed and consent is not required. While the Courts were more permissive regarding the communication requirements, advance communication was an essential component of the Working Group's original intention and is a key component of medical professionalism.
If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians must engage in the conflict resolution process as outlined in Section 8 of this policy. Physicians must allow the patient or substitute decision-maker a reasonable amount of time to disagree before a no-CPR order can be written. While the conflict resolution process is underway, physicians may not write a no-CPR order.	b. If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians **must** engage in the conflict resolution process as outlined in this policy and **must not** write the no-CPR order while conflict resolution is underway.	The current language gives the impression that physicians may try to rush the communication process. The need to respect disagreement is clear, however, and so does not need to be restated in this way. While the Courts were more permissive regarding the communication requirements, it was felt necessary to respect this disagreement as a matter of professionalism that the core elements of this expectation needed to be retained.
If an event requiring CPR occurs, physicians must provide CPR unless the patient's condition will prevent the intended physiologic goals of CPR (i.e., providing oxygenated blood flow to the heart and brain) from being achieved.	c. If the patient experiences cardiac or respiratory arrest while conflict resolution is underway regarding the writing of a no-CPR order, physicians **must** provide all resuscitative efforts required by the standard of care, which may include CPR.	The proposed revision aligns with the Court's determination that consent to withhold CPR is not required and that CPR only needs to be provided in accordance with the standard of care. The proposed language mirrors that which was proposed by members of the Critical Care specialty in 2015.
In determining whether or not CPR must be provided, physicians must act in good faith. As well, in those instances where CPR must be provided, physicians must act in good faith and use their professional judgment to determine how long to continue providing CPR.	This passage has been deleted.	Provision 15. c. makes reference to the need to provide resuscitative efforts as required by the standard of care. This implicitly addresses the nature and duration of the efforts and so no longer needs to be restated this way. Removing this passage may also help address instances of physicians providing inappropriate care for fear of reprisal from the College.

Planning for and Providing Quality End-of-Life Care

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

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

Definitions

Advance care planning is the process of reflection and communication where people consider what sort of treatment they may want at the end of life. It includes the deliberation and communication of wishes, values and beliefs between the individual, their loved ones, their substitute decision-maker and their health care provider(s) about end-of-life care.[1]

Cardiopulmonary resuscitation (CPR) is a potentially life-saving intervention that is provided with the intention of reversing or interrupting a potentially fatal event (e.g. cardiac or respiratory arrest). CPR is often understood to include chest compressions, artificial ventilation and defibrillation.[2]

Potentially life-saving treatment is treatment that is provided with the intention of reversing or interrupting a potentially fatal event (e.g., cardiopulmonary resuscitation, etc.).[3]

Life-sustaining treatment is any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, etc.).[4]

Palliative care is active total care that improves the quality of life of patients and their families facing life-threatening illnesses or life-limiting chronic conditions, with a focus on relieving pain and other symptoms and addressing psychological, social, and spiritual distress.[5]

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[1] Adapted from Ontario Medical Association, *End of Life Terminology*.
[2] Adapted from Canadian Medical Association, *Statement on Life-Saving and -Sustaining Interventions*.
[3] Adapted from Canadian Medical Association, *Statement on Life-Saving and -Sustaining Interventions*.
[4] Adapted from University Health Network, *Appropriate Use of Life-sustaining Treatment* and Canadian Medial Association, *Statement on Life-Saving and -Sustaining Interventions*.
[5] Adapted from World Health Organization, *Definition of Palliative Care*. http://www.who.int/cancer/palliative/definition/en/

26 **Palliative sedation** refers to the practice of relieving intolerable suffering through the
27 proportional and monitored use of opioids and/or sedative medications to intentionally lower a
28 patient's level of consciousness at the end of life.[6]

29 **Substitute decision-maker (SDM):** A person who may give or refuse consent to a treatment on
30 behalf of an incapable person.[7]

31 Policy

32 ***Quality Care and Communication***

33 1. When helping patients plan for or when providing end-of-life care, physicians **must**
34 endeavour to understand what is important to the patient in order to ensure that the
35 patient's goals of care are understood and that quality care is provided.

36 a. In doing so, physicians are **advised** to provide assistance to patients or substitute
37 decision-makers (SDM) in order to help them articulate the patient's goals of care.

38 2. Physicians **must** communicate effectively and compassionately with patients and/or SDMs,
39 in a manner and tone that is suitable to the decisions they may be facing. This includes
40 initiating communication as early as possible and as regularly as is necessary to share
41 information, helping patients and/or SDMs understand the information shared, and
42 answering questions.

43 3. Where patients and/or SDMs wish to involve family and/or others close to them in the
44 patient's care, physicians **must** obtain consent to disclose personal health information
45 about the patient and document this decision.

46 ***Advance Care Planning***

47 4. As it is never too early for physicians to discuss advance care planning with their patients, as
48 part of routine care physicians are **advised** to:

49 a. discuss the importance and benefits of advance care planning, choosing an SDM,
50 documenting and disseminating advance care plans to their loved ones, SDM, and
51 health-care providers, and reviewing advance care plans throughout life; and
52 b. help patients engage in such planning by providing necessary medical information
53 and opportunity for discussion.

[6] Adapted from Ontario Medical Association, *End of Life Terminology*.
[7] For more information on substitute decision-makers please see the College's Consent to Treatment policy.

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54 5. When significant life events or changes in the patient's medical status occur, physicians are
55 **advised** to:

56 a. encourage patients who have already engaged in advance care planning to review
57 existing advance care plans; or
58 b. where the patient has not already done so, remind patients of the importance of this
59 process, create opportunities for discussion, and encourage them to engage in this
60 process.

61 ***Consent to Treatment***[8]

62 6. Physicians **must** obtain valid consent before a treatment is provided.

63 7. In order for consent to be valid, physicians **must** ensure it is obtained from the patient if the
64 patient is capable with respect to the treatment or from the incapable patient's SDM, and it
65 must be related to the treatment, informed, given voluntarily, and not obtained through
66 misrepresentation or fraud.

67 8. Physicians are entitled to presume the patient is capable unless there are reasonable
68 grounds to believe otherwise (e.g., something in a patient's history or behaviour raises
69 questions about their capacity to consent to the treatment). However, physicians are
70 **advised** to exercise caution regarding this presumption in the end-of-life context and to
71 reassess capacity as appropriate, because in this context the capacity to consent to
72 treatment may be affected by a number of health conditions.

73 ***Palliative Care***

74 9. When proposing or providing palliative care, physicians **must** clearly explain what palliative
75 care entails. This includes being clear that palliative care involves providing active care
76 focused on relieving pain and other symptoms and addressing psychological, social, and
77 spiritual distress related to the patient's condition, which can be provided in conjunction
78 with other treatments intended to prolong life, or when these treatments have been
79 stopped.

80 10. While palliative care does not have to be provided by specialists, physicians are **advised** to
81 seek the support or involvement of specialists in palliative care and/or referral to hospice
82 care[9] where appropriate and available.

[8] See the College's *Consent to Treatment* policy for a more comprehensive treatment of physicians' obligations with respect to obtaining consent.
[9] In Canada, both palliative care and hospice care are generally used to refer to an approach to care focused on holistic care of the patient with a life-threatening or life-limiting illness and their family. However, some may use

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83 ***Potentially Life-Saving and Life-Sustaining Treatments***

84 11. Physicians are **strongly advised** to discuss potentially life-saving and life-sustaining
85 treatment options as early as possible and where appropriate (e.g., a change in the patient's
86 medical status, where no further treatment options are available, or when a patient is
87 admitted to an intensive or critical care unit).

88 12. Physicians **must** involve the patient and/or SDM in the assessment of the treatment options
89 that fall within the standard of care and **must** obtain consent to provide potentially life-
90 saving and life-sustaining treatment, unless certain conditions are met during an
91 emergency[10].

92 13. In instances where the outcomes of potentially life-saving and/or life-sustaining treatments
93 are uncertain and physicians propose these treatments on a trial basis, physicians **must** be
94 clear about the outcomes that would warrant the continuation of treatment and the
95 outcomes that would warrant the discontinuation of treatment.

96 14. Physicians **must not** unilaterally make a decision to withdraw life-sustaining treatment and
97 **must** obtain consent in order to withdraw life-sustaining treatment.[11]

98 a. As part of the consent process physicians **must** explain why they are proposing to
99 withdraw life-sustaining treatment and provide details regarding any treatment(s)
100 they propose to provide (e.g., palliative care).
101 b. When consent is not provided, physicians **must** engage in the conflict resolution
102 process as outlined in this policy, which may include an application to the Consent
103 and Capacity Board.[12]

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hospice care to describe care that is associated with a particular time period (e.g. final few days or weeks of life) or location (e.g. community based) (adapted from the Canadian Hospice Palliative Care Association).

[10] For information on when emergency treatment can be provided without consent, please see the College's Consent to Treatment policy.

[11] The Supreme Court of Canada determined in *Cuthbertson v.Rasouli*, 2013, SCC 53, [2013] 3 S.C.R. 341 (hereinafter *Rasouli*) that consent must be obtained prior to withdrawing life-sustaining treatment.

[12] In *Rasouli,* the Supreme Court of Canada determined that when substitute decision-makers refuse to provide consent for the withdrawal of life-support that in the physician's opinion is not in the best interests of the patient, physicians must apply to the Consent and Capacity Board for a determination of whether the substitute decision-maker has met the substitute decision-making requirements of the *HCCA* and whether the refused consent is valid. See in particular paragraph 119 of *Rasouli.*

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104 15. Physicians **must not** unilaterally make a decision regarding a no-CPR order.

105 a. Before writing a no-CPR order in the patient's record, physicians **must** inform the
106 patient and/or substitute decision-maker that the order will be written and the
107 reasons why.[13]
108 b. If the patient or substitute decision-maker disagrees and insists that CPR be
109 provided, physicians **must** engage in the conflict resolution process as outlined in
110 this policy and **must not** write the no-CPR order while conflict resolution is
111 underway.
112 c. If the patient experiences cardiac or respiratory arrest while conflict resolution is
113 underway regarding the writing of a no-CPR order, physicians **must** provide all
114 resuscitative efforts required by the standard of care, which may include CPR.[14]

115 16. Decisions concerning potentially life-saving and life-sustaining treatment may change over
116 time and as such, physicians **must** review these decisions with patients or SDMs whenever it
117 is appropriate to do so (e.g., when the patient's condition changes).

118 ***Aggressive Pain Management and Palliative Sedation***

119 17. When providing aggressive pain management[15] or palliative sedation in order to address
120 pain and symptoms and not to hasten death, physicians **must** provide treatment in
121 proportion to the pain and/or symptoms the patient is experiencing and closely follow any
122 changes in the patient's pain and/or symptoms to ensure that appropriate treatment is
123 provided.

124 ***Dying at Home***

125 18. When patients express a preference for staying at home as long as possible and/or dying at
126 home, physicians **must**:

127 a. help patients and caregivers assess whether home care and/or dying at home are
128 manageable options, including assessing:

129 - patient safety considerations;
130 - the caregiver's ability to cope with the situation; and

[13] Physicians are advised that patients may not be aware of the limitations of CPR and the potential harms of this intervention and so are advised to clearly explain the reasons and clinical justification for not proposing CPR.
[14] In *Wawrzyniak v. Livingstone*, 2019 ONSC 4900 the Court concluded that the writing of a no-CPR order and withholding of CPR do not fall within the meaning of "treatment" in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. As such, consent is not required prior to withholding CPR and physicians are only obliged to provide CPR in accordance with the standard of care.
[15] For example, significantly high dosages of opioids.

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131 • whether the patient can be provided with necessary care (e.g., whether
132 round the clock on-call coverage is needed and available, whether home
133 palliative care physicians or community based programs are available to
134 assist, etc.);
135 b. ensure that patients and caregivers are educated and prepared for what to expect
136 and what to do when the patient is about to die or has just died; and
137 c. ensure that caregivers are instructed regarding whom to contact when a patient is
138 about to die or has just died.

139 19. If the patient has also expressed a wish not to be resuscitated, physicians are **advised** to
140 order and complete the Ministry of Health and Long-Term Care "Do Not Resuscitate
141 Confirmation Form"[16] and, if completed, **must** ensure that caregivers are instructed on the
142 importance of keeping the form accessible and the necessity of showing it to emergency
143 services personnel if they are called.[17]

144 ***Certification of Death***

145 20. A physician[18] who has been in attendance during the last illness of a deceased person, or
146 who has sufficient knowledge of the last illness **must** complete and sign a medical certificate
147 of death immediately following death,[19, 20] unless there is reason to notify the coroner.[21]

148 a. Physicians **must not** rely on the coroner to certify the death when their involvement
149 is not required.

150 21. Physicians are **advised** to plan in advance by designating the physician(s) or nurse
151 practitioner(s) who will be available to attend to the deceased in order to complete and sign

[16] For more information about the "Do Not Resuscitate Confirmation Form", please visit:
http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45
These forms can be ordered by completing and submitting the Ministry of Health and Long-Term Care's "Forms Order Request". For more information please visit:
http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-0350-93~2/$File/0350-93.pdf
[17] Unless this form is completed and presented, emergency services are likely to use resuscitative measures and transfer the patient to hospital.
[18] In limited circumstances a Nurse Practitioner may complete and sign the medical certificate of death instead of a physician.
[19] Section 35(2) of the R.R.O. 1990, Reg. 1094, General, enacted under the *Vital Statistics Act*, 1990; R.S.O. 1990, c. V.4. The certificate must state the cause of death according to the International Statistical Classification of Diseases and Related Health Problems, as published by the World Health Organization, and be delivered to the funeral director.
[20] Medical certificates of death can be obtained by contacting the Office of the Registrar General: 1-800-461-2156.
[21] Section 10 of the *Coroners Act*, R.S.O. 1990, c. C.37 requires physicians to immediately notify a coroner or police officer if there is reason to believe that an individual has died: as a result of violence, misadventure, negligence, misconduct or malpractice; by unfair means; during pregnancy or following pregnancy in circumstances that might be reasonably attributed to the pregnancy; suddenly and unexpectedly; from disease or sickness for which he or she was not treated by a legally qualified medical practitioner; from any cause other than disease; or under circumstances that may require investigation.

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152 the death certificate and to take into consideration any local or community strategies that
153 are in place to facilitate the certification of death.[22]

154 ***Wishes and Requests to Hasten Death***

155 22. Physicians **must** respond to a patient's wish or request to hasten death in a sensitive
156 manner and be prepared to engage patients in a discussion to seek to understand the
157 motivation for their expression and to resolve any underlying issues that can be treated or
158 otherwise addressed (e.g., adjusting pain management strategies, referral for psychological
159 counselling, getting other professionals (e.g., chaplain, social worker, grief counsellor, etc.)
160 involved in the patient's care, etc.).

161 23. With respect to medical assistance in dying, physicians **must** comply with the expectations
162 set out in the College's *Medical Assistance in Dying* policy.

163 24. Patients have a right of access to their personal health information and physicians **must**
164 release patient medical records or personal health information to the patient if they choose
165 to explore medical assistance in dying, unless it is determined that an exception to this right
166 is applicable.[23]

167 ***Managing Conflicts***

168 25. In order to minimize and/or resolve conflict that can arise regarding treatment decisions,
169 physicians **must**:

170 a. communicate clearly, patiently, and in a timely manner information regarding the
171 patient's diagnosis and/or prognosis, treatment options and assessments of those
172 options, and the availability of supportive services (e.g., social work, spiritual care,
173 etc.) and palliative care resources;
174 b. identify misinformation and/or misunderstandings that might be causing the conflict
175 and take reasonable steps to ensure that these are corrected and that questions are
176 answered;
177 c. offer referral to another professional with expertise in the relevant area and
178 facilitate obtaining a second opinion, as appropriate;
179 d. offer consultation with an ethicist or ethics committee, as appropriate and available;
180 e. where appropriate, seek legal advice regarding mediation, adjudication or
181 arbitration processes that are available; and

[22] For example, many communities in Ontario have an expected death in the home (EDITH) protocol in place that can be accessed through the local Community Care Access Centre (CCAC) or Local Health Integration Network (LHIN). In general, it is good practice for physicians providing palliative care at home to connect with local CCAC and LHIN palliative care resources.

[23] Sections 1(b) and 52 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Schedule A.

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182 f. take reasonable steps to transfer the care of the patient to another facility or health
183 care provider as a last resort and only when all appropriate and available methods of
184 resolving conflict have been exhausted. [24]

185 26. Physicians are **advised** to apply to the Consent and Capacity Board[25] when:

186 a. conflicts arise between a physician and SDM over an interpretation of a wish or
187 assessment of the applicability of a wish to a treatment decision, or
188 b. a physician is of the view that the SDM is not acting in accordance with their
189 legislative requirements.

190 27. Physicians who limit their practice[26] on the basis of moral and/or religious grounds **must**
191 comply with the College's *Professional Obligations and Human Rights* policy.

192 ***Documentation***

193 28. In accordance with the College's *Medical Records* policy, physicians **must** document every
194 patient and/or SDM encounter and all patient related information. In addition to these
195 general expectations, in the end-of-life care this means physicians **must**:

196 a. document references to discussions and decisions regarding treatment, goals of
197 care, and advance care planning; and
198 b. explicitly and clearly reference when a no-CPR order is in effect.

199 ***Organ and Tissue Donation***

200 The *Trillium Gift of Life Network Act*[27] sets out requirements relating to organ and tissue
201 transplantation measures for health facilities designated by the Minister of Health and Long-
202 Term Care. In particular, designated facilities have specific reporting obligations to the Trillium
203 Gift of Life Network (TGLN) to ensure the patient's family is able to be approached and affirm
204 the patient's donation decision or make a decision about organ and tissue donation on the
205 patient's behalf.

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[24] In following such a course, the physicians must comply with the College's Ending the Physician-Patient Relationship policy.
[25] Physicians are advised that while consent is not required to withhold CPR, the Consent and Capacity Board has heard and ruled on conflicts pertaining to no-CPR or do not resuscitate orders and so may be a resource in instances where there is disagreement. See for example: Sibbald, R.W. & Chidwick, P. (2010). Best interests at end of life: a review of decisions made by the Consent and Capacity Board of Ontario. *Journal of Critical Care*, 25(1) 171.el-171.e7.
[26] This may include, but is not limited to, refusals to provide care, withdraw care, and/or discuss care options.
[27] *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20 (hereinafter *TGLNA*).

206 29. Physicians working in designated facilities **must** comply with any policies and procedures
207 established in accordance with the *Trillium Gift of Life Network Act*.

208 30. Physicians not working in designated facilities are **advised** to:

209 a. provide their patients with the opportunity to make choices with respect to organ
210 and tissue donation, ideally in the context of an ongoing relationship with the
211 patient and before any medical crisis arises;
212 b. contact TGLN for more information and/or for materials or resources; and
213 c. direct patients to TGLN for more information.[28]

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[28] For more information please visit the Trillium Gift of Life website (http://www.giftoflife.on.ca/). For general inquiries call toll free 1-800-263-2833 or for Referrals and Notifications call toll free 1-877-363-8456.

Advice to the Profession: Planning for and Providing Quality End-of-Life Care

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

Patients are entitled to receive quality end-of-life care that allows them to live as well as possible until they die and physicians have an important role to play in both planning for, as well as providing end-of-life care.

The College's *Planning for and Providing Quality End-of-Life Care* policy sets out expectations for physicians in these contexts. This advice document is intended to help physicians interpret and understand these expectations and provides guidance on how these obligations can be effectively discharged.

What is quality end-of-life care?

Quality end-of-life care generally aims to reduce suffering, while respecting the wishes, values, and beliefs of patients, and minimizing any conflict or distress that might arise. It also means providing care that manages not just the physical, but also the psychological, social, and spiritual needs of patients, while being sensitive to their personal, cultural, and religious values and beliefs.

But there are a number of both medical and non-medical factors that go into assessments of quality end-of-life care. Research and clinical experience show that what is important to patients and their families may often include:

- managing pain and other distressing symptoms, including psychological issues;
- avoiding the unnecessary prolongation of dying;
- strengthening relationships with loved ones and continuing active social interactions;
- attaining feelings of peace or closure, retaining a sense of control and meaning, and satisfying spiritual needs;
- having trust and confidence in physicians who are readily available and take a personal interest in the patient's care;
- preserving dignity, being treated with respect and compassion and in a manner that affirms the whole person;
- supporting decision-making through clear, honest, consistent, and timely communication and feeling listened to; and
- receiving support through the grief and bereavement process.

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34 When planning for and providing end-of-life care, physicians have an important role to play in
35 helping patients or their substitute decision-maker identify meaningful and realistic goals of
36 care that are compassionate, respectful, and that seek to incorporate patient wishes, values,
37 and beliefs. This may take a bit of time and patients or their caregivers may need some
38 assistance articulating these goals.

39 ***What role does communication play in providing quality end-of-life care?***

40 Good communication is a fundamental component of a good physician-patient relationship and
41 is even more important when providing end-of-life care.

42 End-of-life care situations can be highly stressful and difficult for those involved. Frequent and
43 effective communication can help manage these highly emotional situations by building trust
44 and confidence in the physician-patient relationship and it can help to relieve patient or
45 substitute decision-maker anxiety and doubt in what is an otherwise challenging time. For these
46 reasons, the policy sets out expectations for physicians with respect to communication.

47 ***What role can family members or others close to the patient play in end-of-life care?***

48 Involving family and/or others close to the patient in the ongoing care of a patient may be
49 beneficial. For example, it can help patients understand their diagnoses, prognoses,
50 medications, the tests that are required, and the decisions they have to make about treatment
51 options. It can also help family caregivers to provide more effective care and support at home
52 and mitigate their own distress.

53 ***What are the benefits of advance care planning? What resources can I use or direct my***
54 ***patients to?***

55 Advance care planning can lead to improved outcomes and quality of life, help to ensure that
56 the care provided aligns with the patient's wishes, values, and beliefs, and may even help
57 encourage realistic treatment goals. While advance care planning does not constitute consent,
58 it can be helpful in terms of informing treatment discussions and decisions.

59 The policy encourages physicians to take an active role in supporting their patients in advance
60 care planning. This could include: asking general questions about their patient's wishes, values,
61 and beliefs; discussing specific issues such as preferences for the location of their death or
62 attitudes towards certain interventions (e.g., resuscitation, mechanical ventilation, etc.); and, as
63 appropriate, their wishes with respect to organ and tissue donation. These conversations may
64 be difficult to initiate and patients may need multiple opportunities to discuss in order to
65 engage effectively.

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66 Speak Up (www.advancecareplanning.ca) has information intended for both physicians and
67 patients and includes a workbook tailored to Ontario patients
68 (http://www.makingmywishesknown.ca/get-started/).

69 ***What are rules for substitute decision-makers when it comes to giving or refusing consent?***

70 The *Health Care Consent Act, 1996* requires that substitute decision-makers give or refuse
71 consent in accordance with the most recent and known wish expressed by the patient, while
72 the patient was capable and was at least 16 years of age. If no wish is known or the wish is
73 impossible to comply with or not applicable to the circumstances, the substitute decision-
74 maker must make decisions in the incapable patient's best interests.

75 Wishes can be general or specific in nature and can be expressed in writing (including advance
76 care planning document or an "advance directive"), orally or in any other manner. Later wishes
77 expressed while capable, whether written, oral or in any other manner, prevail over earlier
78 wishes. This is the case even if, for example, the earlier wishes are expressed in an advance
79 care planning document.

80 ***Who can provide palliative care other than specialists in palliative care?***

81 Palliative care focuses on relieving pain and other symptoms, as well as addressing
82 psychological, social, and spiritual distress and can be provided at any stage of a patient's life-
83 threatening illness or life-limiting chronic condition. Many physicians, including most family
84 physicians, may have the knowledge, skill, and judgment necessary to provide basic palliative
85 care that aims to alleviate pain and keep patients comfortable.

86 ***How can physicians support good decision-making regarding potentially life-saving and life-***
87 ***sustaining treatments? How can a trial of treatment be beneficial?***

88 Decisions regarding potentially life-saving and life-sustaining treatment can be particularly
89 challenging, both for physicians and for patients or their substitute decision-maker. It is
90 beneficial for these discussions to happen before events requiring a decision occur and so the
91 policy strongly advises physicians to engage in these discussions as early as possible. It's also
92 beneficial for these discussions to be informed by advance care planning, reinforcing the points
93 raised above.

94 There are also times where the outcomes of a potentially life-saving or life-sustaining treatment
95 are uncertain. In these instances, proposing a trial of treatment allows for the exploration of a
96 possibly positive outcome while building consensus about the circumstances where the care
97 should then be withheld or withdrawn.

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98 ***What are the legal requirements regarding no-CPR orders?***

99 The *Rasouli* decision provided clarity regarding the consent requirements for withdrawing life-
100 sustaining treatments. It did not, however, address whether the same requirements apply in
101 the context of withholding CPR or writing a no-CPR order. In August 2019, the Ontario Superior
102 Court released a significant decision specifically assessing whether the analysis and conclusions
103 drawn in *Rasouli* apply in the context of withholding CPR and writing a no-CPR order. The
104 decision was clear that the requirements are not the same – consent is not required prior to
105 writing a no-CPR order and physicians are only obliged to provide CPR when doing so is within
106 the standard of care.

107 The College has set our expectations in accordance with this decision and that emphasis the
108 importance of good communication and conflict resolution when there is disagreement.

109 ***Does the College require that consent be obtained before writing a no-CPR order?***

110 No, the College does not require that consent be obtained prior to writing a no-CPR order.
111 Rather, the policy emphasizes the importance of good and early communication that aims to
112 avoid last minute decisions and intractable disagreements. The policy also does not require that
113 physicians propose a no-CPR order be written. Instead, it requires that physicians *inform* the
114 patient and/or substitute decision-maker that the order be written and the reasons why prior
115 to writing it. Physicians can be fairly straightforward and directive in doing so, while recognizing
116 that this may be particularly difficult news for the patient and/or their family to hear. Only if
117 the patient or substitute decision-maker disagrees upon learning that the order will be written
118 must physicians engage in a conflict resolution process to try and find consensus.

119 ***What happens if there is disagreement about writing the no-CPR order?***

120 If once learning that a no-CPR order will be written, the patient and/or substitute decision-
121 maker disagrees and insists that CPR be provided, the policy requires physicians to engage in
122 conflict resolution as outlined in the policy. During this time, physicians must not write a no-
123 CPR order. However, if the patient's condition deteriorates and they experience a cardiac or
124 respiratory event while conflict resolution is underway, physicians are permitted to make a
125 bedside determination about which resuscitative efforts, including CPR, to provide and are only
126 required to provide those that are within the standard of care.

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

128 The Consent and Capacity Board (CCB) is an expert tribunal, comprised of lawyers, psychiatrists,
129 and members of the public and is supported by full-time legal counsel. The CCB has the ability
130 to convene hearings quickly and has the authority to direct substitute decision-makers to make

131 decision in accordance with a patient's prior capable wishes or best interests. The Supreme
132 Court of Canada has affirmed that the CCB is the appropriate authority to adjudicate
133 disagreements between physicians and substitute decision-makers regarding the withdrawal of
134 life-sustaining treatments. While consent is not required prior to writing a no-CPR order, the
135 CCB has also heard and decided on cases regarding the withholding of CPR in the past and so
136 may be a resource in instances of disagreement.

137 The CCB can also provide assistance when wishes are not clear, when it is unclear if a wish
138 applies, or when it is unclear if a wish was expressed while the patient was capable or at least
139 16 years of age. The CCB can also grant permission to depart from wishes in very limited
140 circumstances.

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

144 ***Am I required to certify the death of a patient when it would be difficult for me to do so (e.g.,***
145 ***distance, length of time away from practice, outside of practice hours, etc.)?***

146 By law, the medical certificate of death must be completed by a physician who has been in
147 attendance during the last illness of a deceased person, or who has sufficient knowledge of the
148 last illness. In limited circumstances, nurse practitioners are also able to complete and sign a
149 medical certificate of death. When death is expected, the policy recommends planning in
150 advance who will be available to attend to the deceased in order to complete and sign the
151 medical certificate of death. The policy also advises physicians to take into consideration any
152 local or community strategies that are in place to facilitate the certification of death. Where
153 possible, planning in advance may help to overcome any practical challenges associated with
154 completing and signing the medical certificate of death.

155 ***How should I respond to a request to hasten death?***

156 A patient's wish or request to hasten death may be a genuine expression of a desire to hasten
157 their death, but it may also be motivated by an underlying and treatable condition such as
158 depression, psychological suffering, unbearable pain or other unmet care needs. Patients may
159 also be attempting to exert control over their lives, expressing acceptance of an imminent
160 death, or seeking information about any options that may exist. For these reasons, the policy
161 requires physicians to respond to these requests in a sensitive manner and to be prepared to
162 engage patients in a discussion to seek to understand their motivation. In some cases, this
163 discussion might reveal ways in which their care can be adjusted to help alleviate the
164 underlying issues. Patients may also be seeking information about medical assistance in dying

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165 and physicians should consult the College's *Medical Assistance in Dying* policy for more
166 information.

167 ***Where can I find or direct patients to for more information about organ and tissue donation?***

168 Physicians and patients can visit the Trillium Gift of Life Network's website
169 (http://www.giftoflife.on.ca/) for more information on organ and tissue donation in Ontario.
170 The website also includes a link where patients can register to become a donor.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: Effective Referral – Policy Changes

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The Council approves:

(a) The revised policy "Medical Assistance in Dying" (a copy of which forms Appendix " " to the minutes of this meeting); and

(b) The revised policy "Professional Obligations and Human Rights", (a copy of which forms Appendix " " to the minutes of this meeting)

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2019

TOPIC: *Effective Referral* – Policy Changes

FOR DECISION

ISSUE:

- Both the *Professional Obligations and Human Rights* and *Medical Assistance in Dying* policies have been the subject of significant debate due to the inclusion of the "effective referral" requirement.

- As part of the policy redesign process and following recent discussions with the Christian Medical and Dental Society, an analysis of the language used to describe the College's expectation was conducted in order to explore whether changes could be made to clarify, but not change, the College's expectation.

- Council is provided with an overview of the most recent policy review processes, as well as the analysis that has been conducted, and is presented with proposed revisions for consideration. Council is asked whether the redesigned policies incorporating the proposed changes can be approved as policies of the College.

BACKGROUND:

- When the *Professional Obligations and Human Rights* policy was last reviewed, Council deliberately sought to balance the rights of physicians who choose to limit the services they provide for reasons of conscience or religion with patients' right to access care.

    - To achieve this balance, an expectation was adopted requiring physicians who have a conscientious objection to make an "effective referral" to another non-objecting, available, and accessible physician, health-care professional, or agency.

    - Consideration was given to options that would have involved patients making this connection themselves (i.e., self-referral) or physicians initiating a full transfer of care. Both options were rejected as they were viewed as being either insufficient to ensure access or as patient abandonment and an expression of personal moral judgment about the patient's lifestyle and beliefs.

- Council then developed the *Medical Assistance in Dying* policy, explicitly applying the "effective referral" requirement in this context after significant consideration to whether the nature of medical assistance in dying (MAID) warranted a different approach.

- Both policies were developed under the oversight of Policy Working Groups and were informed by extensive research, analysis, consultation[1], and debate.

    - Notably, key stakeholder organizations and advocates have called the "effective referral" requirement the "gold standard" in terms of ensuring access to care, and public opinion polling indicated that there was *very strong* support for the requirement among the general public.[2]

    - In contrast, some members of the public and profession oppose this requirement, feeling that it forces physicians to be complicit in the provision of the service.

- The Christian Medical and Dental Society (CMDS) engaged the College in litigation, challenging the effective referral requirement with many intervenors acting both in support of and against the policy position. The College's position was upheld by the Ontario Superior Court and subsequently by the Ontario Court of Appeal. CMDS did not sought leave to appeal the case to the Supreme Court of Canada.

CURRENT STATUS:

A. CMDS Engagement

- CMDS coordinated with the Ministry of Health to facilitate mediated discussions with Senior Leadership at the College in order to express their concerns. Key issues identified include:

    - The term "effective referral" is confusing, as the term "referral" has a pre-existing clinical meaning that is different from what these policies require.

    - The rights of physicians to hold a conscientious objection and the value a diversity of perspectives brings to medicine has not been appropriately acknowledged and/or respected by the College.

    - "Effective" gives the impression that the referral must result in the service actually being provided.

[1] Nearly 20,000 pieces of feedback were received as part of the consultations undertaken for both policies.
[2] In 2016, 73% of Ontarians preferred a direct referral when presented alongside other options including a self-referral. Support increased to 82% when scenarios involving vulnerable populations were provided.

B. Analysis of "Effective Referral"

- An analysis of the term "effective referral" and the language used to articulate the requirement was undertaken in order to assess whether this language is at least partly responsible for causing confusion regarding the expectation.

Making an Effective Referral

- While the term originated in the *Professional Obligations and Human Rights* policy, its application in the *Medical Assistance in Dying* policy and companion *Frequently Asked Questions* and *Effective Referral Fact Sheet* reveal key aspects of the requirement.
    - Effective referrals do not need to made *directly* to another provider. The position was purposefully expanded to allow for a referral to be made to an agency charged with facilitating referrals for the healthcare services.
    - There is no requirement for effective referrals to made in writing; a warm hand-off to a colleague or contacting the Ontario Care Coordination Service for MAID is sufficient.
    - The companion resources repeatedly characterize an effective referral as "taking positive steps to ensure the patient is *connected* with another provider or agency".
    - An effective referral does not require the physician to assess the patient for eligibility or suitability for the service for which they are being referred.

Making a Referral

- The term "referral" is a long-established clinical term with a well understood meaning.
    - Referrals are typically made *directly* to a provider[3], not to an agency;
    - Referrals are made in writing and routinely involve significant information sharing;
    - Referrals are typically made following an assessment done by the referring physician where an issue is identified that requires specialized assistance in assessment or management; and
    - Specialists are also expected to keep the referring provider up-to-date about the care being provided to facilitate their involvement and support continuity of care.

Differences in Meaning

- On the basis of the analysis above, there are important differences between an "effective referral" and a "referral" in the clinical sense, despite sharing a common core term.

[3] Or at minimum a clinic or institution that triages based on physician availability.

C. Policy Redesign

- Both policies have been redesigned in accordance with the policy redesign process and the implementation plan that was put in place for each batch of policies (see **Appendix A** and **C**). For more information about this process, see the *Policy Redesign Implementation – Batch 2* briefing note included in the September 2019 Council materials.

    - Companion *Advice to the Profession* documents have also been created for each policy in order to capture relevant content from the policies and to repurpose existing content currently found in the respective *Frequently Asked Questions* documents (see **Appendix B and D**).

- As part of the redesign process some steps were taken to help clarify the College's expectation and what is meant by "effective referral".

    - Improvements in clarity have been achieved as a result of the redesign process, which may help bring clarity to the effective referral requirement.

    - A definition of effective referral has been moved to the beginning of each policy and now includes a footnote explicitly noting that an effective referral need not be a referral in the clinical sense and that it does not require the physician to assess the patient to determine if they are a suitable candidate for the treatment to which they object. These key points are then repeated in the companion *Advice* documents.

    - The content, including additional explanation and examples, currently found in the *Effective Referral Fact Sheet* has been moved into each respective *Advice* document, minimizing the number of resources physicians need to access in order to understand the expectation. The *Advice* document is then referenced in the body of each policy alongside the definition of effective referral, pointing readers to the additional information found in this document.

    - The policies also include enhanced preambles in the sections on conscientious objection, recognizing the rights of physicians and stating the College's commitment to striking a balance of rights.

D. Proposed Changes

- Supplementing the steps that have been taken as part of the redesign process, additional revisions are being proposed that aim to help further clarify the concept of "effective referral" and the College's expectations in this regard.

- More specifically, revisions are proposed to remove mention of “referral” as a standalone concept from the definition of “effective referral” and to import the concept of a “connection”, as already articulated in the *Effective Referral Fact Sheet*, into the policy.
    - Currently the policies define an “effective referral” as a “*referral*” made to a non-objecting, available, and accessible physician, health-care provider or agency.
    - In contrast, the *Effective Referral Fact Sheet* defines an “effective referral” as “taking positive action to ensure the patient is *connected*” to a non-objecting, available, and accessible physician, healthcare provider, or agency.
- The proposed change simply incorporates the definition from the *Effective Referral Fact Sheet* directly into the policy in a manner that preserves the College’s expectation and retains the term “effective referral”, which has become part of the vernacular in this space, while further minimizing the potential for confusion.
- The proposed change to the definition of “effective referral” has been incorporated into the redesigned policies (see for example Lines 15-17 in **Appendix A**) and corresponding *Advice* documents, along with any additional minor wordsmithing that was necessary throughout each document to reflect this change.

NEXT STEPS:

- Should Council approve the redesigned and updated policies they will replace the existing policies on the College’s website.
- Notification of the redesigned policy will be published in *Dialogue* and announced through the College’s social media properties and will emphasize that the expectations have not changed, but that additional clarification regarding the “effective referral” requirement has been achieved.

DECISION FOR COUNCIL:

1. Does Council approve the redesigned and updated *Medical Assistance in Dying* and *Professional Obligations and Human Rights* draft policies as policies of the College?

Contact: Craig Roxborough, ext. 339
Date: August 30, 2019

Attachments:
Appendix A: *Medical Assistance in Dying* – Redesigned Policy
Appendix B: *Advice to the Profession: Medical Assistance in Dying*
Appendix C: *Professional Obligations and Human Rights* – Redesigned Policy
Appendix D: *Advice to the Profession: Professional Obligations and Human Rights*

1 # Medical Assistance in Dying

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

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

9 ## Definitions

10 **Capacity**: A person is capable with respect to a treatment if they are able to understand the
11 information that is relevant to making a decision or lack of decision and able to appreciate the
12 reasonably foreseeable consequences of a decision or lack of decision.[1] Capacity to consent to a
13 treatment can change over time, and varies according to the individual patient and the
14 complexity of the specific treatment decision.

15 **Effective Referral:** taking positive action to ensure the patient is connected[2] to a non-objecting,
16 available, and accessible[3] physician, other health-care professional, or agency. [4] For more
17 information about an effective referral, see the companion *Advice to Profession* document.

18 **Medical Assistance in Dying**: In accordance with *federal* legislation, medical assistance in dying
19 includes circumstances where a medical practitioner or nurse practitioner, at an individual's
20 request: (a) administers a substance that causes an individual's death; or (b) prescribes a
21 substance for an individual to self-administer to cause their own death.

22 **Medical Practitioner:** A physician who is entitled to practise medicine in Ontario, including
23 postgraduate medical trainees.

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[1] Section 4(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. (hereinafter *HCCA*).
[2] An effective referral does not necessarily, but may in certain circumstances, involve a 'referral' in the formal clinical sense, nor does it necessarily require that the physician conduct an assessment of the patient to determine whether they are a suitable candidate for the treatment to which they object (in the context of medical assistance in dying, this means that the physician is not required to assess whether the patient is eligible for medical assistance in dying prior to making the effective referral).
[3] 'Available and accessible' means that the health-care provider must be in a location the patient can access, and operating and/or accepting patients at the time the effective referral is made.
[4] In the hospital setting, practices may vary in accordance with hospital policies and procedures.

24 **Nurse Practitioner:** A registered nurse who, under the laws of Ontario, is entitled to practise as
25 a nurse practitioner and autonomously make diagnoses, order and interpret diagnostic tests,
26 prescribe substances, and treat patients.

27 Policy

28 Federal legislation establishes the legal framework for medical assistance in dying (MAID) in
29 Canada, including eligibility criteria and safeguards that must be satisfied prior to providing
30 MAID.[5,6]

31 1. Physicians **must** manage all requests for medical assistance in dying (MAID) in accordance
32 with the expectations set out in this policy.[7]

33 Criteria for Medical Assistance in Dying

34 The federal legislation sets out the criteria that must be met in order for an individual to be
35 eligible to access MAID.

36 2. Before providing MAID, physicians **must** be satisfied that the patient meets all of the
37 eligibility criteria set out in federal legislation, which requires that the patient:
38 a. be eligible for publicly funded health-services,
39 b. be capable and at least 18 years of age,
40 c. have a grievous and irremediable medical condition,
41 d. make a request for MAID voluntarily and not as a result of external pressure, and
42 e. provide informed consent to receive MAID after having been informed of the means
43 available to relieve their suffering, including palliative care.
44
45 3. In order to assess the patient against the federal eligibility criteria, physicians **must** use their
46 professional judgement.
47
48 Additional information and expectations relating to each criterion are set out below.

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[5] The framework was enabled through amendments to the *Criminal Code*, R.S.C., 1985, c. C-46.
[6] For more information and resources on medical assistance in dying, see the Ontario Ministry of Health's website: https://www.ontario.ca/page/medical-assistance-dying-and-end-life-decisions
[7] This policy will refer to nurse practitioners and pharmacists, where relevant, in order to reflect the language of the federal law. The policy does not set professional expectations and accountabilities for members of the College of Nurses of Ontario or members of the Ontario College of Pharmacists. For information on the professional accountabilities of nurse practitioners and other members of the College of Nurses of Ontario, please see the College of Nurses of Ontario document titled: Guidance on Nurses' Roles in Medical Assistance in Dying. For information on the professional accountabilities for members of the Ontario College of Pharmacists, please see the Ontario College of Pharmacists document titled: Medical Assistance in Dying: Guidance to Pharmacists and Pharmacy Technicians.

49 ***The individual must be eligible for publicly funded health services***
50
51 4. As the activities involved in assessing patients for and providing MAID are insured services,[8]
52 physicians **must not** charge patients directly for MAID or associated activities. Physicians are
53 **advised** to refer to the OHIP Schedule of Benefits for further information.

54 ***The individual must be capable and at least 18 years of age***[9]

55 5. Physicians **must** ensure the patient is able to understand and appreciate the history and
56 prognosis of their medical condition, treatment options, the risks and benefits of their
57 treatment options, and the certainty of death upon self-administering or having a physician
58 administer the fatal dose of medication.
59 a. As capacity is fluid and may change over time, physicians **must** be alert to potential
60 changes in a patient's capacity.
61 b. Physicians are **advised** to rely on existing practices and procedures for capacity
62 assessments.

63 ***The individual's medical condition must be grievous and irremediable***

64 According to the federal legislation, a person has a grievous and irremediable medical condition
65 only if:

66 - they have a serious or incurable illness, disease, or disability;
67 - they are in an advance state of irreversible decline in capability;
68 - their illness, disease, disability, or state of decline causes them enduring physical or
69 psychological suffering that is intolerable to them and that cannot be relieved under
70 conditions they consider acceptable; and
71 - their natural death has become reasonably foreseeable, taking into account all of
72 the medical circumstances (a prognosis need not have been made as to the specific
73 length of time that they have to live).
74
75 6. As the definition of grievous and irremediable does not follow terminology typically used in
76 a clinical context, physicians **must** use their professional judgment when assessing a patient
77 for a grievous and irremediable medical condition.[10]

[8] For example, counselling and prescribing.
[9] This is notably different than Ontario's *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A, which does not specify an 'age of consent'.
[10] Further details on interpreting the statutory definition of a grievous and irremediable medical condition can be found in companion resources authored by the federal government: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

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78 a. Physicians are **advised** to obtain independent legal advice if they are uncertain
79 about whether a patient meets this eligibility criterion.

80 ***The individual's request must be voluntary and not as a result of external pressure***

81 7. Physicians **must** be satisfied that the patient's decision has been made freely, without
82 undue influence from family members, healthcare providers, or others, and that they have
83 made the request themselves, thoughtfully, and in a free and informed manner.

84 ***The individual must provide informed consent***

85 8. As MAID can only be provided to a capable adult, physicians **must** obtain informed
86 consent[11] directly from the patient, not the substitute decision-maker of an incapable
87 patient.
88
89 9. As part of obtaining informed consent, physicians **must:**
90 a. Discuss all treatment options with the patient, including the associated risks and side
91 effects, which includes informing the patient of means that are available to relieve
92 their suffering, including palliative care.[12]
93 b. Inform patients who are indicating a preference for self-administered MAID:
94 i. of the potential complications associated with this option, including the
95 possibility that death may not be achieved; and
96 ii. that should their death be prolonged or not achieved, it will not be possible
97 for the physician to intervene and administer a substance causing their death
98 unless the patient is capable and can provide consent immediately prior to
99 administering.
100
101 10. Physicians are also **advised** to encourage patients who choose to self-administer MAID to
102 include the physician or nurse practitioner who prescribed the medication among those
103 present when the medication is self-administered.

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[11] The process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to MAID. More information on consent requirements can be found in the College's *Consent to Treatment* policy, which outlines the legal requirements of valid consent as set out in the *Health Care Consent Act, 1996*. In particular, in order for consent to be valid it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.
[12] The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

104 # Conscientious Objection

105 The College recognizes that physicians have the right to limit the health services they provide
106 for reasons of conscience or religion. For clarity, the College does not require physicians who
107 have a conscientious or religious objection to MAID to provide MAID under any
108 circumstances.[13]

109 However, physicians' freedom of conscience and religion must be balanced against the right of
110 existing and potential patients to access care. The Supreme Court of Canada noted, in the
111 *Carter*[14] case, that the rights of physicians and patients would have to be reconciled in any
112 regime governing MAID. The Court of Appeal for Ontario has confirmed that where an
113 irreconcilable conflict arises between a physician's interest and a patient's interest, physicians'
114 professional obligations and fiduciary duty require that the interest of the patient prevails.[15]

115 While the federal legislation does not address the conscientious objections of health care
116 providers, the College has outlined expectations, set out below, for physicians who have a
117 conscientious or religious objection to MAID. These expectations accommodate the rights of
118 objecting physicians to the greatest extent possible, while ensuring that patients' access to
119 healthcare is not impeded.

120 11. Consistent with the expectations set out in the College's *Professional Obligations and*
121 *Human Rights* policy, physicians who decline to provide MAID due to a conscientious
122 objection:
123 a. **must** do so in a manner that respects patient dignity and **must not** impede access to
124 MAID.
125 b. **must** communicate their objection to the patient directly and with sensitivity,
126 informing the patient that the objection is due to personal and not clinical reasons.
127 c. **must not** express personal moral judgments about the beliefs, lifestyle, identity or
128 characteristics of the patient.
129 d. **must** provide the patient with information about all options for care that may be
130 available or appropriate to meet their clinical needs, concerns, and/or wishes and
131 **must not** withhold information about the existence of any procedure or treatment
132 because it conflicts with their conscience or religious beliefs.

[13] The College also does not consider a request for medical assistance in dying to be an emergency.
[14] *Carter v. Canada (Attorney General)*, 2015 SCC 5
[15] See para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019 ONCA 393*

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133 e. **must not** abandon the patient and **must** provide the patient with an effective
134 referral.[16,17]
135 i. Physicians **must** make the effective referral in a timely manner and **must not**
136 expose patients to adverse clinical outcomes due to a delay in making the
137 effective referral.

138 ## Involvement of Postgraduate Medical Trainees

139 12. Postgraduate medical trainees can participate in the MAID process, but **must** do so within
140 the terms, conditions, and limitations of their certificate of registration.[18]
141
142 13. Postgraduate medical trainees and other physician assessor involved in assessing a patient's
143 eligibility for MAID **must** pay particular attention to ensuring that there is independence
144 between the assessors. Specifically, the requirement for independence between the two
145 assessors of a patient's eligibility for MAID is not satisfied if one assessor is a mentor or
146 supervisor to the other.

147 **Reporting Obligations**

148 Depending on the circumstances, physicians who provide MAID or receive a written request for
149 MAID have reporting obligations to both the Office of the Chief Coroner for Ontario (OCC) and
150 Health Canada.

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[16] See the definition of effective referral provided in this policy and the companion *Advice to the Profession* document for more information and examples of what constitutes an 'effective referral'.

[17] The Ministry of Health and Long-Term Care has established the Care Coordination Service (CCS) to allow clinicians, patients, and caregivers to access information about medical assistance in dying and end-of-life care options, and to connect patients with clinicians who provide medical assistance in dying. Clinicians seeking assistance in making an effective referral can call the CCS toll-free: 1-866-286-4023. If physicians have general questions about the CCS, or wish to register for the CCS as a willing provider, please contact the Ministry of Health and Long-Term Care at maidregistration@sasc.ca. The College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

[18] Under section 11(8) of Ontario Regulation 865/93, made under the Medicine Act, 1991 (the "Registration Regulation"), the following are terms, conditions and limitations of a certificate of registration authorizing postgraduate education:

1. The holder shall,
   i. Practise medicine only as required by the program in which the holder is enrolled,
   ii. Prescribe drugs only for in-patients or out-patients of a clinical teaching unit that is formally affiliated with the department where he or she is properly practising medicine and to which postgraduate trainees are regularly assigned by the department as part of its program of postgraduate medical education, and
   iii. Not charge a fee for medical services.

151 14. Physicians who provide MAID **must** report medically assisted deaths to the OCC.[19, 20]
152 a. Physicians **must** provide the OCC with any information about the facts and
153 circumstances related to the medically assisted death that the OCC considers
154 necessary to form an opinion as to whether the death ought to be investigated.
155 Typically, providing the patient's medical record pertaining to the medically assisted
156 death will suffice.
157
158 15. When a written request for MAID is received from the patient (in any form, including email
159 or text message, although not necessary the written request required by the safeguard in
160 the *Criminal Code*[21]) and a medically assisted death *does not* occur, physicians **must** make a
161 report to Health Canada[22] in the following situations:
162 a. The patient was found ineligible for MAID;
163 b. The patient was referred to another practitioner or care coordination service;
164 c. The patient died from another cause;
165 d. The patient withdrew their request for MAID; or
166 e. The physician prescribed a substance for MAID that to their knowledge did not
167 result in a medically assisted death within the prescribed timeframe.
168
169 16. Physicians **must** make their report to Health Canada within 30 days of any of the above
170 outcomes occurring, with the exception of provision 15 (e), in which case a report must be
171 made between 90 and 120 days after the substance is prescribed. Physicians **must** make
172 their report using the Canadian MAID Data Collection Portal.[23]

173 **Medical Record Keeping**

174 17. Physicians **must** comply with the expectations set out in the College's *Medical Records*
175 policy. In particular, physicians **must**:

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[19] While the Office of the Chief Coroner for Ontario (OCC) must be notified of all medically assisted deaths, an investigation is not required unless the OCC deems one to be necessary. See Section 10.1(1) of the *Coroners Act,* R.S.O. 1990, c. C3 (hereinafter, "*Coroners Act*").
[20] Following the provision of medical assistance in dying, the physician must notify a coroner by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.
[21] The written request that is required as a safeguard in the *Criminal Code* must be duly signed, dated, and witnessed. The written request that triggers reporting requirements need not take this form.
[22] For more information on physicians' reporting obligations, including reporting deadlines, please visit the Ministry of Health and Long-Term Care website: http://health.gov.on.ca/en/pro/programs/maid/#regulations
[23] The Canadian MAID Data Collection Portal may be accessed via the Health Canada website: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary.html.

176 a. document each physician-patient encounter in the medical record, including
177 encounters relating to MAID, which will include:
178 i. a focused relevant history;
179 ii. documentation of an assessment and appropriate focused physical exam
180 (where indicated);
181 iii. a provisional diagnosis (where indicated); and
182 iv. a management plan;
183 b. ensure that the record is legible and the information is understandable to other
184 healthcare professionals; and
185 c. ensure that the author of each entry in the medical record is identifiable.
186
187 18. Physicians **must**:
188 a. document all oral and written requests for MAID, the dates they were made, and
189 include a copy of the patient's written request in the medical record;[24]
190 b. document each element of the patient's assessment in accordance with the criteria
191 for MAID; and
192 c. include a copy of their written opinion in the medical record.
193
194 19. Where MAID is provided, physicians **must** document the information needed to comply
195 with their reporting obligations to the OCC, which includes but is not limited to:
196 a. the steps taken to satisfy themselves that the patient's written request for MAID
197 was signed by two independent witnesses;
198 b. the start and end-date for the required 10-day reflection period between the signed
199 request for MAID and the date on which MAID was provided;
200 c. the rationale for shortening the 10-day reflection period, if applicable (i.e., both
201 clinicians and/or nurse practitioners are of the opinion that the patient's death or
202 loss of capacity is imminent);
203 d. the time of the patient's death; and
204 e. the medication protocol used (i.e., drug type(s) and dosages).
205
206 20. Physicians who decline to provide MAID **must** document that an effective referral was
207 made, the date it was made, and the physician, practitioner, and/or agency to which the
208 referral was made.

[24] The Ministry of Health and Long-Term Care (MOHLTC) has developed clinician aids to support the provision of medical assistance in dying. These include forms to: (a) assist patients who request medical assistance in dying (http://bit.ly/29Sovs0); (b) assist physicians who provide medical assistance in dying (http://bit.ly/2a9M8Pf); and (c) assist physicians who provide a written opinion confirming that the patient meets the eligibility criteria to receive medical assistance in dying (http://bit.ly/29Spk3Y).

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209 **Completion of Death Certificate**

210 21. If, after reviewing the report provided, the OCC determines that no investigation is needed,
211 physicians who provided MAID **must** complete the medical certificate of death.[25]
212
213 22. When completing the death certificate[26] physicians:
214 a. **must** list the illness, disease, or disability leading to the request for MAID as the
215 cause of death; and
216 b. **must not** make any reference to MAID or the drugs administered on the death
217 certificate.

218 Process Map for Medical Assistances in Dying

219 The process map that follows details the steps that physicians must undertake in relation to
220 medical assistance in dying. It complies with federal legislation and outlines safeguards that
221 must be adhered to, by law, prior to the provision of medical assistance in dying.

222 The federal legislation sets out safeguards that must be met before medical assistance in dying
223 is provided. The process map that follows provides an illustration of how medical assistance in
224 dying may be carried out, from initial patient inquiry to provision, in compliance with the
225 federal legislation.

226 Nurse practitioners and other professionals are noted in the Process Map only to the extent
227 necessary to reflect relevant provisions of the federal legislation. Expectations for the
228 responsibilities and accountabilities of nurse practitioners, pharmacists and other health care
229 providers are set by their respective regulatory bodies.

230 Physicians and nurse practitioners, along with those who support them, are protected from
231 liability if acting in compliance with the federal legislation and any applicable provincial or
232 territorial laws, standards or rules.[27]

233 **Initial Inquiry for Medical Assistance in Dying**

234 **Patient makes initial inquiry for medical assistance in dying to a physician or nurse**
235 **practitioner.**

[25] If the OCC initiates an investigation, they will complete a replacement death certificate.
[26] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.
[27] Liability protections extend to pharmacists, any individuals supporting physicians or nurse practitioners (not limited to regulated health professionals), and individuals who aid a patient to self-administer the fatal dose of medication, when acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.

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Physicians who have a conscientious objection to medical assistance in dying are not obliged to proceed further through the process map and evaluate a patient's inquiry for medical assistance in dying. As described above, objecting physicians must provide the patient with an effective referral to a non-objecting physician, nurse practitioner, or agency. The objecting physician must document, in the medical record, the date on which the effective referral was made, and the physician, nurse practitioner and/or agency to which the patient was connected.

Safeguards for Medical Assistance in Dying

Physician or nurse practitioner assesses the patient against eligibility criteria for medical assistance in dying.

The physician or nurse practitioner must ensure that the patient meets the criteria for medical assistance in dying. As described above, the patient must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. Provide informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Where the patient's capacity or voluntariness is in question, the attending physician must refer the patient for a specialized capacity assessment.

With respect to the third element of the above criteria, a patient has a grievous and irremediable medical condition if:

- They have a serious and incurable illness, disease or disability;
- They are in an advanced state of irreversible decline in capability;
- That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

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265 • Their natural death has become reasonably foreseeable,[28] taking into account all of
266 their medical circumstances, without a prognosis necessarily having been made as to
267 the specific length of time that the individual has to live.

268 If the physician concludes that the patient does not meet the criteria for medical assistance in
269 dying as outlined above, the patient is entitled to make a request for medical assistance in
270 dying to another physician who would again assess the patient using the above criteria.

271 The physician must document the outcome of the patient's assessment in the medical record.

272 **Patient makes written request for medical assistance in dying before two independent**
273 **witnesses.**

274 The patient's request for medical assistance in dying must be made in writing. The written
275 request must be signed and dated by the patient requesting medical assistance in dying on a
276 date after the patient has been informed that they have a grievous and irremediable medical
277 condition.

278 Physicians are advised that a patient may have been informed that they have a grievous and
279 irremediable medical condition by a physician who is not involved in assessing their eligibility
280 for medical assistance in dying. The federal legislation does not require that a patient be
281 informed that they have a grievous and irremediable medical condition in the context of an
282 eligibility assessment for medical assistance in dying. As long as the patient was informed that
283 their condition is grievous and irremediable before making a formal written request for medical
284 assistance in dying, these requirements of the federal legislation are met.

285 If the patient requesting medical assistance in dying is unable to sign and date the request,
286 another person who is at least 18 years of age, who understands the nature of the request for
287 medical assistance in dying, and who does not know or believe that they are a beneficiary
288 under the will of the person making the request, or a recipient, in any other way, of a financial
289 or material benefit resulting from the patient's death, may do so in the patient's presence, on
290 the patient's behalf, and under the patient's express direction.

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[28] The case of *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759, provides some assistance on what is meant by "reasonably foreseeable" in this context, stating at paras. 79 and 80:

> [...] *natural death need not be imminent and that what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan.*
>
> *Although it is impossible to imagine that this exercise of professional knowledge and judgment will ever be easy, in those cases where a prognosis can be made that death is imminent, then it may be easier to say that the natural death is reasonably foreseeable. Physicians, of course have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime.*

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The patient’s request for medical assistance in dying must be signed and dated before two independent witnesses, who then must also sign and date the request. An independent witness is someone who is at least 18 years of age, and who understands the nature of the request for medical assistance in dying.

An individual may not act as an independent witness if they are a beneficiary under the patient’s will, or are a recipient in any other way of a financial or other material benefit resulting from the patient’s death; own or operate the health care facility at which the patient making the request is being treated; or are directly involved in providing the patient’s healthcare and/or personal care.

Physicians must document the date of the patient’s request for medical assistance in dying in the medical record. Additionally, physicians must document the steps taken to satisfy themselves that the patient’s written request for medical assistance in dying was signed by two witnesses. A copy of the physician’s written opinion regarding whether the patient meets the eligibility criteria must also be included in the medical record.

The physician or nurse practitioner must remind the patient of his/her ability to rescind the request at any time.

The physician or nurse practitioner must remind the patient that they may, at any time and in any manner, withdraw their request.

An independent second physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for medical assistance in dying.

A second physician or nurse practitioner must assess the patient in accordance with the criteria provided above, and provide their written opinion confirming that the requisite criteria for medical assistance in dying have been met.

The first and second physician or nurse practitioner assessing a patient’s eligibility for medical assistance in dying must be independent of each other. This means that they must not:

- Be a mentor to, or be responsible for supervising the work of the other physician or nurse practitioner;
- Know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person’s death, other than standard compensation for their services relating to the request; or
- Know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

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324 If the second physician concludes that the patient does not meet the criteria for medical
325 assistance in dying as outlined above, the patient is entitled to have another physician assess
326 them against the criteria.

327 **A 10-day period of reflection from date of request to provision of medical assistance in dying.**

328 A period of at least 10 clear days[29] must pass between the day on which the request for medical
329 assistance in dying is signed by or on behalf of the patient, and the day on which medical
330 assistance in dying is provided.

331 In accordance with federal legislation, this timeframe may be shortened if both the physician(s)
332 and/or nurse practitioner(s) agree that death or loss of capacity to provide consent is imminent.

333 Physicians must document the start and end-date of the 10-day reflection period in the medical
334 record, and their rationale for shortening the 10-day reflection period if applicable.

335 **Physician or nurse practitioner informs the dispensing pharmacist that prescribed substance**
336 **is intended for medical assistance in dying.**

337 Medical assistance in dying includes both situations where the physician or nurse practitioner
338 writes a prescription for medication that the patient self-administers, and situations where the
339 physician or nurse practitioner is directly involved in administering an agent to end the
340 patient's life.

341 Physician(s) and/or nurse practitioner(s) must inform the pharmacist of the purpose for which
342 the substance is intended before the pharmacist dispenses the substance.

343 Physicians are advised to notify the pharmacist as early as possible (e.g. at the commencement
344 of the reflection period) that medications for medical assistance in dying will likely be required.
345 This will provide the pharmacist with sufficient time to obtain the required medications.

346 Physicians must exercise their professional judgement in determining the appropriate drug
347 protocol to follow to achieve medical assistance in dying. The goals of any drug protocol for
348 medical assistance in dying include ensuring the patient is comfortable, and that pain and
349 anxiety are controlled.

350 Physicians must document the medication protocol utilized (i.e. drug type(s) and dosages) in
351 the medical record.

[29] The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day. Therefore, in the context of medical assistance in dying, the 10-day reflection period would commence on the day following the day on which the patient's request is made, and would end the day following the tenth day.

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352 College members may wish to consult resources on drug protocols used in other
353 jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the
354 College's website.

355 **Providing Medical Assistance in Dying**

356 The patient must be capable not only at the time the request for medical assistance in dying is
357 made, but also at the time they receive medical assistance in dying.

358 Immediately before providing medical assistance in dying, the physician(s) and/or nurse
359 practitioner(s) involved must provide the patient with an opportunity to withdraw the request
360 and if the patient wishes to proceed, confirm that the patient has provided express
361 consent. This must occur either immediately before the medication is administered or
362 immediately before the prescription is provided.

363 Where medical assistance in dying is provided, physicians must document the patient's time of
364 death in the medical record.

365 Physicians and nurse practitioners who provide medical assistance in dying, and those who
366 assist them throughout the process, are protected from liability if they are acting in compliance
367 with the federal legislation and any applicable provincial or territorial laws, standards or rules.
368 These protections would extend, for example, to pharmacists, any individual who supports a
369 physician or nurse practitioner (not limited to regulated health professionals), or individuals
370 who aid a patient to self-administer the fatal dose of medication.

371 Where the patient plans to self-administer the fatal dose of medication at home, physicians
372 must help patients and caregivers assess whether this is a manageable option. This includes
373 ensuring that the patient is able to store the medication in a safe and secure manner so that it
374 cannot be accessed by others.

375 Further, physicians must ensure that patients and caregivers are educated and prepared for
376 what to expect, and what to do when the patient is about to die or has just died. This includes
377 ensuring that caregivers are instructed regarding whom to contact at the time of death. For
378 further information, physicians are advised to consult the College's *Planning for and Providing*
379 *Quality End-of-Life Care* policy.

380 **Reporting Requirements and Certification of Death**

381 Physicians who provide medical assistance in dying must report the medically assisted death to
382 the Office of the Chief Coroner for Ontario (OCC). [30, 31] Upon notification, the OCC will

[30] Section 10.1(2) of the *Coroners Act*.

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383 determine whether the death ought to be investigated. If the OCC determines that an
384 investigation is not required, the physician or nurse practitioner who provided medical
385 assistance in dying completes the death certificate. If the OCC is of the opinion that an
386 investigation is required, the OCC would complete the death certificate.[32]

387 When completing the death certificate for a medically assisted death, the illness, disease, or
388 disability leading to the request for medical assistance in dying must be recorded as the
389 underlying cause of death. The death certificate must not make reference to medical assistance
390 in dying, or the drugs administered to achieve medical assistance in dying.[33]

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[31] Physicians notify the OCC of a medically assisted death by contacting provincial dispatch. Provincial dispatch will then contact the on-duty member of the OCC MAID Review Team, who will obtain information from the reporting physician regarding the facts and circumstances relating to the death. Documentation pertaining to the medically assisted death is to be faxed, as soon as is reasonably possible, to the MAID review team at 416-848-7791.

[32] Section 21(7) of the *Vital Statistics Act*, R.S.O. 1990, c. V.4.

[33] Instructions on completing the Medical Certificate of Death reflect joint guidance developed by the Ministry of Health and Long-Term Care, the Ministry of Government and Consumer Services, and the Office of the Chief Coroner.

1 # Advice to the Profession: Medical Assistance in Dying

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

6 Historically, it has been a crime in Canada to assist another person to end their own life. This
7 criminal prohibition has applied to circumstances where a physician provides or administers
8 medication that intentionally brings about a patient's death, at the request of the patient.

9 However, in the case of *Carter v. Canada*,[1] the Supreme Court of Canada (SCC) determined that
10 the criminal prohibition on medical assistance in dying (MAID) violates the *Charter* rights of
11 competent adults, who are suffering intolerably from grievous and irremediable medical
12 conditions, and seek assistance in dying. The federal government subsequently enacted
13 legislation, through amendments to the *Criminal Code*, to establish a federal framework for
14 MAID in Canada.

15 The *Medical Assistance in Dying* policy, including the 'Process Map' contained within the policy,
16 set out physicians' legal and professional obligations regarding MAID. This companion Advice
17 document is intended to help physicians interpret the expectations set out in the policy and
18 provide guidance on how these expectations may be effectively discharged.

19 ## *Effective Referrals: What Physicians Need to Know*

20 The College recognizes that physicians have the right to limit the health services they provide
21 for reasons of conscience or religion and so may choose not to be involved in assessing or
22 providing MAID. In recognizing this right, the College *does not* require physicians to assess a
23 patient's eligibility for MAID or provide MAID in any circumstances.

24 When physicians limit the health services they provide for reasons of conscience or religion, the
25 College requires that they provide patients with an 'effective referral'.

26 **What is an effective referral?**

27 Physicians make an effective referral when they take positive action to ensure the patient is
28 connected in a timely manner to a non-objecting, available, and accessible physicians, other-
29 health-care professional, or agency that provides the service or connects the patient directly
30 with a health-care professional who does.

[1] *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter*].

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The objective is to ensure access to care and respect for patient autonomy. An effective referral *does not* guarantee that a patient will receive a treatment or signal that the objecting physician endorses or supports the treatment. An effective referral also *does not necessarily* require that a referral in the formal clinical sense be made and does not require the physician to assess or determine whether the patient is a suitable candidate or eligible for the treatment to which the physician objects.

An effective referral involves taking the following steps:

1) **The physician takes positive action to connect a patient with another physician, healthcare professional, or agency.** The physician can take these steps themselves or assign the task to someone else, so long as that person complies with the College's expectations.

2) **The effective referral must be made to a non-objecting physician, healthcare professional, or agency that is accessible and available to the patient.** The physician, healthcare professional, or agency must be accepting patients/open, must not share the same religious or conscience objection as the physician making the effective referral, and must be in a location that is reasonably accessible to the patient or accessible via telemedicine where appropriate.

3) **The effective referral must be made in a timely manner, so that the patient will not experience an adverse clinical outcome due to a delay in making the connection.** A patient would be considered to suffer an adverse outcome due to a delay if, for example, the patient is no longer able to access care (e.g., for time sensitive matters such as emergency contraception, an abortion, or where a patient wishes to explore MAID), their clinical condition deteriorates, or their untreated pain or suffering is prolonged.

What are some examples of an effective referral?

The following are examples of the steps physicians can take to ensure their patient is connected in a timely and appropriate manner. The examples provided are not exhaustive and the steps needed to ensure a connection is made depend on the patient's circumstances. Physicians will need to use their judgement, considering the patient's particular circumstances, when determining how to meet this obligation.

The physician or designate contacts a non-objecting physician or non-objecting healthcare professional and arranges for the patient to be seen or transferred[2].

[2] A transfer of care in this situation would be specific to the care to which the physician objects. A transfer is not equivalent to ending the physician-patient relationship. Physicians must not terminate the physician-patient relationship simply because the patient wishes to explore a care option to which the physician has a conscientious objection.

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63 The physician or designate connects the patient with an agency charged with facilitating
64 referrals for the healthcare service, and arranges for the patient to be seen at that agency. For
65 instance, in the MAID context, in appropriate circumstances an effective referral could include
66 the physician or designate contacting Ontario's Care Coordination Service (CCS). The CCS would
67 then connect the patient with a willing provider of MAID-related services.

68 A practice group in a hospital, clinic or family practice model identifies patient queries or needs
69 through a triage system. The patient is directly matched with a non-objecting physician in the
70 practice group with whom the patient can explore all options in which they have expressed an
71 interest.

72 A practice group in a hospital, clinic or family practice model identifies a point person who will
73 facilitate referrals or who will provide the healthcare to the patient. The objecting physician or
74 their designate connects the patient with that point person.

75 For more information regarding physicians' right to freedom of conscience and religion and the
76 basis for the College's expectations, please see the College's *Advice to the Profession:*
77 *Professional Obligations and Human Rights* companion resource.

78 *Other Frequently Asked Questions*

79 ***What does the term 'medical assistance in dying' encompass?***

80 As set out in the federal legislation, MAID refers to an individual seeking and obtaining the
81 assistance of a physician or nurse practitioner to end his/her life. This assistance encompasses
82 two potential scenarios:

83 i. The physician or nurse practitioner provides the patient with the means to end
84 his/her own life (e.g., a prescription for a fatal dose of medication); or
85 ii. The physician or nurse practitioner is directly involved in administering an agent to
86 end the patient's life. This is often referred to as voluntary euthanasia.

87 ***What criteria must be met in order for an individual to access MAID?***

88 As set out in the federal legislation, for an individual to access MAID, they must:

89 i. Be eligible for publicly-funded health services in Canada;
90 ii. Be at least 18 years of age and capable of making decisions with respect to their
91 health;
92 iii. Have a grievous and irremediable medical condition (including an illness, disease or
93 disability);
94 iv. Make a voluntary request for MAID that is not the result of external pressure; and

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95 v. Provide informed consent to receive MAID after having been informed of the means
96 that are available to relieve their suffering, including palliative care.

97 As noted in the policy, before providing MAID, physicians must be satisfied that patients meet
98 all of these criteria.

99 ***What is a grievous and irremediable medical condition?***

100 An individual must have a grievous and irremediable medical condition to access MAID. As set
101 out in the federal legislation, an individual has a grievous and irremediable medical condition if:

102 i. They have a serious and incurable illness, disease or disability;
103 ii. They are in an advanced state of irreversible decline in capability;
104 iii. That illness, disease or disability, or that state of decline, causes them enduring
105 physical or psychological suffering that is intolerable to them and that cannot be
106 relieved under conditions that they consider acceptable; and
107 iv. Their natural death has become reasonably foreseeable, taking into account all of
108 their medical circumstances, without a prognosis necessarily having been made as to
109 the specific length of time that the individual has to live.

110 Further details on interpreting the statutory definition of a grievous and irremediable medical
111 condition can be found in the companion resources developed by the federal
112 government: https://www.canada.ca/en/health-canada/services/medical-assistance-
113 dying.html

114 ***Does an individual have to be terminally ill to receive MAID?***

115 The federal government has stated that an individual need not have a terminal condition to be
116 eligible for medical assistance in dying. Rather, there must be a real possibility of death,
117 evidenced by the individual's irreversible decline, within a period of time that is foreseeable in
118 the not too distant future. The federal government advises that the nature of the illness causing
119 the individual intolerable and enduring suffering, and any other medical conditions or health-
120 related factors such as age and/or frailty, are to be considered in assessing the individual's
121 trajectory towards death.

122 ***Patients must be capable with respect to making a decision about MAID in order to receive***
123 ***MAID. Does this mean they have to be capable at the time of their request or when they***
124 ***receive MAID, or both?***

125 The federal legislation specifies that medical assistance in dying is available only to individuals
126 who are capable of making decisions with respect to their health. In accordance with the
127 legislation, the patient must provide the physician or nurse practitioner with their expressed

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consent immediately prior to receiving medical assistance in dying. This means that the patient must maintain decision-making capacity from the time the request for medical assistance in dying is made, right up to the time at which medical assistance in dying is provided.

This is important if the patient decides to self-administer MAID. If the patient's death is prolonged or not achieved, it will not be possible for the clinicians involved in the process to administer a fatal dose of medication to achieve death unless the patient remains capable and can provide consent immediately prior to MAID being provided by the clinician.

Can requests for MAID be made through an advance directive or the patient's substitute decision-maker?

No. All requests for medical assistance in dying must be made directly by the patient, and not through an advance directive, or the patient's substitute decision-maker. The federal legislation specifies that medical assistance in dying is available only to individuals who are capable of making decisions with respect to their health. The individual's decision-making capacity must be maintained right up until the time medical assistance in dying is provided. A substitute decision-maker would only make decisions for a patient in circumstances where the patient no longer has capacity. Similarly, advance directives only take effect if the patient loses capacity. With respect to medical assistance in dying, therefore, substitute decision-makers do not have a role to play, and advance directives are not applicable.

Could an individual with a mental illness potentially meet the criteria for MAID?

Individuals with mental illness are not prevented from accessing medical assistance in dying, as long as they meet the criteria for medical assistance in dying, as set out in the federal legislation. This includes the requirement that the individual who is seeking medical assistance in dying has decision-making capacity. The federal government has stated that where an individual is suffering only from a mental illness, the criteria for medical assistance in dying would not be satisfied. The federal government has committed to conducting further studies to examine the legal, medical and ethical questions that arise where individuals, who suffer from mental illness only, are seeking a medically assisted death.

I'm a patient and looking for assistance in accessing MAID or looking for more information, what can I do?

The provincial government has established a Care Coordination Service (CCS) for MAID to help clinicians connect patients with willing providers of MAID related services.

Patients may contact the CCS directly to receive information about end-of-life options in Ontario, including information on hospice care, other palliative care options in their

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161 communities, and medical assistance in dying. Patients can also call the CCS to request to be
162 connected to a physician or nurse practitioner who provides medical assistance in dying
163 services, such as eligibility assessments. The CCS can be reached toll free by calling 1-866-286-
164 4023. Patients may also find the College's *Medical Assistance in Dying: 10 Things Patients*
165 *Should Know* document to be helpful.

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Professional Obligations and Human Rights

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

Discrimination: an act, decision, or communication that results in the unfair treatment of a person or group by either 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 entirely unintentional, where rules, practices or procedures appear neutral but have the effect of disadvantaging certain groups of people.

Effective referral: taking positive action to ensure the patient is connected[1] to a non-objecting, available, and accessible[2] physician, other health-care professional, or agency.[3] For more information about an effective referral, see the companion *Advice to the Profession* document.

Policy

General Expectations

1. Physicians **must** act in their patients’ best interests.[4]

    a. In doing so, physicians **must** strive to create and foster an environment in which the rights, autonomy, dignity and diversity of all patients, or those seeking to become patients, are respected.

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[1]An effective referral does not necessarily, but may in certain circumstances, involve a ‘referral’ in the formal clinical sense, nor does it necessarily require that the physician conduct an assessment of the patient to determine whether they are a suitable candidate for the treatment to which they object.
[2] ‘Available and accessible’ means that the health-care provider must be in a location the patient can access, and operating and/or accepting patients at the time the effective referral is made.
[3] In the hospital setting, practices may vary in accordance with hospital policies and procedures.
[4] Please see the College’s *Practice Guide* for further details.

Human Rights, Discrimination, and Access to Care

2. Physicians **must** comply with the Ontario *Human Rights Code* (the "*Code*"),[5] and the expectations of the College, when making any decision relating to the provision of health services. This means that physicians **must not** discriminate, either directly or indirectly, based on a protected ground under the *Code* when, for example:

    a. accepting or refusing individuals as patients;
    b. providing existing patients with health care or services;
    c. providing information or referrals to existing patients or those seeking to become patients; and/or
    d. ending the physician-patient relationship.

The Duty to Accommodate

3. Physicians **must** take reasonable steps to accommodate the needs of existing patients, or those seeking to become patients, where a disability[6] or other personal circumstance may impede or limit their access to care.[7] The purpose in doing so is to eliminate or reduce any barriers or obstacles that patients may experience.

4. Physicians **must** comply with their duty to accommodate as set out in the *Code*, and to make accommodations[8] in a manner that is respectful of the dignity, autonomy and privacy of the person, unless the accommodation would

    a. subject the physician to undue hardship, i.e. where excessive cost, health or safety concerns would result; or
    b. significantly interfere with the legal rights of others.[9]

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[5] *Human Rights Code*, R.S.O. 1990, c. H.19 (the "*Code*"). The *Code* articulates the right of every Ontario resident to receive equal treatment with respect to services, goods and facilities – including health services – without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. The *Code* requires that all those who provide services in Ontario, including physicians providing health services, do so free from discrimination, whether intentional or unintentional.

[6] "Disability" is defined in s. 10 of the *Code* and includes any degree of physical disability, infirmity, malformation, or disfigurement; a condition of mental impairment or a developmental disability; a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language; a mental disorder; or an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act*, 1997.

[7] The *Code*, R.S.O. 1990, c. H.19.

[8] Please see the *Advice to the Profession* document for guidance about the duty to accommodate.

[9] Further explanation of "undue hardship" is provided in the Ontario Human Rights Commission's *Policy and Guidelines on Disability and the Duty to Accommodate*.

49 ## Limiting Health Services for Legitimate Reasons

50 The duty to refrain from discrimination does not prevent physicians from limiting the health
51 services they provide for legitimate reasons (for instance, because the care is outside their
52 clinical competence or contrary to their conscience or religious beliefs).[10]

53 5. While physicians may limit the health services they provide for legitimate reasons, they
54 **must** do so in a manner that respects patient dignity and autonomy, upholds their fiduciary
55 duty to the patient, and does not impede equitable access to care for existing patients, or
56 those seeking to become patients.

57 ***Clinical Competence***

58 The duty to refrain from discrimination does not prevent physicians from making decisions in
59 the course of practicing medicine that are related to their own clinical competence.[11]

60 6. Physicians **must** provide patients with quality health care in a safe manner. If physicians feel
61 they cannot appropriately meet the health-care needs of an existing patient, or those who
62 wish to become patients, they are not required to provide that specific health service or to
63 accept that person as a patient. However, physicians **must**:
64
65 a. comply with the *Code*, and College expectations, in so doing; and
66 b. make any decision to limit the provision of health services on the basis of clinical
67 competence in good faith.[12]
68
69 7. Where clinical competence may restrict the type of services or treatments provided, or the
70 type of patients a physician is able to accept, physicians **must** inform patients of this as soon
71 as is reasonable.
72

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[10] For more information see the College's *Accepting New Patients* and *Ending the Physician-Patient Relationship* policies.

[11] This section of the policy reflects the College's general expectation that physicians will always practice within the limits of their own knowledge, skill, and judgment.

[12] As stated in the College's *Accepting New Patients* policy, "Physicians **must not** use clinical competence and/or scope of practice as a means of discriminating against prospective patients or to refuse patients:

a. with complex or chronic health needs;
b. with a history of prescribed opioids and/or psychotropic medication;
c. requiring more time than another patient with fewer medical needs; or
d. with an injury, medical condition, psychiatric condition or disability that may require the physician to prepare and provide additional documentation or reports [footnotes omitted]."

73 a. Physicians **must** communicate this information in a clear and straightforward
74 manner to ensure that individuals or patients understand that their decision is based
75 on an actual lack of clinical competence rather than discriminatory bias or prejudice,
76 which will lessen the likelihood of misunderstandings.
77
78 8. In order to protect patients' best interests and to ensure that existing patients (or those
79 seeking to become patients) are not abandoned, physicians **must** provide a referral to
80 another appropriate health-care provider for the elements of care the physician is unable to
81 manage directly.

82 ***Conscience or Religious Beliefs***

83 The College recognizes that physicians have the right to limit the health services they provide
84 for reasons of conscience or religion.

85 However, physicians' freedom of conscience and religion must be balanced against the right of
86 existing and potential patients to access care. The Court of Appeal for Ontario has confirmed
87 that where an irreconcilable conflict arises between a physician's interest and a patient's
88 interest, physicians' professional obligations and fiduciary duty require that the interest of the
89 patient prevails.[13]

90 The College has outlined expectations, set out below, for physicians who have a conscientious
91 or religious objection to the provision of certain health services. These expectations
92 accommodate the rights of objecting physicians to the greatest extent possible, while ensuring
93 that patients' access to healthcare is not impeded.

94 9. Where they choose to limit the health services they provide for reasons of conscience or
95 religion, physicians **must** to do so in a manner that respects patient dignity, ensures access
96 to care, and protects patient safety.

97 *Respecting Patient Dignity*

98 10. Where physicians object to providing certain elements of care for reasons of conscience or
99 religion, they **must** communicate their objection directly and with sensitivity to existing
100 patients, or those seeking to become patients, and inform them that the objection is due to
101 personal and not clinical reasons.
102
103 11. In the course of communicating their objection, physicians **must not** express personal moral
104 judgments about the beliefs, lifestyle, identity, or characteristics of existing patients, or

[13] See para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2019 ONCA 393.

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105 those seeking to become patients. This includes not refusing or delaying treatment because
106 the physician believes the patient's own actions have contributed to their condition.
107
108 a. Furthermore, physicians **must not** promote[14] their own religious beliefs when
109 interacting with patients, or those seeking to become patients, nor attempt to
110 convert them.

111 *Ensuring Access to Care*

112 12. Physicians **must** provide information about all clinical options that may be available or
113 appropriate to meet patients' clinical needs or concerns.
114
115 13. Physicians **must not** withhold information about the existence of any procedure or
116 treatment because it conflicts with their conscience or religious beliefs.
117
118 14. Where physicians are unwilling to provide certain elements of care for reasons of
119 conscience or religion, they **must** provide the patient with an effective referral.
120
121 a. Physicians **must** provide the effective referral in a timely manner to allow patients to
122 access care.
123
124 b. Physicians **must not** expose patients to adverse clinical outcomes due to a delayed
125 effective referral.
126
127 15. Physicians **must not** impede access to care for existing patients, or those seeking to become
128 patients.
129
130 16. Physicians **must** proactively maintain an effective referral plan for the frequently requested
131 services they are unwilling to provide.

132 *Protecting Patient Safety*

133 17. Physicians **must** provide care in an emergency, where it is necessary to prevent imminent
134 harm, even where that care conflicts with their conscience or religious beliefs.[15]

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[14] This includes implying that the physician's religion is superior to the patient's beliefs (spiritual, secular or religious).

[15] This expectation is consistent with the College's *Providing Physician Services During Job Actions* policy. For further information specific to providing care in health emergencies, please see the College's *Public Health Emergencies* policy.

1 # Advice to the Profession: Professional Obligations and Human Rights

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

6 The *Professional Obligations and Human Rights* policy articulates physicians' professional and
7 legal obligations to provide health services without discrimination. The key values of
8 professionalism articulated in the College's *Practice Guide* – compassion, service, altruism and
9 trustworthiness – and physicians' obligations under the Ontario *Human Rights Code* form the
10 basis for the expectations in the policy. This Advice document is intended to help physicians
11 interpret and understand the College's expectations.

12 ## *Effective Referrals: What Physicians Need to Know*

13 The College recognizes that physicians have the right to limit the health services they provide
14 for reasons of conscience or religion. However, physicians' freedom of conscience and religion
15 must be balanced against the right of existing and potential patients to access care.

16 When physicians limit the health services they provide for reasons of conscience or religion, the
17 College requires that they provide patients with an 'effective referral'.

18 **What is an effective referral?**

19 Physicians make an effective referral when they take positive action to ensure the patient is
20 connected in a timely manner to a non-objecting, available, and accessible physicians, other-
21 health-care professional, or agency that provides the service or connects the patient directly
22 with a health-care professional who does.

23 The objective is to ensure access to care and respect for patient autonomy. An effective referral
24 *does not* guarantee that a patient will receive a treatment or signal that the objecting physician
25 endorses or supports the treatment. An effective referral also *does not necessarily* require that
26 a referral in the formal clinical sense be made and does not require the physician to assess or
27 determine whether the patient is a suitable candidate or eligible for the treatment to which the
28 physician objects.

29 An effective referral involves taking the following steps:

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30 1) **The physician takes positive action to connect a patient with another physician,**
31 **healthcare provider, or agency.** The physician can take these steps themselves or assign the
32 task to someone else, so long as that person complies with the College's expectations.
33 2) **The effective referral must be made to a non-objecting physician, healthcare provider, or**
34 **agency that is accessible and available to the patient.** The physician, healthcare provider,
35 or agency must be accepting patients/open, must not share the same religious or
36 conscience objection as the physician making the effective referral, and must be in a
37 location that is reasonably accessible to the patient or accessible via telemedicine where
38 appropriate.
39
40 3) **The effective referral must be made in a timely manner, so that the patient will not**
41 **experience an adverse clinical outcome due to a delay in making the connection.** A patient
42 would be considered to suffer an adverse outcome due to a delay if, for example, the
43 patient is no longer able to access care (e.g., for time sensitive matters such as emergency
44 contraception, an abortion, or where a patient wishes to explore medical assistance in
45 dying), their clinical condition deteriorates, or their untreated pain or suffering is prolonged.

46 **What are some examples of an effective referral?**

47 *The following are examples of the steps physicians can take to ensure their patient is connected*
48 *in a timely and appropriate manner. The examples provided are not exhaustive and the steps*
49 *needed to ensure a connection is made depend on the patient's circumstances. Physicians will*
50 *need to use their judgement, considering the patient's particular circumstances, when*
51 *determining how to meet this obligation.*

52 The physician or designate contacts a non-objecting physician or non-objecting healthcare
53 professional and arranges for the patient to be seen or transferred[1].

54 The physician or designate connects the patient with an agency charged with facilitating
55 referrals for the healthcare service, and arranges for the patient to be seen at that agency. For
56 instance, in the medical assistance in dying (MAID) context, in appropriate circumstances an
57 effective referral could include the physician or designate contacting Ontario's Care
58 Coordination Service (CCS). The CCS would then connect the patient with a willing provider of
59 MAID-related services.

60 A practice group in a hospital, clinic or family practice model identifies patient queries or needs
61 through a triage system. The patient is directly matched with a non-objecting physician in the

[1] A transfer of care in this situation would be specific to the care to which the physician objects. A transfer is not equivalent to ending the physician-patient relationship. Physicians must not terminate the physician-patient relationship simply because the patient wishes to explore a care option to which the physician has a conscientious objection.

62 practice group with whom the patient can explore all options in which they have expressed an
63 interest.

64 A practice group in a hospital, clinic or family practice model identifies a point person who will
65 facilitate referrals or who will provide the healthcare to the patient. The objecting physician or
66 their designate connects the patient with that point person.

67 **What is the basis for physicians' right to limit the health services they provide for reasons of**
68 **conscience or religion and why has the College set out an effective referral requirement?**

69 The *Canadian Charter of Rights and Freedoms* (the "*Charter*") protects the right to freedom of
70 conscience and religion.[2] Although physicians have this freedom under the *Charter*, the
71 Supreme Court of Canada has determined that no rights are absolute and that there is no
72 hierarchy of rights; all rights are of equal importance.[3] The right to freedom of conscience and
73 religion can be limited, as necessary, to protect public safety, order, health, morals, or the
74 fundamental rights and freedoms of others.[4]

75 Where physicians choose to limit the health services they provide for reasons of conscience or
76 religion, this may impede access to care in a manner that violates patient rights under the
77 *Charter* and *Code*.[5] Should a conflict of rights arise, the aim of the courts is to respect the
78 importance of both sets of rights to the extent possible.

79 The balancing of rights must be done in context.[6] In relation to freedom of religion specifically,
80 courts will consider the degree to which the act in question interferes with a sincerely held
81 religious belief. Courts will seek to determine whether the act interferes with the religious
82 belief in a manner that is more than trivial or insubstantial. The less direct the impact on a
83 religious belief, the less likely courts are to find that freedom of religion is infringed.[7] Conduct
84 that would potentially cause harm to and interfere with the rights of others would not
85 automatically be protected.[8] The Court of Appeal for Ontario has confirmed that where an
86 irreconcilable conflict arises between a physician's interest and a patient's interest, physicians'
87 professional obligations and fiduciary duty require that the interest of the patient prevails.[9]

[2] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 2(a).
[3] *Dagenais v. Canadian Broadcasting Corp*., [1994] 3 S.C.R. 835 at p 839.
[4] *R. v. Big M Drug Mart Ltd*., [1985] 1 S.C.R. 295 at para 95.
[5] *R. v. Morgentaler*, [1988] 1 S.C.R. 30 at pp 58-61; *Human Rights Code*, R.S.O. 1990, c. H. 19.
[6] Ontario Human Rights Commission, *Policy on Competing Human Rights*, (Ontario: Jan 26, 2012).
[7] *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551 at paras 59-61.
[8] *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551 at paras 59-61.
[9] See para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2019 ONCA 393.

88 The College has outlined expectations, set out below, for physicians who have a conscientious
89 or religious objection to the provision of certain health services including that they make an
90 effective referral. These expectations accommodate the rights of objecting physicians to the
91 greatest extent possible, while ensuring that patients' access to healthcare is not impeded.

92 *Other Frequently Asked Questions*

93 **What is the duty to accommodate and what does this duty look like?**

94 The legal, professional, and ethical obligation to provide services free from discrimination
95 includes a duty to accommodate. Accommodation is a fundamental and integral part of
96 providing fair treatment to patients. The duty to accommodate reflects the fact that each
97 person has different needs and requires different solutions to gain equal access to care.

98 Examples of accommodation may include: enabling access for those with mobility limitations,
99 permitting a guide dog to accompany a patient into the examination room, ensuring that
100 patients with hearing impairment can be assisted by a sign-language interpreter, being
101 considerate of older patients who may face unique communication barriers, providing
102 reasonable flexibility around scheduling appointments where patients have family-related
103 needs,[10] ensuring signage reflects diverse family configurations (e.g., families with two mothers
104 or two fathers), and/or creating forms to accommodate patients' gender identity and
105 expression.

106 **The policy discusses physicians' legal duty to accommodate the needs of patients up to the**
107 **point of undue hardship. When would an accommodation be considered to impose undue**
108 **hardship?**

109 An accommodation is considered to cause undue hardship if it imposes excessive costs, or gives
110 rise to health or safety concerns.

111 The Ontario Human Rights Commission has stated that:

112 • 'Costs' include the actual, present financial cost of carrying out an accommodation
113 measure, as well as any reasonably foreseeable costs that may arise.
114 • 'Health and safety risks' include risks to the person requesting the accommodation, as
115 well as to other employees and/or the general public.

[10] Ontario Human Rights Commission, *Submission Regarding College of Physicians and Surgeons Policy Review: Physicians and the Ontario Human Rights Code*, (Ontario: August 1, 2014).

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Determinations of whether the duty to accommodate has been satisfied and whether an accommodation imposes an undue hardship are made by the Ontario Human Rights Tribunal and the courts.

For further detail, physicians are advised to consult the policies of the Ontario Human Rights Commission, including *Policy and Guidelines on Disability and the Duty to Accommodate*.

The policy says that "physicians must not promote their own religious beliefs when interacting with patients, or those seeking to become patients, nor attempt to convert them." What is meant by "promoting religious beliefs"? Does this mean that physicians can never discuss religious or spiritual beliefs with their patients?

No. The College recognizes that patients' spiritual and religious beliefs can play an important role in the decisions they make about health care, and can offer comfort if patients are faced with difficult news about their health. It is appropriate for physicians to inquire about and/or discuss patients' spiritual and religious beliefs when those are relevant to patient decision-making, or where it will enable the physician to suggest supports and resources that may assist the patient.

However, as noted in the policy, physicians must not attempt to convert patients to their own religion, imply the physician's religion is superior to the patient's beliefs (spiritual, secular or religious), or otherwise make personal moral judgments about the patient's conduct that are based in the physician's religion.

What will happen if the College receives a complaint that a physician has not complied with this policy?

Physicians must comply with their legal obligations and the expectations set out in the *Professional Obligations and Human Rights* policy.

If the College receives a complaint that a physician has not complied with policy, the complaint will be investigated. A panel consisting of physicians and members of the public will consider the circumstances of the case and evaluate the physician's conduct as against the policy expectations. The College will consider any concerns regarding the professional obligations set out in this policy in accordance with its duty to serve and protect the public interest.

If physicians do not comply with their legal obligations under the Ontario *Human Rights Code*, they may be the subject of a separate complaints process: a complaint to the Ontario Human Rights Commission and Tribunal. This process is separate from the College's complaints processes.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: ***Criminal Record Screening* – Policy Changes**

Date of Meeting:

It is moved by____,

and seconded by____, that:

The Council approves the revised policy “Criminal Record Search”, formerly titled “Criminal Record Screening”, (a copy of which forms Appendix “ ” to the minutes of this meeting).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: *Criminal Record Screening* – Policy Changes

FOR DECISION

ISSUE:

- During the policy redesign process for the *Criminal Record Screening* policy, issues arose and opportunities to streamline the policy were identified that warranted making some minor changes to the policy.
- Council is provided with an overview of the current policy, the issues and opportunities that have been identified, and the proposed amendments. Council is asked whether the revised draft policy can be approved as a policy of the College.

BACKGROUND:

- Last reviewed in 2013, the *Criminal Record Screening* policy requires all first-time applicants and those transferring class, to submit to a criminal record check or provide a valid letter of clearance based on a criminal record check that was conducted within the last six months.
- The policy also notes that new members of Council and new Non-Council Committee members will also be subject to a criminal record check as part of the governance protocols.

CURRENT STATUS:

- The policy has been redesigned in accordance with the policy redesign process and the implementation plan set out in the *Policy Redesign Implementation – Batch 2* briefing note included in the September 2019 Council Materials. The redesigned policy (**Appendix A**), has also been updated to incorporate the changes outlined below.

A. Program Area Changes

- The policy indicates that the College will conduct criminal record checks for applicants so long as they bear the cost of doing so. However, the program area no longer offers this option. As a result, an amendment is proposed to eliminate this option from the policy.
- In practice, criminal record checks are conducted for *all* applicants, not just "first-time" applicants as the policy currently states. This includes any applicant who is re-applying after a period of absence. The revised draft policy language has been amended accordingly.

B. Streamlining Policies and Governance Processes

- The policy currently combines a registration requirement and a governance requirement. However, policies are intended to address issues of professionalism or, in the case of registration policies, to set out clear criteria for registration. To that end, it would be clearer to focus the policy on the registration requirement only.
- The criminal record check requirements for Council members and Non-Council Committee members are already integrated into the onboarding process and do not need to be reflected in policy. When the planned Governance Process Manual review is complete, this process requirement for Committee members will be integrated more explicitly.

C. Updating Terminology

- The terminology used to describe background checks is both evolving and inconsistent across jurisdictions. Within Ontario there are three types of checks (i.e., criminal, judicial, vulnerable sector) and other jurisdictions use terminology such as “police information check”, “criminal record search”, or “criminal record check”.
- Given this variability, the program area has recently changed their internal terminology to refer to a “criminal record search”.
- To align with program area changes and to reflect the variability in terminology used across jurisdictions, the policy has been renamed *Criminal Record Search* and the language of the revised draft policy has been updated as well.

NEXT STEPS:

- Should Council approve the revised draft policy, it will be recategorized as a Registration policy and elements of the current policy relating to Governance will be further integrated into the onboarding process for new Council and Non-Council Committee members.

DECISION FOR COUNCIL:

1. Does Council approve the revised *Criminal Record Search* draft policy as a policy of the College?

Contact: Craig Roxborough, Ext. 339
Date: August 30, 2019

Attachments:
Appendix A: *Criminal Record Search* – Revised Draft Policy

Criminal Record Search

1 ## Definitions

2 **Criminal Record Search:** A completed criminal record search run against the Canadian Police
3 Information Centre (CPIC) database or valid letter of clearance based on a CPIC check. See the "Guide to
4 Acceptable Criminal Record Search" for more information about the types of criminal record searches
5 acceptable to the College.

6 ## Policy

7 Any positive findings arising from a criminal record screen will be considered for further action by the
8 College based on: the time period of the findings of guilt; the seriousness of the offence; and the
9 relevance of the details of the offence to the practice of medicine.

10 1. As a requirement of registration, all Ontario physicians **must** submit to a criminal record search.
11 More specifically, all applicants for a certificate of registration (regardless of class) and physicians
12 applying for a transfer in a certificate class **must** submit a completed criminal record search
13 conducted no longer than six months before the date of submission of application to the College.

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: Transparency: Charges and Findings of Guilt from International Jurisdictions

FOR DECISION

ISSUE:

- Intensive work on the College's transparency initiative ended in 2015. However, the issue of posting charges and findings of guilt from other jurisdictions was recently revisited, in part due to concerns raised in media reports about this gap..
- In May 2019, Council approved for circulation to the profession a proposal that would require the College post charges and findings of guilt from other jurisdictions.
- Council is provided with an update on this work and is asked to approve a motion for the required by-law amendments.

BACKGROUND:

- The Transparency Initiative was a strategic priority in the 2014-2018 strategic plan, and involved intensive work from 2014-2016 to examine the College's approach to providing information to the public. This initiative was prompted by increasing public demand for information as well as Ministerial direction.
- The College made many changes to increase transparency via by-law and ultimately most of these changes were embedded in the *Protecting Patients Act, 2017* (Bill 87).
- Currently, only charges, bail conditions and findings of guilt under the *Criminal Code, Controlled Drugs and Substances Act* (*CDSA*) and *Health Insurance Act* must be posted on the public register. This means that criminal information from other jurisdictions is not included.

- In May 2018, the Toronto Star did a series on information not being publicly reported by medical regulators.[1] Included in the series were some serious criminal offences in other jurisdictions (e.g., U.S.) that were not made public by the College.

CURRENT STATUS:

- Through late 2018 and 2019, the Executive Committee considered this issue and concluded that it is a reasonable expectation of the public for this kind of information from other jurisdictions to be available.
- In June, Council approved for circulation a draft by-law amendment that would require posting on the public register, if known to the College, charges and findings of guilt under any criminal laws of another jurisdiction or under laws of another jurisdiction comparable to the *Health Insurance Act (Ontario)* or the *CDSA* that occur on or after January 1, 2019.
- The proposed change was circulated to the profession between June 5 and August 2, 2019.

CONSIDERATIONS:

- The College received three pieces of feedback during the consultation period, two from individual physicians and one from the CMPA.
- The feedback from individual physicians requested that the College take into consideration the country/jurisdiction in question. It also requested that the College not require the posting of charges, only convictions.
    - However, the draft by-law amendment has been worded in such a way as to achieve some uniformity in the information collected and posted, and at least two other AGRE colleges broadly capture information from other jurisdictions in their bylaws.
    - Moreover, the College is required by regulation to post information relating to outstanding charges brought against a member under the *Criminal Code* and the *CDSA*. The inclusion of charges in the by-law as information to be posted is intended to align with this requirement.
- Feedback from the CMPA suggested that the go-forward reporting date, which was proposed to be January 1, 2019, be moved to the date the amended by-law takes effect (anticipated to be September 20, 2019).

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[1] Medical Disorder, The Veil of Secrecy, When Doctors Lie, 2018 http://projects.thestar.com/doctor-discipline/

- The main consideration around moving the reporting date is that some relevant information regarding incidents that occurred between January 1 and September 20, 2019 are not posted. (It is currently unknown how many incidents this would affect.)

- For the sake of simplicity and to avoid the creation of a retroactive reporting period, the date in the proposed by-law has been moved to September 20, 2019.

RECOMMENDATION:

- It is recommended that the draft amending by-law be approved by Council. The proposed by-law changes to reflect this decision are attached as Appendix A and the Council motion is attached as Appendix B.

- Pending Council's approval, the College will begin posting information related to charges and findings of guilt from international jurisdictions that occurred on or after September 20, 2019.

DECISION FOR COUNCIL:

1. Does Council approve the motion for by-law amendments as set out in **Appendix B**?

Contact: Lisa Brownstone, ext. 472
Heather Webb, ext. 753

Date: August 22, 2019

Attachment:

Appendix A: By-law amendments

Appendix B: Council motion for By-Law No. 125

Appendix A

Content of Register Entries

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

19. Where there has been a finding of guilt made against a member (a) under the *Health Insurance Act* (Ontario), on or after June 1, 2015, (b) under any criminal laws of another jurisdiction, on or after September 20, 2019, or (c) under laws of another jurisdiction comparable to the *Health Insurance* Act (Ontario) or the *Controlled Drugs and Substances Act* (Canada), on or after September 20, 2019 and if the finding and/or appeal is known to the College:

    (i) a brief summary of the finding;

    (ii) a brief summary of the sentence;

    (iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

    (iv) the dates of (i)-(iii), if known to the College.

26. Where a member has been charged with an offence under the *Health Insurance Act* (Ontario), under any criminal laws of another jurisdiction or under laws of another jurisdiction comparable to the *Health Insurance Act* (Ontario) or the *Controlled Drugs and Substances Act* (Canada), and the charge is outstanding and is known to the College, the fact and content of the charge and, if known to the College, the date and place of the charge.

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Appendix B

Council Motion for By-Law No. 125

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Register By-law Amendments**

Date of Meeting: **September 20, 2019**

It is moved by____,

and seconded by_____________________________________, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 125:

By-law No. 125

(1) Paragraph 49(1)19 of By-law No. 1 (the General By-law) is revoked and the following is substituted:

19. Where there has been a finding of guilt made against a member (a) under the *Health Insurance Act (Ontario)*, on or after June 1, 2015, (b) under any criminal laws of another jurisdiction, on or after September 20, 2019, or (c) under laws of another jurisdiction comparable to the *Health Insurance* Act (Ontario) or the *Controlled Drugs and Substances Act* (Canada), on or after September 20, 2019 and if the finding and/or appeal is known to the College:

   (i) a brief summary of the finding;

   (ii) a brief summary of the sentence;

   (iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

   (iv) the dates of (i)-(iii), if known to the College.

(2) Paragraph 49(1)26 of the By-law No. 1 (the General By-law) is revoked and the following is substituted:

26. Where a member has been charged with an offence under the *Health Insurance Act* (Ontario), under any criminal laws of another jurisdiction or under laws of another jurisdiction comparable to the *Health Insurance Act* (Ontario) or the *Controlled Drugs and Substances Act* (Canada), and the charge is outstanding and is known to the College, the fact and content of the charge and, if known to the College, the date and place of the charge.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: **By-law Amendments – Housekeeping Matters**

FOR DECISION

ISSUE:

We wish to make three non-substantive (housekeeping) amendments to the By-laws to correct and clarify certain provisions.

EXPLANATION:

Please see the proposed revisions in Appendix A.

Section 11 (Term of Office)

- Change the reference "regular meeting of the council held in November" to "annual general meeting of the council" as this is more accurate and consistent with other references in the By-laws.

Section 18 (Registrar's Election Duties)

- Correct a typo (the by-law was passed many years ago with the typo).

Section 28 (Council Meetings)

- The specific reference to "physician councillors" is being changed to "members of the College" as it was intended to be a reference to being a physician.

The proposed motion for Council is attached as Appendix B.

These by-law amendments do not require circulation to the profession.

DECISION FOR COUNCIL:

1. Does Council approve the motion for by-law amendments in Appendix B?

Contact: Marcia Cooper, Ext. 546

Date: August 20, 2019

Attachments:

Appendix A: By-law amendments

Appendix B: Council motion

Appendix A

Term of Office

11. The term of office of a member elected in a regular election is three years, starting at the first annual general meeting of the council held after the election and expiring at the annual general meeting of the council held after the election three years later.

Deleted: regular
Deleted: in November
Deleted: first regular
Deleted: in November

Registrar's Electoral Duties

18. (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 this by-law,

(a) appoint returning officers and scrutineer;

(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;

(e) provide for the notification to all candidates and members of the results of the elections; and

(f) provide for the destruction of ballots or records of ballots following an election.

Deleted: or
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MEETINGS AND OFFICERS

Council Meetings

28. (1) The council shall hold,

(a) an annual general meeting, which shall be called by the president between November 1st and December 14th of each year,

(b) an annual financial meeting, which shall be called by the president between March 1st and June 30th of each year,

(c) regular meetings other than the annual general meeting and the annual financial meeting, which shall be called by the president from time to time, and

(d) special meetings, which may be called by the president or by any 12 councillors if the president or 12 councillors deposit with the registrar a written requisition for the meeting containing the matter or matters for decision at the meeting.

(1.1) In this Section 28, councillors appointed to council by the Lieutenant Governor in Council are referred to as “public councillors”, and physician members of council are referred to as “physician councillors”.

(2) The council shall,

(a) annually elect a president and vice-president to hold office starting upon the adjournment of the next annual general meeting (or if elected at an

Appendix A

annual general meeting, starting upon the adjournment of that meeting) until the following annual general meeting and, if an election is not so held, the president and vice-president shall continue in office until their successors are elected;

(b) annually appoint the Executive Member Representatives (as defined in subsection 39(1)) to the executive committee. The Executive Member Representatives shall be determined in accordance with the following:

(i) If one or both of the president-elect and the past president-to-be are not members of the College, or the then current president is unwilling or unable to serve on the executive committee as the past president in the following year, the council shall hold an election of nominees for the remaining number of physician councillor positions required in order to have a minimum of two physician councillors on the executive committee, as required by subsection 39(1);

Deleted: physician councillors

(ii) If one or both of the president-elect and the past president-to-be are not public councillors, or the then current president is unwilling or unable to serve on the executive committee as the past president in the following year, the council shall hold an election of nominees for the remaining number of public councillor positions required in order to have a minimum of two public councillors on the executive committee as required by subsection 39(1);

(iii) The council shall then hold an election of nominees for the number of unfilled Executive Member Representative positions. The nominees for this election may be physician councillors and /or public councillors;

(iv) All of the elections contemplated under this subsection 28(2)(b) shall be in accordance with the procedure set out in subsection 28(3.1); and

(v) Following such elections, the council shall consider a motion to appoint the successful nominees to serve as the Executive Member Representatives starting upon the adjournment of the next annual general meeting (or if appointed at an annual general meeting, starting upon the adjournment of that meeting) until the following annual general meeting; and

(c) at the annual general meeting, approve a budget authorizing expenditures for the benefit of the College during the following fiscal year.

Appendix B

Council Motion

Motion Title: **By-law Amendments – housekeeping matters**
Date of Meeting: **September 20, 2019**

It is moved by____,
and seconded by______________________________________, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 128:

By-law No. 128

1. Section 11 of the General By-Law is revoked and the following is substituted:

> **11.** The term of office of a member elected in a regular election is three years, starting at the first annual general meeting of the council held after the election and expiring at the annual general meeting of the council held after the election three years later.

2. Paragraph 18(1)(e) of the General By-Law is amended by deleting "or a ll" and replacing it with "to all".

3. Clause 28(2)(b)(i) of the General By-Law is revoked and the following is substituted:

(2) The council shall,

...

(b) annually appoint the Executive Member Representatives (as defined in subsection 39(1)) to the executive committee. The Executive Member Representatives shall be determined in accordance with the following:

(i) If one or both of the president-elect and the past president-to-be are not members of the College, or the then current president is unwilling or unable to serve on the executive committee as the past president in the following year, the council shall hold an election of nominees for the remaining number of physician councillor positions required in order to have a minimum of two physician councillors on the executive committee, as required by subsection 39(1);

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2019

TOPIC: **Governance Modernization – By-law Amendments**

A) Removal of Standing Committees
B) Term Limits
C) Length of Committee Appointments
D) Eligible Practice Criteria
E) Exceptional Circumstances

FOR DECISION

ISSUE:

- In an effort to align with leading governance practices, the Governance Committee has made a series of non-legislative change recommendations to further its ongoing governance modernization work.

- Council is provided with an overview of these recommendations and is asked to approve the proposed by-law amendments required to accomplish these changes.

BACKGROUND:

- Over the last several months, the Governance Committee has been engaged in modernization work with the goal of incorporating good governance practices and better aligning the College's work with its 2020-2025 Strategic Plan.

- Through the summer of 2019, the Governance Committee considered formal proposals based on governance modernization and reform principles identified by Council last year. With a focus on the non-legislative changes as a first step, the Governance Committee made a series of recommendations, relating to five areas:

    - Removal of three CPSO Standing Committees;
    - Term limits for Council and Committee members;
    - Length of Committee appointments;

- Eligible practice criteria; and
- An “exceptional circumstances” provision.

- Amended by-laws are required to effect the Governance Committee’s recommendations. In August 2019, the Executive Committee approved that the amended by-laws be forwarded to Council for consideration and approval.

- Council is provided with an overview of the Governance Committee’s recommendations below, as well as the required by-laws amendments.

CURRENT STATUS:

A) Removal of Standing Committees (Appendix A, ss. 39 and 41)

- The Governance Committee has reviewed the mandates and structure of all Standing Committees to evaluate their alignment with the strategic plan.

- As a result of this review, the Governance Committee has recommended removing three of CPSO’s Standing Committees: Council Awards Selection, Education, and Outreach.

- No changes are being contemplated at this time for the Finance & Audit, Governance, or Premises Inspection Committees.[1]

- Pending Council’s approval of the by-law amendments, the Council Awards Selection Committee and the Education Committee will both continue as Advisory Groups.

- It is proposed that the Outreach Committee’s core mandate be incorporated into the mandate of the Executive Committee (the draft by-law amendments will update the Executive Committee’s mandate in this respect).

B) Term Limits (Appendix C, ss. 11(3), 37(5), and 37(6))

- The Governance Committee has reviewed best practices relating to term limits for Committee members in an effort to promote succession planning and Committee membership renewal as well as to promote diversity with regard to demographics and clinical and Committee experience.

- To achieve these goals, the Governance Committee is recommending by-law changes to enact the following clear term limits:

[1] The Governance Committee has approved in principle a proposal to subsume the current Independent Health Facilities Review Panel as modality-specific panels under PIC, but this is not anticipated to move forward until summer 2020, which is when CPSO’s oversight of fertility services premises is expected to take effect.

- a 9-year term limit for Council members (excluding LGIC-appointed members) and members of any one Committee, whether those years are consecutive or non-consecutive; and
- an 18-year limit for individuals who have participated in any combination of Committees or Council, whether those years are consecutive or non-consecutive.

- For the purposes of calculating the 18-year total, the proposed by-law contemplates that any period of time spent by a Council or Committee member on Council and one or more committees concurrently will count as one period of time.

- The proposed by-law has been drafted to exclude LGIC-appointed members (i.e. public members of Council) from the 9-year Council term limit, as CPSO Council does not have authority to enact rules about the appointment or eligibility of public members.

C) Length of Committee Appointments (Appendix C, ss. 25, 37(2), 37(2.1))

- Currently, members are appointed to Committees for a one-year term, however, it is the view of the Governance Committee that there is value in extending the length of Committee appointments:
    - permit candidates to commit to Committee service for more extended periods of time;
    - promote Committee succession planning; and
    - enable the Governance Committee to focus on more strategic issues by reducing the amount of time spent on appointment and reappointment processes.

- The Governance Committee has recommended extending the length of most Committee appointments, including members of the Academic Advisory Committee, to up to three years.
    - members of the Governance and Executive Committees will continue to be appointed for one-year terms, given the unique composition of these Committees.

- Pending Council approval, it is anticipated that new Committee members may be offered three-year appointments beginning in the 2019-2020 year. Depending on succession planning and Committee needs as well as Committee member availability, one-, two-, and three-year appointments may be proposed for existing Committee members.

D) Eligible Practice Criteria (Appendix C, ss. 13(a.1), 35(1)(f), and 35(3))

- It is the view of the Governance Committee that the majority of Committee work reasonably requires current or recent medical practice experience and knowledge. As a result, the Governance Committee has recommended the application of "eligible practice" criteria to physician members of Council and Committees.

- The eligible practice criteria will require that a member:

    - is practicing medicine, or is engaged in medical education or supervision or senior medical administrative roles, for at least 750 hours per year; or
    - practised medicine, or engaged in medical education or supervision or senior medical administrative roles, for fewer than 750 hours per year, or has not engaged in any of the foregoing activities, for a combined total of no more than two consecutive years prior to such date.[2]

- Eligible practice criteria will apply across all Committees, Standing and Statutory, as well as Council (for physician members) and has been drafted broadly to capture a variety of roles to account for the fact that different Committees may require different competencies.

- As a mechanism to avoid disruption among Council and Committee membership, the proposed by-laws have been drafted so that eligible practice criteria is assessed only at the time the individual is elected or appointed and includes.

    - Where a member may fall below the threshold in the course of their term on Council or Committee, they will serve the remainder of their term but will be ineligible for re-election or reappointment if they are still not meeting the eligible practice requirement at the time of re-election or reappointment.

- The proposed by-laws have been drafted so that the minimum threshold for "eligible practice" is calculated on an annual basis, which will provide flexibility for those Committee members who are regularly scheduled for lengthy multi-week hearings.

[2] The Governance Committee generally supported criteria that would require committee members to practice 15 hours per week. On an annual basis, taking into account weekends and statutory holidays, this results in approximately 750 hours per year.

E) Exceptional Circumstances (Appendix C, s. 37(9))

- The Governance Committee has recommended the creation of an "exceptional circumstances" provision that could apply in instances where a Committee requires the extension of an appointment for a particular member that exceeds the applicable term limit.

- This provision has been drafted to provide some flexibility to maintain stability and promote effective functioning of Committees, including in situations where a member's particular expertise is proving difficult to replace or a member requires leave for a sudden illness or very unexpected personal reasons.

- To ensure that the "exceptional circumstances" provision is applied appropriately, requests by Committees for an "exceptional circumstance" would first be made to the Governance Committee, then the Executive Committee, and finally Council (unless there is urgency, in which case the Executive Committee would have authority to make the decision).

- The Governance Committee expects that a critical lens will be applied to requests for exceptions by requiring that the Committee in question clearly explain and justify the need for the exception, which may include a demonstration of efforts to recruit where possible.

- The Governance Committee support staff will provide guidance to Committees on how to seek an exception and the criteria that will be applied in considering these requests.

NEXT STEPS:

- The Governance Committee recognizes that the impacts of these changes will vary by Committee and the Committee support staff has examined each one individually to develop implementation plans that will maintain effective functioning of the Committee.
- A staged implementation approach is being recommended to facilitate smooth implementation of the changes and minimize disruption to Committees which may include applying the "exceptional circumstances" provision where appropriate:

Phase	Proposed Change	Effective Date
1	3-year appointments for Committee members	December 2019 (Committees)
2	9-year term limits for members of Council (except LGIC public members) and Committees	September 2020 election cycle (Council) December 2020 (Committees)
	18-year limit for any non-concurrent combination of Council and Committee service	September 2020 election cycle (Council) December 2020 (Committees)
3	Eligible practice criteria for physician Council and Committee members	September 2021 election cycle (Council) December 2021 (Committees)

- **Appendix A** sets out the draft by-law amendments that will remove the three Standing Committees from the General By-law. **Appendix B** sets out the Council motion to reflect these decisions.

- **Appendix C** sets out the draft by-law amendments that will enact term limits, the extended Committee appointments, eligible practice criteria, and the exceptional circumstances provision. **Appendix D** sets out the Council motion to reflect these decisions.

- Pending Council's approval of the by-law amendments, Governance Committee support staff will roll out a communications plan in the fall of 2019 for all current Committee Chairs/Co-chairs, Committee members, and senior support staff to advise of upcoming governance modernization changes.

DECISIONS FOR COUNCIL:

1. Does Council approve the motion for by-law amendments set out in **Appendix B**?

2. Does Council approve the motion for by-law amendments set out in **Appendix D**?

Contact: Steven Bodley, Chair, Governance Committee
Laurie Cabanas, ext. 503
Heather Webb, ext. 753
Marcia Cooper, ext. 546
Suzanne Mascarenhas, ext. 843

Date: August 30, 2019

Attachments:

- **Appendix A**: Draft by-law amendments – Standing Committees
- **Appendix B**: Council motion for By-Law No. 129 – Standing Committees
- **Appendix C**: Draft by-law amendments – Term and practice limits
- **Appendix D**: Council motion for By-Law No. 130 – Term and practice limits

Appendix A

STATUTORY COMMITTEES

Executive Committee

39. (1) The executive committee shall be composed of the following six members,

(a) the president and the vice-president;

(b) the past president, subject to clause (c); and

(c) three or, if the past president is unwilling or unable to serve on the executive committee, four councillors (each, an "Executive Member Representative").

A minimum of two members of the executive committee (regardless of their position on the executive committee) shall be members of the College. A minimum of two members of the executive committee (regardless of their position on the executive committee) shall be councillors appointed to the council by the Lieutenant Governor in Council.

(2) The president is the chair of the executive committee.

(3) In addition to the duties of the executive committee set out in section 30 of this bylaw and section 12 (1) of the Health Professions Procedural Code under the *Regulated Health Professions Act*, the executive committee shall,

(a) -review the performance of the registrar and shall set the compensation of the registrar; and

~~(a)~~(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.~~.~~

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

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

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

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

STANDING COMMITTEES

Establishment

41. The following committees are the standing committees.

1 ~~Council Award Selection Committee~~

2 ~~Education Committee~~

3 Finance and Audit Committee

3a Governance Committee

4 Methadone Committee *[repealed: May 2018]*

5 Nominating Committee *[repealed: May 2003]*

6 ~~Outreach Committee~~

7 Premises Inspection Committee

8 Compensation Committee *[repealed: May 2017]*

~~Council Award Selection Committee~~

~~**41a.** (1) The Council Award Selection Committee shall be composed of,~~

~~(a) the president and the three most immediate past presidents except for any of the three most immediate past presidents who are unable or unwilling to be on the committee; and~~

~~(b) a member of the Council who was appointed to the Council by the Lieutenant Governor in Council appointed by the Executive Committee.~~

~~(2) The past president shall be the chair of the Council Award Selection Committee if he or she is a member of the committee.~~

~~(3) The Council Award Selection Committee shall select the person or people to whom to award the Council Awards.~~

~~Education Committee~~

~~**42.** (1) The education committee shall include all the persons appointed to the academic advisory committee under section 24, as well as any other persons the council may appoint.~~

~~(2) The education committee shall,~~

(a) review and make recommendations to the council respecting matters of undergraduate and postgraduate medical education in Ontario;

(b) establish mechanisms to enhance continuing professional development by College members including:

(i) systematically tracking College-observed trends of needs in physician education;

(i) advocating for these needs to be met by external educational providers; and

(ii) endorsing methods for measuring outcomes of educational interventions by the College.

(c) approve, monitor and/or evaluate methods for use by the College, which may include the following:

(i) Assessment methods and tools for competence and performance;

(i) Programs to promote and enhance professionalism; and

(ii) Supervision roles.

Outreach Committee

47. (1) The Outreach Committee shall work collaboratively with the Communications and Government Relations department to:

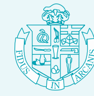
(a) help develop major communications and outreach initiatives to the profession and public;

(b) assist in the development of major communications and government relations activities; and

develop plans to deliver on each of the communications and outreach related components of the College's strategic plan

Appendix B

Council Motion



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **By-law Amendments – Standing Committees**
Date of Meeting: **September 20, 2019**

It is moved by____,
and seconded by____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 129:

By-law No. 129

1. Paragraph 39(3) of the General By-Law is revoked and the following is substituted:

(3) In addition to the duties of the executive committee set out in section 30 of this bylaw and section 12 (1) of the Health Professions Procedural Code under the *Regulated Health Professions Act*, 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.

2. Paragraphs 41(1), (2), and (6) of the General By-Law are revoked.

Term of Office

11. (1) The term of office of a member elected in a regular election is three years, starting at the first annual general meeting of the council held after the election and expiring at the first annual general meeting of the council held after the election three years later.

(2) Subject to subsection 11(3), a member may not be a council member for more than a total of nine years, whether consecutively or non-consecutively.

(3) **Transition.** For a member whose most recent term of office on council commenced in 2017, 2018 or 2019, subsection 11(2) does not apply to the member for that term of office. If the member will have been a council member for more than a total of nine years by the end of that term of office, the member will not be eligible for election to the council for any additional terms.

Eligibility For Election

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

(a) for elections held prior to or in 2020, the member is engaged in the practice of medicine in the electoral district for which he or she is nominated or, if the member is not engaged in the practice of medicine, is resident in the electoral district for which he or she is nominated;

(a.1) for elections held in 2021 or in subsequent years, the member is in Eligible Practice (as defined in subsection 35(3)) in the electoral district for which he or she is nominated;

(b) the member is not in default of payment of any fees prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the election;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario;

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

(h) council has not disqualified the member during the three years before the election date, and

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

(2) A member is not eligible for election to the council who, if elected, would be unable to serve completely the three-year term prescribed by subsection 11(1) by reason of (a) the nine-

consecutive-year term limit prescribed by subsection 5(2) of the Health Professions Procedural Code, or (b) the total nine-year term limit prescribed by subsection 11(2) of this by-law.

* * * *

ACADEMIC SELECTION

Academic Advisory Committee

24. (1) An Academic Advisory Committee shall be established and shall be composed of members appointed under this section.

(2) Between one and two months before the meeting of the council when the term of office of newly elected councillors starts, the dean of each faculty of medicine of a university in Ontario may appoint one member to the academic advisory committee.

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

(a) the member is on the academic staff of the faculty of medicine;

(b) the member is not in default of payment of any fee payable to the College;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the appointment;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation;

~~(e)~~(f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario; ~~and~~

~~(f)~~(g) the member does not hold a position which would cause the member, if appointed to the Academic Advisory Committee, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization;

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

(i) subject to subsections 37(7) and 37(9), if the member is not a council member, the member is in Eligible Practice (as defined in subsection 35(3)).

Appointments

25. A member shall be appointed to the academic advisory committee for a term of three years~~about a year~~, from the first meeting of the council after his or her appointment when elected councillors take office until the third ~~next~~ such meeting or until such earlier time as specified in the appointment, except that the term of office for a member appointed to the academic advisory committee prior to the 2019 annual general meeting of the council shall be one year.

Part 3. Committees

APPOINTMENTS AND PROCEDURE

Appointment of Members to Committees

35. (1) The council may appoint a member of the College to a committee only if, on the date of the appointment,

(a) the member practises medicine in Ontario or resides in Ontario;

(b) the member is not in default of payment of any prescribed fees;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the appointment; and

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation; .

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

(g) subject to subsections 37(7) and 37(9), if the member is not a council member, the member is in Eligible Practice (as defined in subsection 35(3)).

(2) The council may appoint a person who is not a member of the College or a councillor to a committee. The council may appoint such a person to a committee only if, on the date of the appointment, the person is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(b).

(3) **"Eligible Practice"** in respect of a member of the College as of a particular date, means:

(a) the member has practised medicine, or has been engaged in senior medical administrative roles or in providing medical education or supervision, in Ontario no fewer than 750 hours in the year prior to such date; or

(b) the member has practised medicine, or engaged in senior medical administrative roles or in providing medical education or supervision, in Ontario for fewer than 750 hours per year, or has not engaged in any of the foregoing activities, for a combined total of no more than two consecutive years prior to such date.

Committee Appointments and Term

37. (1) The term of office of a committee member starts when he or she is appointed or at such later time as the council specifies in the appointment.

(2) Except as provided in section 25 and in subsection 37(2.1), the term of office of a committee member automatically expires at the third annual general meeting of the council

which occurs after the appointment or at such earlier time as the council specifies in the appointment.

(2.1) The term of office of (a) each member of the Governance Committee and the Executive Committee, and (b) a ~~committee~~ member of a committee (other than the Governance Committee or the Executive Committee) appointed to the committee prior to the 2019 annual general meeting of the council, automatically expires at the annual general meeting of the council which occurs next after the appointment.

(3) Where 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 this by-law.

(4) 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.

(5) Subject to subsections 37(8) and 37(9), a person is not eligible for appointment to a committee if the person has been a member of that committee for a total of nine years or more, whether consecutively or non-consecutively.

(6) Subject to subsections 37(8) and 37(9),

(a) a member of the College is not eligible for appointment to a committee if the member has been a council member 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 member of the College 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 subsection 37(6), any period of time spent on council and/or one or more committees concurrently counts as one period of time, and is not counted separately for council and each committee.

(7) **Transition re Practice Requirements.** Subsections 24(3)(i) and 35(1)(g) shall not be effective in respect of appointments to, and terms of office on, committees until the beginning of the annual general meeting of council held in 2021.

(8) **Transition re Term Limits.** Subsections 37(5) and 37(6) shall not be effective in respect of appointments to, and terms of office on, committees until the beginning of the annual general meeting of council held in 2020.

(9) **Exceptional Circumstances.** Despite subsections 24(3)(h), 24(3)(i), 35(1)(f), 35(1)(g), 35(2), 37(5) and 37(6), Council may appoint a member to a committee if council determines it is necessary to do so due to exceptional circumstances in order to ensure that the composition and quorum requirements for the committee can be met or that the committee can function properly and in a stable manner.

Appendix D

Council Motion

Motion Title: **By-Law Amendments – Term and Practice Limits**

Date of Meeting: **September 20, 2019**

It is moved by____,

and seconded by____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 130:

By-law No. 130

1. Section 11 of the General By-Law is amended by adding the following subsections (2) and (3):

(2) Subject to subsection 11(3), a member may not be a council member for more than a total of nine years, whether consecutively or non-consecutively.

(3) **Transition.** For a member whose most recent term of office on council commenced in 2017, 2018 or 2019, subsection 11(2) does not apply to the member for that term of office. If the member will have been a council member for more than a total of nine years by the end of that term of office, the member will not be eligible for election to the council for any additional terms.

2. Section 13 of the General By-Law is revoked and the following is substituted:

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

(a) for elections held prior to or in 2020, the member is engaged in the practice of medicine in the electoral district for which he or she is nominated or, if the member is not engaged in the practice of medicine, is resident in the electoral district for which he or she is nominated;

(a.1) for elections held in 2021 or in subsequent years, the member is in Eligible Practice (as defined in subsection 35(3)) in the electoral district for which he or she is nominated;

(b) the member is not in default of payment of any fees prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the election;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario;

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

(h) council has not disqualified the member during the three years before the election date, and

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

(2) A member is not eligible for election to the council who, if elected, would be unable to serve completely the three-year term prescribed by subsection 11(1) by reason of (a) the nine-consecutive-year term limit prescribed by subsection 5(2) of the Health Professions Procedural Code, or (b) the total nine-year term limit prescribed by subsection 11(2) of this by-law.

3. Subsection 24(3) of the General By-Law is revoked and the following is substituted:

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

(a) the member is on the academic staff of the faculty of medicine;

(b) the member is not in default of payment of any fee payable to the College;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the appointment;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation;

(f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario;

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

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

(i) subject to subsections 37(7) and 37(9), if the member is not a council member, the member is in Eligible Practice (as defined in subsection 35(3)).

4. Section 25 of the General By-Law is revoked and the following is substituted:

25. A member shall be appointed to the academic advisory committee for a term of three years, from the first meeting of the council after his or her appointment when elected councillors take office until the third such meeting or until such earlier time as specified in the appointment, except that the term of office for a member appointed to the academic advisory committee prior to the 2019 annual general meeting of the council shall be one year.

5. Section 35 of the General By-Law is revoked and the following is substituted:

35. (1) The council may appoint a member of the College to a committee only if, on the date of the appointment,

(a) the member practises medicine in Ontario or resides in Ontario;

(b) the member is not in default of payment of any prescribed fees;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the appointment;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation;

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

(g) subject to subsections 37(7) and 37(9), if the member is not a council member, the member is in Eligible Practice (as defined in subsection 35(3)).

(2) The council may appoint a person who is not a member of the College or a councillor to a committee. The council may appoint such a person to a committee only if, on the date of the appointment, the person is not ineligible for such appointment under subsection 37(5) or subsection 37(6)(b).

(3) **"Eligible Practice"** in respect of a member of the College as of a particular date, means:

(a) the member has practised medicine, or has been engaged in senior medical administrative roles or in providing medical education or supervision, in Ontario no fewer than 750 hours in the year prior to such date; or

(b) the member has practised medicine, or engaged in senior medical administrative roles

or in providing medical education or supervision, in Ontario for fewer than 750 hours per year, or has not engaged in any of the foregoing activities, for a combined total of no more than two consecutive years prior to such date.

6. Section 37 of the General By-Law is revoked and the following is substituted:

37. (1) The term of office of a committee member starts when he or she is appointed or at such later time as the council specifies in the appointment.

(2) Except as provided in section 25 and in subsection 37(2.1), the term of office of a committee member automatically expires at the third annual general meeting of the council which occurs after the appointment or at such earlier time as the council specifies in the appointment.

(2.1) The term of office of (a) each member of the Governance Committee and the Executive Committee, and (b) a member of a committee (other than the Governance Committee or the Executive Committee) appointed to the committee prior to the 2019 annual general meeting of the council, automatically expires at the annual general meeting of the council which occurs next after the appointment.

(3) Where 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 this by-law.

(4) 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.

(5) Subject to subsections 37(8) and 37(9), a person is not eligible for appointment to a committee if the person has been a member of that committee for a total of nine years or more, whether consecutively or non-consecutively.

(6) Subject to subsections 37(8) and 37(9),

(a) a member of the College is not eligible for appointment to a committee if the member has been a council member 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 member of the College 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 subsection 37(6), any period of time spent on council and/or one or more committees concurrently counts as one period of time, and is not counted separately for council and each committee.

(7) **Transition re Practice Requirements.** Subsections 24(3)(i) and 35(1)(g) shall not be effective in respect of appointments to, and terms of office on, committees until the beginning of the annual general meeting of council held in 2021.

(8) **Transition re Term Limits.** Subsections 37(5) and 37(6) shall not be effective in respect of appointments to, and terms of office on, committees until the beginning of the annual general meeting of council held in 2020.

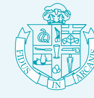
(9) **Exceptional Circumstances.** Despite subsections 24(3)(h), 24(3)(i), 35(1)(f), 35(1)(g), 35(2), 37(5) and 37(6), Council may appoint a member to a committee if council determines it is necessary to do so due to exceptional circumstances in order to ensure that the composition and quorum requirements for the committee can be met or that the committee can function properly and in a stable manner.

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

Member Topics

No meeting materials

Council Motion



Motion Title: **Appointment of 2019-2020 Chairs**

Date of Meeting: September 20, 2019

It is moved by____,

and seconded by____, that:

The Council appoints the following committee members as Chairs, Co-Chairs or Vice Chairs of the following committees as of the close of the Annual General Meeting of Council in December 2019:

Discipline Committee:
Dr. Melinda Davie, Co-Chair
Dr. Eric Stanton, Co-Chair

Executive Committee:
Dr. Brenda Copps, Chair

Finance and Audit Committee:
Mr. Peter Pielsticker, Chair

Fitness to Practise Committee:
Dr. Deborah Hellyer, Chair

Governance Committee:
Dr. Peeter Poldre, Chair

Inquiries, Complaints and Reports Committee:

Dr. David Rouselle, Co-Chair, ICRC
Dr. Anil Chopra, Co-Chair, ICRC
Ms. Joan Fisk, Vice Chair, General Panels
Dr. Brian Burke, Co-Vice Chair, Settlement Panels
Ms. Joan Powell, Co-Vice Chair, Settlement Panels
Dr. Rob Gratton, Vice Chair, Obstetrical Panels
Dr. Andrew Hamilton, Vice Chair, Surgical Panels
Dr. Akbar Panju, Vice Chair, Internal Medicine Panels
Dr. Lesley Wiesenfeld, Vice Chair, Mental Health and Health Inquiry Panels
Dr. Judith Plante, Vice Chair, Family Practice Panels

Patient Relations Committee:

Ms. Lisa McCool-Philbin, Chair

Premises Inspection Committee:

Dr. Gillian Oliver, Chair

Quality Assurance Committee:

Dr. Hugh Kendall, Co-Chair
Dr. Deborah Robertson, Co-Chair

Registration Committee:

Dr. Akbar Panju, Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: **Governance Committee Report**

FOR DECISION:

1. **Election of 2019/2020 Academic Representatives on Council**
2. **2019-2020 Chair Appointments**

FOR INFORMATION:

3. **Committee Appointments**

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1. Election of 2019-2020 Academic Representatives on Council

- The Deans of the six medical schools were asked to appoint their academic representative for the 2019/2020 session of Council. The following representatives have been appointed:

  Dr. Janet van Vlymen, (Queen's University)
  Dr. Mary Jane Bell, (University of Toronto)
  Dr. Terri Paul, (Western University)
  Dr. Akbar Panju, (McMaster University)
  Dr. Robert Smith, (Northern Ontario School of Medicine)
  Dr. Paul Hendry, (University of Ottawa)

- The academic representatives will meet prior to the September Council meeting, and recommend three voting academic representatives for the 2019/2020 session of Council.
- Appointments to Council will be effective following the induction of new Council members at the annual meeting of Council on December 6, 2019.

DECISION FOR COUNCIL:

1. Council will decide whether to accept the recommended slate of 2019-2020 voting academic representatives at its September meeting. [If the slate is not approved, a vote will be held at the September meeting of Council in which all members of the academic advisory committee are placed on a ballot].

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2. 2019-2020 Chair Appointments

- Committee Chairs, Co-Chairs and Vice Chairs are elected at the September Council meeting. These appointments will take effect following the December 5 and 6, 2019 AGM.
- In considering nominations for these leadership positions, the Governance Committee followed Council's Nominations Guidelines
- All Chairs, Co-Chairs and Vice Chairs are nominated and appointed annually pursuant to the General Bylaw
- It is recommended that Chairs serve for no more than three consecutive years as Chair of a specific committee.
- Annual reappointment during the three-year term depends on criteria, including link to Council, demonstrated key leadership and committee-specific competencies, succession planning, term limits and performance.
- In cases where Committees have two Chairs or Vice Chairs, Chair appointments are staggered where possible, to ensure continuity and facilitate mentoring of new Chairs.
- Role descriptions and key competencies for Committee Chairs are set out in the Governance Process Manual
- Committee Chairs must have an understanding of, and a commitment to the public interest mandate and the strategic plan of the College.
- The Governance Committee proposes the following Chairs, Co-Chairs and Vice-Chairs for 2019-2020:

2019-2020 PROPOSED COMMITTEE CHAIR/CO-CHAIR/VICE CHAIR NOMINEES

Committee	Proposed 2019-2020 Chairs/Co-chairs/Vice Chairs
Discipline	Dr. Melinda Davie, *(non-Council),* Co-chair Dr. Eric Stanton, *(non-Council),* Co-chair
Executive	Dr. Brenda Copps, Chair
Finance and Audit	Mr. Peter Pielsticker, Chair
Fitness to Practise	Dr. Deborah Hellyer, Chair
Governance	Dr. Peeter Poldre, Chair
Inquiries, Complaints and Reports	Dr. David Rouselle/Dr. Anil Chopra *(non-Council),* ICRC Co-Chairs Dr. Brian Burke, *(non-Council)*/Ms. Joan Powell, Co-Vice Chairs, Settlement Panels Ms. Joan Fisk, Vice Chair, General Panels Dr. Rob Gratton, Vice Chair, Obstetrical Panels Dr. Akbar Panju, Vice Chair, Internal Medicine Panels Dr. Lesley Wiesenfeld, *(non-Council),* Vice Chair, Mental Health & Health Inquiry Panels Dr. Andrew Hamilton *(non-Council)* Vice Chair, Surgical Panels Dr. Judith Plante, Vice Chair, Family Practice Panels

Committee	Proposed 2019-2020 Chairs/Co-chairs/Vice Chairs
Patient Relations	Ms. Lisa McCool-Philbin, *(non-Council),* Chair
Premises Inspection	Dr. Gillian Oliver, *(non-Council),* Chair
Quality Assurance	Dr. Hugh Kendall, *(non-Council),* Co-Chair Dr. Deborah Robertson, *(non-Council),* Co-Chair
Registration	Dr. Akbar Panju, Chair

DECISION FOR COUNCIL:

1. Council will decide whether to approve the recommended slate of 2019-2020 Chairs/Co-Chairs/Vice Chairs.

FOR INFORMATION:

3. Committee Appointments

- The Executive Committee appointed the following individuals at the May 10th and June 11th, 2019 meetings:
  - ICR Committee: Mr. Shahid Chaudhry (public member)
  - Premises Inspection Committee: Dr. Patrick Davison, Dr. Holli-Ellen Schlosser and Dr. Ted Xenodemetropoulos

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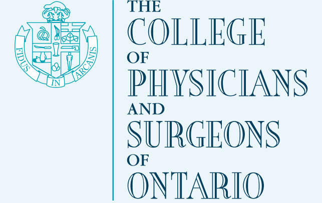
Contact: Steven Bodley, Chair, Governance Committee
Laurie Cabanas, Ext. 503
Marcia Cooper, Ext. 546
Suzanne Mascarenhas, Ext. 843
Debbie McLaren, Ext. 371

Date: August 30, 2019

Council Motion



Motion Title: **Pension Resolution**

Date of Meeting: **September 20, 2019**

It is moved by____,

and seconded by____, that:

WHEREAS the College of Physicians and Surgeons of Ontario (the "**College**") established the Employees' Retirement Savings Plan for The College of Physicians and Surgeons of Ontario, Registration No. 0951756 (the "**Plan**") effective January 1, 1986; and

WHEREAS Council of the College passed a resolution on May 31, 2019 relating to the Plan and the New DCPP (as defined below) but wishes to make certain changes to the resolution by replacing it with this resolution; and

WHEREAS pursuant to Section 13.01 of the Plan, the College reserves the right to amend and terminate the Plan; and

WHEREAS the College wishes to fully terminate the Plan effective September 30, 2019, or shortly thereafter, and replace it with a new defined contribution pension plan, the CPSO Retirement Savings Plan 2019 ("**New DCPP**"); and

WHEREAS the New DCPP will provide the same investment line up as is provided under the Plan as at date the Plan winds up, subject to any future amendments; and

WHEREAS the New DCPP will have a different contribution formula than that provided under the Plan as at date the Plan winds up, subject to any future amendments; and

WHEREAS the College, acting through its Council, wishes to delegate to the Executive Committee the necessary powers and duties to complete the wind-up of the Plan and to implement the New DCPP and to register the New DCPP with the applicable regulatory authorities; and

WHEREAS with the exception of the authority to determine the contribution formula under the New DCPP now and in the future, the College, acting through its Council also wishes to delegate to the Executive Committee the ability to determine all details in connection with the provisions, operation and administration of the New DCPP, including the power to adopt any subsequent compliance and plan design amendments that do not impact the contribution formula; and

WHEREAS employees hired on or after October 1, 2019 (or such later date as may be determined by the Executive Committee) will not be eligible to participate in the New DCPP and instead such employees will be eligible to participate in the Healthcare of Ontario Pension Plan ("**HOOPP**"); and

WHEREAS certain employees hired prior to October 1, 2019 (or such later date as may be determined by the Executive Committee) will have the option to participate in the New DCPP or HOOPP on or after such date.

NOW THEREFORE IT IS RESOLVED THAT:

1. This resolution replaces and supersedes the resolution passed by Council on May 31, 2019 relating to the Plan and the New DCPP.
2. The Plan is fully terminated and wound-up with respect to members, former members and other persons entitled to payments under the Plan (collectively, "**Members**") effective September 30, 2019 or such later date as may be determined by the Executive Committee (the "**Wind-up Date**").
3. Contributions to the Plan shall be made with respect to service with the College up to and including the Wind-up Date.
4. The College shall notify the Members entitled to payments under the Plan in accordance with the provisions of the Ontario *Pension Benefits Act*.
5. Each Member shall have the required options provided to him regarding the payment of his benefit entitlement in accordance with the terms of the Plan, the Ontario *Pension Benefits Act* and the *Income Tax Act* (Canada).
6. A wind-up report for the Plan shall be prepared in accordance with the Ontario *Pension Benefits Act* and the regulations thereunder as may be required by the Financial Services Commission of Ontario (or its successor).
7. The following employees will have the option to participate in the New DCPP or HOOPP, subject to making an election as to which plan to join by August 30, 2019 or such later date as may be determined by the Executive Committee:
   a) employees who were members of the Plan on September 30, 2019;
   b) employees who were hired prior to October 1, 2019, were not enrolled as members of the Plan on September 30, 2019 but were eligible to be enrolled as members of the Plan on September 30;
8. The Executive Committee is authorized to:
   a. approve all decisions relating to the wind-up of the Plan, including but not limited to determining the date on which such wind-up is to occur in accordance with section 2 (above);
   b. approve all decisions relating to the New DCPP, including but not limited to the terms and conditions of the New DCPP (with the exception of the contribution formula); and

c. approve all amendments to the New DCPP, as may be required or recommended, in the future in connection with compliance and plan design changes that do not affect the contribution formula.

Effective October 1, 2019 or such later date as may be determined by the Executive Committee:

1. The New DCPP will be established.

2. The New DCPP shall provide the same investment line-up as is provided under the Plan as at the Wind-up Date, subject to any future amendments.

3. The employee contribution formula under the New DCPP will be as follows:

    - 5% of pensionable earnings

4. The employer contribution formula under the New DCPP will be as follows:

    - 10% of pensionable earnings

BE IT FURTHER RESOLVED THAT the College employees, as authorized by the College General By-law, are hereby authorized and directed to sign all documents and to perform any or all acts necessary or desirable to give effect to the foregoing resolution.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: Pension Plan Resolution

FOR DECISION

ISSUE:

In preparation for the implementation of Healthcare of Ontario Pension Plan (HOOPP) and the ability for staff to buy back past service credits with HOOPP, the current Defined Contribution Pension Plan needs to be wound-down. A new Defined Contribution Pension Plan is being established for those employees who choose to remain in a Defined Contribution arrangement.

BACKGROUND:

On May 31, 2019 Council approved a Resolution to terminate the current Defined Contribution Pension Plan and establish a new Defined Contribution Pension Plan (New DCPP). The establishment of the New DCPP was part of the commitment the College made to existing staff when the decision was made to move to the Healthcare of Ontario Pension Plan (HOOPP) as an alternative option to joining HOOPP.

The Resolution delegated to the Executive Committee the ability to determine all details in connection with provisions, operation and administration of the New DCPP, including the power to adopt any subsequent compliance and plan design amendments. However, it did not provide for the Executive Committee to approve changes to the contribution formula as it was not completed this would change.

However, upon further review, it has been determined that there will be a change to the employee portion of the contribution formula in the New DCPP, and the Executive Committee does not have the authority to approve this.

Under the current plan, employees who started prior to 2008 have the option of not contributing to the plan or contributing an amount less than 5%. This affects only 12 existing employees. The employee also has the ability to change his/her contribution rate at any time. The current plan also included a category of staff hired between June 1, 2008 and December 31, 2016. The Plan required each employee in this category of staff to be contributing 5% by the end of his/her 4th year of employment. There are no employees

currently in this category. The New DCPP will require all employees who join the plan to contribute the full 5%.

A new resolution is required to reflect the change in the contribution formula in place of the resolution approved by Council in May.

DECISION FOR COUNCIL:

Does Council approve the Resolution as presented?

Contact: Leslee Frampton, Manager, Finance and Business Services
Douglas Anderson, Corporate Services Officer
Marcia Cooper, Corporate Counsel and Privacy Officer

Date: August 19, 2019

Attachments:

Appendix A: Motion Pension Plan Resolution

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

September 2019

TOPIC: **GOVERNMENT RELATIONS REPORT**

FOR INFORMATION

1. Ontario's Political Environment
2. Issues of Interest

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1. ONTARIO'S POLITICAL ENVIRONMENT:

- The Legislature has been on recess since the beginning of June and is not scheduled to return until the end of October.
- Following the rise of the House, the Premier shuffled his Cabinet, with the most significant change for CPSO being the creation of a separate Ministry of Long-Term Care (headed by Merrilee Fullerton) apart from the Ministry of Health (headed by Christine Elliott).
- The Cabinet shuffle was accompanied by significant controversy regarding a number of public appointments facilitated by the Premier's former Chief of Staff, Dean French.
    - As a result of the controversy, the Premier has indicated that all upcoming public appointments will be the subject of increased scrutiny.
- At the end of the July, the Final Report of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the Wettlaufer Inquiry) was released, with a number of recommendations for the College of Nurses of Ontario (CNO).
- In August, the joint Ministry-OMA Appropriateness Working Group submitted its first 11 recommended updates to OHIP-insured services to eliminate duplicative, outdated or unnecessary tests and procedures.
    - The Working Group was established as part of Arbitrator Kaplan's award in February 2019 between the Government of Ontario and the OMA, and is tasked with finding $460 million in savings (the first 11 recommendations will save $83 million).

2. ISSUES OF INTEREST:

- Over the summer, the CPSO has continued to work closely with decision-makers on issues of importance to CPSO, including productive meetings with the Deputy Minister of Health and senior government staff.

Public Appointments Update

- The College continues to have the benefit of a full complement of 15 public members.
- Given that a number of public members' terms are expiring at the end of 2019 and early 2020, public member appointments and reappointments have been an area of focus in our conversations with government.
- On request from the Public Appointments Secretariat, a letter was sent to the Minister of Health from the Registrar regarding the College's upcoming needs for public member reappointments (see Appendix A).
- The College will continue to emphasize to government the importance of a full complement of public members at all times while advocating for long-term, sustainable solutions.

Red Tape Reduction

- Red tape reduction and regulatory simplification have also been areas of focus in our recent conversations with government.
- Following the CPSO's red tape reduction submissions in early 2019, overall signals from government regarding the CPSO's red tape recommendations have been positive.
- The College is continuing to work to identify additional opportunities and recommendations that would comprehensively modernize our regulatory legislation and achieve increased efficiency in organizational processes.

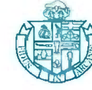
Physician Assistants (PAs)

- The College was previously asked by the Liberal government to put together an implementation plan for the direct oversight of PAs. In April 2018, just prior to the provincial election, the College proposed including PAs as a new class of CPSO member in a submission delivered to then-Minister Helena Jaczek.
- It was anticipated at the time that further work on the initiative would be informed by the priorities of the new government. The Ministry has now expressed renewed interest in the issue of regulating physician assistants.
- As a result, the College has been re-examining the April 2018 proposal in light of other jurisdictional examples of PA regulation.

Contact: Laurie Cabanas, ext. 503
Heather Webb, ext. 753

Date: August 26, 2019
Attachment: Appendix A: Correspondence to the Minister of Health, July 16, 2019

Appendix A



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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July 16, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health
Ministry of Health
777 Bay Street, 5th Floor
Toronto ON M7A 1N3

Dear Minister,

I am pleased to provide you with the following information about CPSO's upcoming needs for public member reappointments.

CPSO Council currently has the benefit of a full complement of 15 public members, and we recognize and appreciate your team's assistance in this respect. A full complement is essential under current *RHPA* quorum requirements in order to efficiently constitute statutory committee panels. The ICR Committee, for example, struck 304 panels in 2018 and each must include one public member. A long-term vacant position in 2018 created significant difficulties in scheduling large ICR Committee panels due to public member unavailability. As our organization actively works to reduce timelines for completed ICR and Discipline Committee matters by increasing the frequency of panels, we will appreciate your assistance in ensuring that CPSO has a full complement at all times.

To that end, the terms of four public members are due to expire in December 2019:

Public Member	Appointed	Term Expiry
1. Pierre Giroux	December 5, 2012	December 4, 2019
2. Hilary Alexander	December 20, 2018	December 19, 2019
3. Joan Powell	July 22, 2015	December 31, 2019
4. Christine Tebbutt	January 1, 2019	December 31, 2019

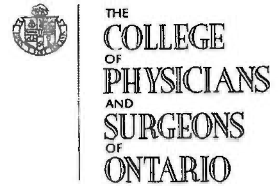
The CPSO is recommending that all four public members be reappointed (please see attached correspondence from the Chair of the Governance Committee).

In addition, the terms of seven more public members are due to expire in 2020 (three in February 2020):

Public Member	Appointed	Term Expiry
5. Geraldine Sparrow	February 2, 2017	February 1, 2020
6. Harry Erlichman	February 17, 2010	February 16, 2020
7. Judy Mintz	March 1, 2017	February 29, 2020
8. Shahid Chaudhry	May 2, 2019	May 1, 2020
9. John Langs	August 13, 2014	August 12, 2020
10. Ellen Mary Mills	September 6, 2017	September 5, 2020
11. Joan Fisk	November 1, 2017	October 31, 2020

The Governance Committee will be considering reappointment recommendations for these seven members in due course, in accordance with the Ministry's requirements and timelines.

Appendix A



In the event that reappointment for any recommended public members cannot be facilitated, we would appreciate your assistance in ensuring that any candidates under consideration are available to contribute between 100-120 days per year to College business and are aware of the government's compensation scheme. In addition, we would also ask that technological proficiency (including with Microsoft Outlook, Microsoft SharePoint, and videoconferencing platforms) be considered an essential criterion.

We look forward to working with you and your team in the months ahead on this issue, including on longer-term, sustainable legislative solutions that will promote the efficiency of the CPSO and its committees. Please let me know if you require any further information.

Sincerely,

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

Cc: Christy Hackney, Acting Manager, Agency Liaison and Public Appointments, Ministry of Health
Dr. Peeter Poldre, President, CPSO

Encl.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2020 Council and Executive Committee Meeting Dates

Meeting	Date
Executive Committee	**Tuesday, February 4**
Council Orientation	**Thursday, March 5**
Council	**Friday, March 6**
Executive Committee	**Tuesday, March 24**
Executive Committee	**Tuesday, April 28**
Council	**Thursday, May 28** **Friday, May 29**
Executive Committee	**Tuesday, June 23**
Executive Committee	**Tuesday, August 11**
Council	**Friday, September 11**
Executive Committee	**Tuesday, October 6**
Executive Committee	**Tuesday, November 10**
Council	**Thursday, December 3** **Friday, December 4**

July 31, 2019

Discipline Committee
Report of Completed Cases – September 2019 Council

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between May 15, 2019 and August 30, 2019. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse – 1 case 2

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Failed to Maintain the Standard of Practice of the Profession – 9 cases 7

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4. Dr. A. P. Denys 26
5. Dr. S. J. Goldstein 29
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Sexual Abuse – 1 case

1. Dr. J. S. Sloka

Name:	Dr. Jeffrey Scott Sloka
Practice:	Neurology
Practice Location:	Kitchener
Hearing:	Uncontested Facts and Plea of No Contest Penalty – Joint Submission
Finding/Penalty Decision Date:	April 30, 2019
Written Decision Date:	June 25, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Sloka is a neurologist who practised in Kitchener, Ontario. He received his certificate of registration authorizing independent practice from the College in 2009.

Patient A

Patient A was referred to Dr. Sloka for an appointment in August 2010 for an assessment regarding seizures. At the time, she was a teenager and was living in a group home.

At her appointment, Dr. Sloka told Patient A that he had to perform a physical assessment and to look over her body. She understood that he would look for "anything like moles," as this could be connected to her seizures.

Expert neurologists retained by the College to review this matter advised that certain skin lesions can be a marker of syndromes causing epilepsy, but that any skin examination would require appropriate draping.

Dr. Sloka left the room so Patient A could change, directing her to take off her bra and underwear and to gown. When Dr. Sloka returned to conduct the examination, however, he instructed her to fully remove her gown and stand with her arms and legs out, facing the window of the examining room. Patient A did so, while Dr. Sloka slowly and closely looked over her entire body, including crouching down with his face close to her skin. This made Patient A very uncomfortable.

Afterwards, Dr. Sloka had Patient A lie down on the examining table and conducted neurological assessments, including testing the strength in her legs and her reflexes. Patient A recalls that she was still ungowned throughout this process.

Patient A expressed her discomfort with her first encounter with Dr. Sloka to another physician, who made a report to the College in January 2016, leading the College to investigate Patient A's concerns.

During the College's investigation, Dr. Sloka stated to the College that he had conducted a skin examination but denied he had required Patient A to disrobe. He did not mention a skin examination in the consultation letter he dictated about the appointment, though the letter indicated Patient A herself had mentioned having a spot on her abdomen.

Dr. Sloka engaged in disgraceful, dishonourable or unprofessional conduct towards and sexual abuse of Patient A during her first medical appointment with him, when he required her to be examined in the nude, which was behaviour of a sexual nature and not of a clinical nature.

Patient B

Patient B was Dr. Sloka's patient between 2010 and 2012, having been referred to him by her family physician with respect to a seizure disorder.

During one of Patient B's first appointments with Dr. Sloka, Dr. Sloka indicated that he had to check her skin for abnormal markings or moles. Her understanding was that this could indicate she had cancer. Dr. Sloka required Patient B to take off her gown and stand naked with her arms outstretched, facing the window. He first checked her back and then her front. When he checked her front, Dr. Sloka cupped each of her breasts separately and lifted them up and moved them.

As noted above in respect of Patient A, appropriate draping would be required for any skin examination. As advised by an expert retained by the College to review this matter, it was not clinically appropriate for Dr. Sloka to touch Patient B's breasts.

Patient B felt uncomfortable. She continued to see Dr. Sloka for four additional consultation appointments, but in 2015 she discussed her concerns with her family physician, who reported them to the College, resulting in an investigation.

During the investigation, Dr. Sloka suggested that Patient B had been mistaken in saying that Dr. Sloka had asked her to disrobe, and denied lifting or cupping her breasts.

Dr. Sloka engaged in disgraceful, dishonourable or unprofessional conduct towards and sexual abuse of Patient B during a medical appointment, by requiring her to be

examined in the nude, and by touching her body, including lifting and cupping her breasts. This was behaviour and touching of a sexual nature and not a clinical nature.

Patient C

After learning that allegations regarding Dr. Sloka's conduct towards Patients A and B had been referred to the Discipline Committee, Patient C contacted the College in October 2017 to express her concerns regarding his conduct towards her.

Patient C was Dr. Sloka's patient between 2011 and 2017. She had been referred to Dr. Sloka initially by her family doctor for a neurology consultation after she began to feel tingling from the waist down.

At her first appointment, Dr. Sloka directed Patient C to remove her bra and leave her underwear on and to put on a gown. He left the room while she changed and returned. In addition to such items as checking her reflexes while she sat on the examining table, Dr. Sloka told Patient C he would examine her breasts and 'check for lumps'. Dr. Sloka asked Patient C to lie on her back. He stood at her side and lifted her gown from the right side to the left with the gown gathered almost to her face and her right breast exposed, and then did the same on the other side. On each side, after he had lifted her gown, Dr. Sloka exposed and touched Patient C's breast, squeezing each breast with his fingers, with the palm of his hand on the breast. Patient C described it as a gentle touch, "like I would do to my babies". Dr. Sloka told her he felt no lumps and that "they're good".

Dr. Sloka's patient chart for Patient C contains no record of any breast examination.

After her first appointment with Dr. Sloka, Patient C disclosed to her family that she believed she had been "felt up" by Dr. Sloka. She wanted to see another neurologist but returned to Dr. Sloka because she could not find another physician.

Dr. Sloka engaged in disgraceful, dishonourable or unprofessional conduct towards and sexual abuse of Patient C in touching her breasts during her medical appointment. This was touching of a sexual nature and not of a clinical nature.

Patient D

After learning that allegations regarding Dr. Sloka's conduct towards Patients A and B had been referred to the Discipline Committee, Patient D contacted the College in October 2017 to express her concerns regarding his conduct towards her.

Patient D was Dr. Sloka's patient between 2011 and 2018 for management of her seizure disorder. She was first referred to him as a university student after having a seizure.

At a number of appointments, Dr. Sloka checked Patient D's skin all over her body. She would begin the examination wearing a gown, but as he examined her from her arms down the rest of the body, Dr. Sloka would slowly remove her gown himself, undoing the ties and letting it fall. He would examine her with his face up close to her body, getting on his knees when examining her legs. He explained that he was checking for skin abnormalities linked to neurological issues. While doing this, he would move her breasts, squeezing and pushing them, including around the nipples. Dr. Sloka had Patient D lift her leg to a ninety degree angle while the gown was around her waist with her breasts exposed so that he could examine a birthmark in her inguinal area.

During a follow-up visit in 2013-2014, Patient D complained of twitching in her leg and back pain. Dr. Sloka asked her to lie on the examining table. He proceeded to insert two fingers into her vagina while she lay with her legs flat on the table, which had no stirrups. This occurred after another skin examination. He had not told Patient D that he would touch her genital area or offered a reason for doing so. Dr. Sloka told Patient D that her cervix was low and invited her to feel it for herself, but she declined.

While Patient D remained lying flat on the table, Dr. Sloka then moved his hand and put a finger or fingers into her rectum for approximately five seconds, commenting that he was going to check whether constipation could be causing nerve pain. Dr. Sloka's hand that he used to touch Patient D's vagina and rectum was ungloved.

Patient D recalls that Dr. Sloka touched her vagina and rectum in the manner described above again at subsequent medical appointments, on a total of three to four occasions.

As opined by an expert neurologist retained by the College to review this matter, Dr. Sloka's conduct towards Patient D described above was not clinically indicated. There was no clinical rationale for the invasive physical maneuvers involving Patient D's vagina and rectum. Nor were repeated skin examinations, the lack of draping, or the touching of Patient D's breasts clinically appropriate.

Dr. Sloka engaged in disgraceful, dishonourable or unprofessional conduct towards and sexual abuse of Patient D, in requiring her to be examined without adequate draping, by moving her gown to expose her body, and by touching her vaginal area, rectum, breasts, and groin area. This was touching of a sexual nature and not of a clinical nature.

Dr. Sloka's Discipline History

Dr. Sloka has no prior discipline history.

Undertaking with the College

Dr. Sloka entered into an interim undertaking to the College on September 19, 2017, pending final disposition of this case. It has required all of his patient encounters to take place in the presence of a practice monitor who is a regulated health professional acceptable to the College. The practice monitor has submitted reports to the College, and there was a requirement to post signage advising patients of these practice restrictions. Dr. Sloka has agreed to undertake not to apply or reapply to practise medicine in Ontario or any other jurisdiction.

Disposition

On April 30, 2019 the Discipline Committee ordered that:

- The Registrar revoke Dr. Sloka's certificate of registration effective immediately.
- Dr. Sloka attend before the panel to be reprimanded.
- Dr. Sloka reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty (30) days of this Order in the amount of $64,240.00.

Failed to Maintain the Standard of Practice of the Profession – 9 cases

1. Dr. B. N. Barwin

Name:	Dr. Bernard Norman Barwin
Practice:	Infertility, Hormone Therapy, Weight Loss, and Transgender Care
Practice Location:	Ottawa
Hearing:	Statement of Uncontested Facts and Plea of No Contest Penalty – Uncontested
Finding/Penalty Decision Date:	June 25, 2019
Written Decision Date:	August 19, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **proven**

Summary

Dr. Barwin is an 80 year old former physician who received his certificate of registration authorizing independent practice from the College in 1976. Dr. Barwin resigned his certificate of registration on August 30, 2014. At the relevant times, Dr. Barwin practised at the Ottawa General Hospital and later at a clinic in Ottawa, Ontario. Dr. Barwin's practice involved infertility, hormone therapy, weight loss and transgender care.

Patient A and Ms. AA

In around 1989, Patient A went to Dr. Barwin with her husband for infertility treatment in order to conceive a child. Patient A's husband stored sperm with Dr. Barwin, which Dr. Barwin was to use to artificially inseminate Patient A.

Patient A and her husband attended at Dr. Barwin's clinic on a number of occasions in 1989 for insemination attempts. Dr. Barwin represented to Patient A that he was inseminating her with her husband's sperm. At each insemination attempt, Dr. Barwin showed Patient A and her husband the straw containing the sperm that he was using to inseminate Patient A. Dr. Barwin asked Patient A and her husband to verify that her husband's initials or name were on it, in order to verify that Dr. Barwin was using Patient A's husband's sperm for the inseminations.

Patient A conceived through the infertility treatment provided by Dr. Barwin, and had a daughter, Ms AA, in 1990.

From the time of her birth until her young adult years, Patient A, her husband and Ms. AA believed that Ms. AA was the biological daughter of Patient A's husband.

In 2016, Ms. AA was diagnosed with celiac disease, which is genetic. Patient A and her husband do not have celiac disease. Ms. AA and Patient A's husband underwent blood testing. Ms. AA's blood type is O+, but Patient A's husband's blood type is AB. Patient A's family learned that it is impossible for a person with type AB blood to conceive a child with type O blood. Patient A's family underwent DNA testing, which revealed that Patient A's husband was not Ms. AA's biological father. Patient A, her husband, and Ms AA were shocked.

Patient B and Ms. BB

In around 1990, Patient B and her husband went to Dr. Barwin for infertility treatment. Patient B and her husband decided to try to conceive a child through artificial insemination using sperm from an anonymous donor. Patient B and her husband were shown a donor card with biographical information about the donor, including that he was a medical student. They selected this donor because of certain traits and characteristics the donor had that were important to them.

Patient B and her husband attended at Dr. Barwin's clinic on a number of occasions for insemination attempts. Dr. Barwin represented to Patient B and her husband that all of the insemination attempts were performed using the anonymous donor sperm they had selected.

Through the infertility treatment provided by Dr. Barwin, Patient B became pregnant, and had a daughter, Ms. BB, in the early 1990's.

Until late 2015, Patient B and her family believed that Ms. BB was conceived with anonymous donor sperm.

In the summer of 2015, Ms. BB became curious about her genetic background and decided to look for half-siblings. She contacted an online DNA registry, which matched her with a second cousin of hers. Through contact with her second cousin and family tree research, Ms. BB determined that her second cousin was a relative of Dr. Barwin. Ms. BB began to suspect that Dr. Barwin was her biological father.

Ms. BB contacted Dr. Barwin to inquire whether he was her biological father. Dr. Barwin arranged for a DNA test and, in an email dated October 27, 2015, confirmed to Ms. BB that he was her biological father. Dr. Barwin also sent an email dated April 22, 2016, to Patient B's husband, and met with him to discuss the matter. In these emails and when he met with them, Dr. Barwin told Ms. BB and Patient B's husband that he did not know how this had happened and that the only occasion he had used his own semen was

when he was calibrating an automatic sperm counter. This was false. Patient B and her husband felt betrayed and violated by Dr. Barwin.

In September 2015, Ms. BB and Ms. AA compared their DNA test results, which strongly suggested that they were half-siblings. Further DNA testing confirmed that they were half-sisters by way of the same biological father. Dr. Barwin is that biological father.

Civil Proceeding

Dr. Barwin is now the defendant in a class action lawsuit from his former patients and their children. It is alleged that:

- 50-100 children were conceived after their mothers received the wrong semen from Dr. Barwin;
- Of these, 11 children are genetically matched to Dr. Barwin through DNA testing with Ms. AA and/or Ms. BB

The class action was commenced in 2016 and attracted media coverage. The College initiated an investigation on the basis of the media coverage.

Patient C

Patient C and her husband were referred to Dr. Barwin for infertility treatment around 1975 -1976. They decided to try to conceive a child through artificial insemination performed by Dr. Barwin. Patient C's husband provided sperm samples to Dr. Barwin, which were to be used to inseminate Patient C.

Patient C and her husband attended at the hospital for a number of insemination attempts performed by Dr. Barwin. Dr. Barwin represented to Patient C that all of the inseminations were performed using her husband's sperm.

After a number of attempts, Patient C conceived through the treatment provided by Dr. Barwin, and had twins, a boy and a girl, in the late 1970's. Dr. Barwin also provided pre-natal care to Patient C.

Until 2016, Patient C had complete trust in Dr. Barwin and believed that her children were the biological children of her husband. Patient C continued to see Dr. Barwin for routine gynaecological care for ten to fifteen years after her children were born.

Patient C and her husband raised their two children. They always believed them to be the biological children of Patient C's husband.

In 2016, Patient C and her husband saw media coverage about Ms. AA and Ms. BB. They subsequently obtained DNA testing for their children, which confirmed that their twin children are not the biological children of her husband, and that they are the half-

siblings of Ms. AA and Ms. BB by way of the same biological father. Dr. Barwin is that biological father.

Patient D

Patient D and her husband went to see Dr. Barwin for infertility treatment in around 1975-1977 in order to conceive a child through artificial insemination performed by Dr. Barwin using Patient D's husband's sperm.

Patient D conceived through the artificial insemination treatment performed by Dr. Barwin. Her son was born in the late 1970's.

Patient D raised her son believing him to be the biological son of her husband.

In 2016, Patient D's son saw media coverage about Ms. AA and Ms. BB, and noted similarities in appearance between Ms. AA and Ms. BB and himself. When he was in school, people had often joked that they thought he was adopted. Patient D's son subsequently underwent DNA testing, which confirmed that he is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father.

Patient E

Patient E and her husband went to Dr. Barwin for infertility treatment in around 1982. They were unable to conceive children and decided to try to conceive a child through artificial insemination provided by Dr. Barwin. The insemination was to be performed by Dr. Barwin using donor sperm chosen by Patient E, which Dr. Barwin represented was provided by an anonymous local medical student. Patient E specifically requested that Dr. Barwin use a donor who resembled her husband.

Patient E and her husband attended at the hospital to see Dr. Barwin for a number of insemination attempts. Dr. Barwin represented to Patient E that all of the inseminations were performed using the donor sperm chosen by Patient E.

Patient E conceived through the treatment provided by Dr. Barwin, and had a daughter in the 1980's.

Patient E and her husband returned to Dr. Barwin again for infertility treatment in 1986. Patient E again underwent artificial insemination provided by Dr. Barwin. The insemination was to be performed by Dr. Barwin using the same donor sperm as was used for her daughter, so that her daughter would have a full biological sibling. Patient E told Dr. Barwin that this was very important to her, and Dr. Barwin told her that it was the same donor.

Patient E conceived again, and gave birth to another daughter in the late 1980's.

Patient E often felt that her first daughter resembled Dr. Barwin, but she would push those thoughts aside because she could not believe that Dr. Barwin would have used his sperm to father her child. Patient E and her husband saw media coverage about Ms

AA in 2016, and noticed that Ms. AA resembled their first daughter. Patient E's daughters subsequently underwent DNA testing, which confirmed that her first daughter is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father. DNA testing revealed that Patient E's other daughter is not the biological child of Dr. Barwin. This means that Patient E's children are biological maternal half-siblings, rather than biological full siblings. Patient E's family found this traumatic.

Patient F

Patient F and her husband went to see Dr. Barwin for infertility treatment in around 1989. Patient F decided to undergo artificial insemination provided by Dr. Barwin. The artificial insemination was to be performed by Dr. Barwin using donor sperm chosen by Patient F from an anonymous local medical student. Dr. Barwin told Patient F and her husband some information about the donor's background, appearance and interests. Patient F requested that Dr. Barwin use this donor for her alone. It was important to her to have children who were full biological siblings.

Patient F and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. Dr. Barwin represented to Patient F and her husband that all of the inseminations were performed using sperm from her chosen donor.

Patient F became pregnant through treatment provided by Dr. Barwin, and had a daughter in the 1990's.

Patient F and her husband returned to Dr. Barwin for infertility treatment in around 1992. Patient F again underwent artificial insemination provided by Dr. Barwin. The artificial insemination was to be performed by Dr. Barwin using the same donor as for her first daughter, so that her daughter would have a full biological sibling. Dr. Barwin knew that Patient F wanted to have children who were biological siblings, and assured her that the sperm from her previous donor had been saved and would be used for her alone.

Patient F became pregnant through Dr. Barwin's treatment a second time, and her son was born in the 1990's.

In 2017, Patient F saw media coverage about Ms. AA, who she saw resembled her daughter. Patient F's daughter subsequently underwent DNA testing, which confirmed that she is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father. The DNA testing also confirmed that Patient F's son is not the biological child of Dr. Barwin. This means that Patient F's children are biological maternal half-siblings, rather than biological full siblings.

Mr. G

Mr. G was born in the late 1980's. When he was in his twenties, Mr. G's parents told him that they had received fertility treatments to conceive him through *in vitro* fertilization (IVF) in Ottawa.

In around 2016 or 2017, Mr. G registered his DNA on a DNA registry website, which put him in contact with Dr. Barwin's family member. Dr. Barwin's family member told Mr. G about Ms. AA and Dr. Barwin.

Mr. G subsequently underwent DNA testing, which confirmed that he is the half-sibling of Ms. AA by way of the same biological father. Dr. Barwin is that biological father.

Patient H

Patient H and her husband went to see Dr. Barwin for infertility treatment in around 2002 in order to conceive a child. Patient H and her husband decided to try to conceive a child through artificial insemination provided by Dr. Barwin. Initially, the inseminations were to be performed by Dr. Barwin using her husband's sperm, but after a number of attempts Patient H and her husband decided to try using donor sperm that she and her husband selected from a sperm bank, based on characteristics that were important to them.

Patient H and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. At each appointment, Dr. Barwin showed Patient H the vial to verify that the donor number was printed on the label and that he was using the donor sperm she and her husband had chosen.

Patient H became pregnant through the treatment provided by Dr. Barwin, and her son was born in the early 2000's.

Patient H later tried to have a second child through artificial insemination provided by Dr. Barwin. This child was supposed to be a full biological sibling of her son. Patient H purchased all the remaining samples from her donor and underwent several more treatments with Dr. Barwin. Dr. Barwin told Patient H that he would split the remaining samples and only use half of a vial at each attempt, in order to make them last longer. Patient H did not conceive another child.

After seeing media coverage about Ms. AA and Ms. BB in November 2016, Patient H looked for the donor on a donor sibling registry website. The donor that she had selected had voluntarily put his contact information on the site. Patient H contacted the donor and obtained DNA testing for her son and her chosen donor, which confirmed that her son is not the biological child of the donor she had chosen. The testing also confirmed that her son is not a half-sibling of Ms. AA or Ms. BB.

Patient H's son has learning disabilities. She is unable to locate any information about the medical history of her son's biological father. This has been very difficult for Patient H.

Patient I

Patient I and her husband were not able to have children, so they attended Dr. Barwin for infertility treatments in around 1987-1988. Patient I decided to try to have children through artificial insemination provided by Dr. Barwin. Patient I was to receive artificial insemination for two children, both from the same anonymous donor. Dr. Barwin told Patient I that the donor was a local medical student and gave Patient I some information about the donor, including that he had a similar background and the same blood type as Patient I's husband. Dr. Barwin only ever provided Patient I with a single donor profile.

Patient I and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. Dr. Barwin represented to Patient I that he performed all of her inseminations with sperm from the same donor.

Patient I conceived twice through treatment provided by Dr. Barwin, and had two children: a daughter born in the late 1980's, and a son born in the late 1980's.

Patient I always trusted Dr. Barwin to use the same donor sperm for all inseminations. As such, she believed that her children were full biological siblings.

After Patient I heard about the lawsuit involving Dr. Barwin, she obtained DNA testing for her children, which confirmed that they are biological maternal half-siblings rather than biological full siblings.

Patient J

Patient J and her husband attended Dr. Barwin for infertility treatment in around 2003 and 2005. Patient J's husband provided samples of his semen that were frozen in 2002, which Dr. Barwin was to use to artificially inseminate her.

Patient J and her husband attended at Dr. Barwin's clinic for a number of insemination attempts. At each appointment, Dr. Barwin showed Patient J and her husband the vial, with her husband's name and date of birth printed on the sticker, in order to verify that he was using her husband's sperm. During the inseminations, Dr. Barwin had Patient J's husband push the plunger on the syringe, which was supposed to contain his sperm.

Patient J conceived through treatment provided by Dr. Barwin twice and had two children: a daughter, born in the early 2000's; and a son, born in the mid-2000's.

In 2016, Patient J saw media coverage about Ms. AA and Ms. BB. Patient J subsequently obtained DNA testing for her children that confirmed that her husband was not their biological father.

Patient J's children are full biological siblings. Through DNA registry websites, Patient J was able to track down the donor that was used to conceive her children. The news that Patient J's children are not the biological children of her husband was very difficult for their family.

Patient K

Patient K attended Dr. Barwin for fertility treatment in around 1991-1993. Patient K underwent 11 artificial insemination procedures provided by Dr. Barwin. The artificial insemination was supposed to be performed using sperm from a donor selected by Patient K from donor profiles provided by Dr. Barwin. Patient K reviewed the donor profiles Dr. Barwin provided and selected a donor based on the donor's medical history. The donor number selected by Patient K was stored in her patient chart, and Dr. Barwin represented to Patient K that all of her inseminations were performed using the donor sperm she had selected.

Patient K conceived through the treatment provided by Dr. Barwin, and her son was born in the early 1990's.

Patient K decided to have a second child, and returned to Dr. Barwin for further artificial inseminations after her son was born. The insemination was supposed to be performed by Dr. Barwin using the same donor she had chosen for her son. Dr. Barwin knew that Patient K wanted her son to have a full biological sibling.

Patient K became pregnant again through the treatment provided by Dr. Barwin, and had a daughter, born in the early 1990's.

After her daughter was born, Patient K requested a copy of the donor profile she selected from Dr. Barwin. Dr. Barwin provided Patient K with a donor profile that was not the one she had selected for her children. When Patient K pointed out to Dr. Barwin that the profile she had been given was not the donor she had selected, Dr. Barwin told Patient K that she should just be happy that she had two children. Patient K was upset, because it was important to her for Dr. Barwin to have used the donor selected and to have the information about that donor.

After seeing media coverage about the lawsuit against Dr. Barwin, Patient K obtained DNA testing for her children, which confirmed that they are biological maternal half-siblings, rather than biological full siblings. This confirmed that, contrary to what she had been told at Dr. Barwin's clinic, Dr. Barwin did not use the same donor for both of her children.

Patient L

Patient L went to see Dr. Barwin for fertility treatment in around 1994-1996. She underwent artificial insemination provided by Dr. Barwin. The artificial insemination was supposed to be performed by Dr. Barwin using donor sperm. Dr. Barwin provided Patient L with background information on the donor, including ancestry, height, and eye colour.

Patient L conceived through the treatment provided by Dr. Barwin, and her son was born in the early-1990's.

Patient L returned to Dr. Barwin for further artificial insemination after her son was born. Dr. Barwin was supposed to perform the insemination with the same sperm donor as was used for her son.

Patient L conceived again, and her daughter was born in the mid 1990's.

Patient L's two children have undergone DNA testing, which confirmed that they are not biological full siblings, and that Dr. Barwin did not use the same donor sperm for both of Patient L's children.

Patient M

Patient M and her husband went to see Dr. Barwin for infertility treatment in 2002. Patient M's husband had previously frozen his semen prior to receiving treatment for a medical condition. Patient M underwent a number of artificial inseminations provided by Dr. Barwin. Dr. Barwin was to use the sperm Patient M's husband had previously frozen and provided to Dr. Barwin. At the appointments, Dr. Barwin showed Patient M the straw with her husband's name and birth date on it in order to verify that he was using her husband's sperm.

Patient M conceived through the treatment provided by Dr. Barwin, and her daughter was born in the early 2000's.

After Patient M saw media coverage about Dr. Barwin, she obtained DNA testing for her daughter. The DNA test confirmed that her daughter is not the biological daughter of Patient M's husband.

Patient M's daughter grew up believing Patient M's husband to be her father. Patient M and her husband have not told their daughter that Patient M's husband is not her biological father. Patient M and her husband have had a difficult time as a result of the news that Patient M's husband is not her child's father.

College Expert

The College retained Dr. Edward G. Hughes, an experienced obstetrician/gynecologist who practises fertility medicine and works as a faculty member at McMaster University, to review this matter and opine on Dr. Barwin's care. In his reports, Dr. Hughes opined as follows:

> *Was Dr. Barwin's care below the standard for the relevant time period?*
>
> My response to this question is based on the practice of other REI [Reproductive Endocrinology and Infertility] clinics and physicians at that time and what was taught to Residents and Fellows in training. It was always made clear to these clinicians, that preparing and administering gametes to patients is a very serious process with a debt of care to both the potential parent(s) and unborn children. As

such, profound care and diligence were expected and required in this process, similar in many ways to the administration of a blood transfusion or the transplantation of an organ. Failure to get this right could result in serious harm to recipients and their children. And yet the actual process of handling and administering gametes was and is, straightforward. It requires great care and attention to detail, but the steps required are simple: careful cleaning, preparation, identification and labeling, careful handling of gametes then multiple cross-checking with staff and the recipient-patient(s). Careful, accurate and secure record keeping is also mandatory. This degree of care and attention ensures that patients receive the correct sample: the one with which they expected to be inseminated.

Dr. Barwin's handling and administration of gametes to his patients fell well below the expected standard of care. […] That standard was to provide safe, effective and secure management of patients' gametes, to communicate with them clearly and honestly about the nature of the husband- or donor- sample being used for insemination and to keep accurate and complete records of what has transpired. Repeatedly, over several decades, his care fell below this standard. However, it is the scale of this deficiency that's startling, with up to 51 cases so far identified with the wrong paternal DNA and 11 so far identified with Dr. Barwin's as the biological father."

Lack of knowledge, skill or judgment?

…

Though it's hard to be certain, Dr. Barwin was likely well informed and up to date with developments at the time. However, the extraordinary number of cases involving the administration of incorrect samples to patients, suggest that he lacked the basic skills required and expected, in the management of samples and records relating to them.

Regarding the insemination of patients with his own sperm, could lack of knowledge or skill have been to blame? Dr. Barwin suggested to two patients that his paternity must have occurred as a result of accidental contamination, resulting form *[sic*] his failure to clean an automated counting chamber that he tested using his own sperm (explanation given to Patient B's husband, Ms. BB's father…). He told Ms. BB and her father that "at the time I was testing a new automated sperm counter and used my own sample as a control" (email to Ms. BB's father).

Dr. Hughes considered Dr. Barwin's explanation involving Dr. Barwin's use of an automated sperm counter, which Dr. Barwin provided to Ms. BB and Patient B's husband as the reason for him being the biological father of Ms. BB. Dr. Hughes outlined several reasons why Dr. Barwin's explanation is implausible, and concluded that it could not have been the cause of all of the errors:

> "Counting" sperm is a process that uses only a tiny aliquot of the whole semen sample and that aliquot is always subsequently discarded. It usually measures between 5070 microliters or approximately 3% of a 2.5ml ejaculate. The aliquot is taken from the whole sample with a clean, sterile, disposable plastic micropipette tip and placed on a microscope slide or into an automated counting chamber for evaluation. The micro-pipette tip used to draw up the aliquot is immediately discarded, once the 75 microliter droplet has been placed into the counting chamber. Once that evaluation is done, whether manually or automatically, that slide is also discarded. The micro-drop of semen assessed is never, ever, reintroduced into the sample being processed for insemination. Failure to clean the counting chamber might thus interfere with and confound the counting of the next sample to be evaluated, but would not introduce any of Dr. Barwin's sperm into the patient's insemination sample
>
> …
>
> For a single pregnancy to have occurred in these ways would have been remarkable. For eleven pregnancies to have been sired in this way, over two or more decades is neither statistically plausible nor believable
>
> …
>
> … Even if Dr. Barwin had continued to make the same error over and over again, because he was testing yet another 'new automated sperm counter,' the 11 pregnancies so far identified from his sperm would simply not have been conceived, based on the above explanations and probabilities. The use of his own sperm thus appears to be unrelated to poor skill, knowledge or judgment.

Dr. Hughes opined on whether Dr. Barwin's actions caused harm to patients:

> *…* Dr. Barwin's actions have resulted in significant pain and suffering that will extend forward through future generations, as offspring have their own children and grandchildren.
>
> Whether Dr. Barwin's actions were accidental or willful, the suffering he has caused remains deep and wide. Husbands and partners have

been denied a genetic link to their offspring. Siblings now find that not only do they have an unknown man as their biological parent, they are not paternally related to each other. Mothers expecting their husbands' sperm or those of a particular donor's to be used, instead have conceived and birthed biologically unrelated children.

Offspring are living an avoidable genetic disconnection from their fathers and have no access to their genetic heritage. This clearly has and will continue to create stress, angst and pain among families. The children whom Dr. Barwin fathered himself are burdened in these and other even more profound ways. They know that their own DNA and that of their children and beyond, will always be linked to him and his actions.

…

It is thus clear that Dr. Barwin's insemination practice leaves in its wake, deep, wide and extraordinary harm to the parents who in good faith and trust, sought his care and to their affected offspring. His patients trusted him.

…

The children whom Dr. Barwin's patients bore, also attest to the pain he caused. The sample of interviews conducted by Ms. Jenereaux sheds some light on the scope of this harm, but many other voices have not informed this report. Some of those are seeking redress through a class action suit, but still other patients may be suffering in silence because fear or shame prevents them from coming forward. It is impossible to know who many of those cases exist, but it seems likely to me that patients who know about, but have been unable to face up to their circumstances, may actually be suffering more acutely and deeply than those who have come forward, because they have no options for support or redress.

Remember too, that many patients in a fertility practice fail to conceive. As many as half of the couples presenting for care may remain childless, because of advanced maternal age and other negative prognostic factors. Thus, for 51 children to have been born with incorrect sperm heritage, as many as 100 may have received the wrong sperm during their treatment. And for 11 babies to have been born as a result of Dr. Barwin inseminating women with his own sperm, others were very likely subjected to it, but failed to conceive. The point here is that we are seeing some of the scope of harm, but not all of it.

Dr. Hughes concluded:

> Clearly, when delivering care to patients, accidental harm occasionally occurs, despite due diligence and adherence to the standard of care. The appropriate response to such accidental harm is to understand and learn from what has happened, take responsibility for any avoidable elements and make redress for those. Did Dr. Barwin adhere to these standards? With regard to the 51 babies conceived with the 'wrong sperm,' clearly not. Regarding the use of his own sperm, could Dr. Barwin have done this accidentally? With eleven offspring so far identified and an implausible explanation given to two of them, again I believe not.
>
> Did Dr. Barwin's practice fall below the standards of care for that time? Absolutely.
>
> Was his knowledge below standard? Uncertain.
>
> Were his skills below standard? Yes.
>
> Was his judgment below standard? Yes.
>
> Was harm done to patients? Yes. This is a tragic situation, in which a sea of avoidable harm was done.

Dr. Barwin's History with the College

On February 15, 2012, Dr. Barwin entered into an undertaking with the College to voluntarily cease the practice of artificial insemination and intrauterine insemination (IUI).

Dr. Barwin was the subject of a Discipline Committee hearing on January 31, 2013 regarding errors in his IUI practice. The hearing proceeded by way of an agreed statement of facts and admission. Dr. Barwin admitted that in two cases, he failed to use the donor sperm selected by the patients, and that in two other cases, unbeknownst to the patients, he failed to use the patients' husbands' sperm. The Committee ordered a two month suspension of his certificate of registration, a reprimand, and costs.

Following another complaint involving a child conceived with sperm that did not match the intended father, Dr. Barwin entered into an undertaking effective August 30, 2014, resigning his certificate of registration with the College.

Disposition

On June 25, 2019, the Discipline Committee ordered that:

- The Registrar revoke Dr. Barwin's certificate of registration effectively immediately.
- Dr. Barwin attend before the panel to be reprimanded.
- Dr. Barwin pay costs to the College in the amount of $10,370.00 within 30 days of the date of this Order.

2. Dr. F. T. Bray

Name:	Dr. Frederick Thomas Bray
Practice:	Gastroenterology
Practice Location:	Ottawa
Hearing:	Agreed Statement of Facts on Liability Penalty – Joint Submission
Finding/Penalty Decision Date:	June 18, 2019
Written Decision Date:	August 12, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Bray is a 54 year old gastroenterologist practising in Ottawa, Ontario. Dr. Bray received his certificate of registration authorizing independent practice in Ontario in 1992. Dr. Bray received his specialist qualification in internal medicine in 1993 and in gastroenterology in 2000.

The Out-of-Hospital Premises Inspection Program, "OHPIP", is administered by the College and applies to all premises outside a hospital ("OHP premises") that perform procedures involving the use of anesthesia or sedation as defined in O.Reg. 114/94, made under the *Medicine Act, 1991*, ("the Regulation"). Part XI of the Regulation sets out the definition of "procedure" for the purposes of the OHPIP. The OHP program is based on trust and relies on self-reporting from Medical Directors and physicians.

Mandatory standards for OHP premises are set out in Program Standards ("the Standards"), authorized under the Regulation. Pursuant to Standard 2.2, the Medical Director of an OHP is responsible for the duties outlined in the Standards. In order to ensure patient safety and quality of care, strict adherence is required to the detailed requirements set out in the Standards.

As set out Standard 3.2, "Anesthesia", medications producing "deep sedation", including propofol, "must be administered by a physician qualified to provide deep sedation". This point is further clarified in Standard 5.3 that states that general anesthesia can only be administered by an anesthesiologist.

By letter dated May 17, 2016, sent to all Medical Directors of OHPs, including Dr. Bray, Dr. Steven Bodley, then-chair of the Premises Inspection Committee ("PIC"), reminded Medical Directors that OHP Standard 3.2 required that only a qualified anesthesiologist is permitted to administer propofol.

Disgraceful, Dishonourable or Unprofessional Conduct

In contravention of Program Standards and his duties as Medical Director, Dr. Bray administered propofol to patients, in the absence of an anesthesiologist or any other physician qualified to administer propofol in accordance with the Standards.

On July 19, 2017, the OHPIP conducted an inspection-assessment of Dr. Bray's OHP. The inspection–assessment included a review of the premises' controlled substances storage and included review of the care provided by the premises to sedated patients. Dr. Bray did not advise the assessors that he was using propofol despite the fact that the assessors reviewed his practices and procedures around sedation and controlled substances.

The College became aware of Dr. Bray's use of propofol through an anonymous report made to the College on August 3, 2017. As a result of the report, the College conducted an unannounced visit on August 24, 2017, and verified that Dr. Bray was administering propofol to patients without an anesthesiologist.

Twenty-five (25) patient charts were obtained in the College investigation. The charts were reviewed by an expert retained by the College, Dr. Ted Xenodemetropoulos, a gastroenterologist**.** As set out in Dr. Xenodemetropoulos' report, Dr. Bray administered propofol to eleven (11) patients in contravention of Program Standards, in the absence of an anesthesiologist.

Failure to Maintain Standard of Practice

In respect of the eleven (11) patients to whom propofol was administered by Dr. Bray in the absence of an anesthesiologist, Dr. Xenodemetropoulos opined that Dr. Bray failed to maintain the standard of practice in his administration of intravenous propofol as additional sedation during procedures and displayed a moderate lack of judgment both in his role as Medical Director of the OHP and as most responsible physician to the patients in question.

Dr. Xenodemetropoulos concluded that Dr. Bray's use of propofol did not result in an increased risk of harm or injury in a sedation-related adverse event to the patients.

Disposition

On June 18, 2019, the Committee ordered that:

- The Registrar suspend Dr. Bray's certificate of registration for a period of 4 months.
- Dr. Bray attend before the panel to be reprimanded.
- Dr. Bray pay costs to the College in the amount of $6000.00

3. Dr. J. M. Brown

Name:	Dr. Jeffrey Marlowe Brown
Practice:	Family Medicine
Practice Location:	Thornhill
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	May 10, 2019
Written Decision Date:	June 24, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Brown is a 58 year old physician practising Thornhill, Ontario in the areas of weight loss and complementary/alternative medicine. Dr. Brown received his certificate of independent practice from the College in 1988.

The College commenced an investigation into Dr. Brown's practice in 2014, followed by investigations into two public complaints received in 2014 and 2017.

As part of its investigation, the College obtained independent opinions from Dr. Michael Lyon, a physician who practices in the area of medical weight management, Dr. Jennifer Pearlman, a physician who practices in the area of women's health and wellness, including complementary/alternative medicine and bio-identical hormone replacement therapy, and Dr. Pauline Pariser, a primary care physician. Dr. Pearlman reviewed 25 of Dr. Brown's patient charts, while Dr. Lyon reviewed 24 patient charts and observed 6 of Dr. Brown's patient encounters. Dr. Pariser reviewed Dr. Brown's patient records for his family members. In its investigation of the one of the public complaints, the College also obtained an independent opinion from Dr. Yoni Freedhoff, a physician who practices in office-based weight management.

Dr. Brown obtained opinions from Dr. Esther Konigsberg, a physician who practices complementary/alternative medicine and bio-identical hormone replacement therapy, and Dr. Deborah Martin, a physician who practices in metabolic medicine.

Failure to Maintain the Standard Of Practice Of The Profession

Record-Keeping

The charts reviewed were obtained by the College from Dr. Brown's practice in 2014 and included care in some cases provided as far back as ten years of patients that entered and exited the weight loss program, restarting the weight loss program often

many times over the years. Dr Brown's practice was to re-assess patients at each restart and create a new chart, including a new patient history profile and CPP.

The expert reviews of Dr. Brown's medical records revealed a number of deficiencies in Dr. Brown's charting, including:

a) *Organization:* Dr. Brown's charts were disorganized, with test results and patient history profiles inserted throughout the chart and sometimes duplicated, and with no way to identify who made a particular chart entry other than Dr. Brown;

b) *Legibility:* Dr. Brown's chart entries were frequently illegible;

c) *Completeness:* In a number of charts, Dr. Brown did not document physical examinations, or record in the chart key relevant information about weight loss patients such as height, body mass index (BMI), or relevant diagnoses such as diabetes or metabolic syndrome;

d) *Consent:* Dr. Brown did not clearly document informed patient consent to receive Complementary/Alternative Medicine in accordance with College Policy #3-11, *Complementary/Alternative Medicine*;

e) *CPPs:* Dr. Brown did not have complete Cumulative Patient Profiles in a number of charts;

f) *Prescribing:* Dr. Brown failed to clearly state prescription and supplement additions in a number of patient charts;

g) *Testing:* Dr. Brown did not always record tests that he ordered or lab work received in the patient charts; and

h) *Rationale for testing or prescribing:* Dr. Brown failed to document his rationale for ordering tests or for prescribing medications despite normal test results in a number of charts.

Since the commencement of the investigation Dr. Brown voluntarily enrolled in and successfully completed the University of Toronto Medical Record Keeping course on November 16, 2016.

Complementary/Alternative Medicine

Dr. Brown's provision of Complementary/Alternative Medicine was deficient in that:

a) Dr. Brown did not always reach a conventional diagnosis; and
b) In one instance, in his prescribing of transdermal estrogen therapy.

Treatment of Family Members

Dr. Pariser opined that Dr. Brown failed to maintain the standard of practice of the profession by providing treatment to his family member in circumstances that were not episodic or emergent, contrary to College Policy #7-06, *Physician Treatment of Self, Family Members or Others Close to Them*, including completing a requisition for saliva hormone testing and allergy blood testing. Dr. Pariser opined that Dr. Brown's conduct did not expose his family member to risk of harm.

Disgraceful, Dishonourable or Unprofessional Conduct

Conduct Towards College Investigators

On March 12, 2015, College Investigators attended at Dr. Brown's office in order to notify him of an investigation into a patient complaint and to obtain relevant information and records, including a patient chart and supplement sample. Dr. Brown became upset with the investigators, and began to speak loudly and angrily. Dr. Brown interrupted the investigators and made disparaging comments about the investigators and disputed their authority to obtain the charts and the supplements. Dr. Brown subsequently provided the requested materials and apologized to the investigator for his conduct.

Disposition

On May 10, 2019, the Discipline Committee Ordered that:

- Dr. Brown attend before the panel to be reprimanded.
- The Registrar suspend Dr. Brown's certificate of registration for a period of two (2) months effective June 10, 2019.
- The Registrar impose the following terms, conditions and limitations on Dr. Brown's certificate of registration:
  (a) Dr. Brown shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation";
  (b) Dr. Brown shall, within six (6) months of the end of the period of the suspension, complete professional education in communications and ethics acceptable to the College;
  (c) Within sixty (60) days of the date of this Order, Dr. Brown shall obtain a clinical supervisor acceptable to the College, who will supervise Dr. Brown for a period of twelve (12) months, and who will sign an undertaking in the form attached hereto as Schedule "A" (the "Clinical Supervisor");
  (d) The Clinical Supervisor will meet with Dr. Brown initially to discuss practice improvement recommendations;
  (e) The Clinical Supervision shall be at a moderate level for three (3) months, commencing on the date following the expiry of the suspension of Dr. Brown's certificate of registration. During moderate level supervision, the Clinical Supervisor will meet with Dr. Brown monthly, review a minimum of twenty (20) of Dr. Brown's patient charts and observe Dr. Brown's patient encounters for one (1) day at each meeting, and discuss Dr. Brown's patient care and documentation, identify any concerns regarding the care and documentation, make recommendations for improvement, and provide a report to the College each month;
  (f) After three (3) months, with approval of the College and on the recommendation of the Clinical Supervisor, the Clinical Supervision shall be at a low level for the remainder of the period of Clinical Supervision. During low level supervision, the Clinical Supervisor will review a minimum of twenty (20) of Dr. Brown's patient charts per month, and discuss with Dr. Brown his patient care and documentation, identify any concerns regarding the care and

documentation, make recommendations for improvement and report to the College every three (3) months;

(g) Within six (6) months after the completion of the Clinical Supervision, Dr. Brown will submit to a reassessment of his practice (the "Reassessment") by an assessor or assessors selected by the College (the "Assessor(s)"). The Reassessment may include a chart review, direct observation of Dr. Brown's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. The results of the Reassessment will be reported to the College and may form the basis of further action by the College;

(h) Dr. Brown shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor(s) with respect to practice improvements and education;

(i) Dr. Brown shall consent to the disclosure by the Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Brown's compliance with this Order. This shall include, without limitation, providing the Clinical Supervisor with any reports of any assessments of Dr. Brown's practice in the College's possession;

(j) If a Clinical Supervisor who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Brown shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time;

(k) If Dr. Brown is unable to obtain a Clinical Supervisor in accordance with paragraphs 4(b) or 4(g) of this Order, he shall cease practising medicine until such time as he has done so, and the fact that he has will constitute a term, condition or limitation on his certificate of registration until that time;

(l) Dr. Brown shall co-operate with unannounced inspections and shall consent to the monitoring of his OHIP billings of his Practice by a College representative(s), for the purpose of monitoring and enforcing his compliance with the terms of this Order;

(m) Dr. Brown shall inform the College of each and every location that he practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location; and

(n) Dr. Brown shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Brown pay the College costs in the amount of $6000, within thirty (30) days of the date of this Order.

4. Dr. A. P. Denys

Name:	Dr. Allen Phillip Denys
Practice:	Respirology
Practice Location:	Windsor
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	May 13, 2019
Written Decision Date:	July 3, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Denys is a 68 year old respirologist practising in Windsor, Ontario who received his certificate of registration authorizing independent practice in 1977.

On August 24, 2016, the College received information from a physician who had previously practised under the supervision of Dr. Denys at the Windsor Sleep Disorders Clinic. The physician expressed concern that Dr. Denys routinely ordered pulmonary function tests without appropriate clinical indication for patients referred to the Windsor Sleep Disorders Clinic. On the basis of this information, the Inquiries, Complaints and Reports Committee of the College (the "ICRC") approved the appointment of investigators under section 75(1)(a) of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act,* 1991 (the "Code") in order to conduct a broader investigation into Dr. Denys's practice.

Investigation into Dr. Denys's Practice

Facilities in which Dr. Denys and his family members have or had an interest

At the relevant times, Dr. Denys was the Quality Advisor and an interpreting physician at a sleep medicine clinic known as the Windsor Sleep Disorders Clinic. The Windsor Sleep Disorders Clinic is an Independent Health Facility, which is permitted pursuant to a license to bill facility fees to OHIP. Dr. Denys's daughter was the sole shareholder of the corporation that held the license to operate this Independent Health Facility.

Dr. Denys is the Quality Advisor and the main interpreting physician at a pulmonary function lab known as Essex County Respiratory Services, an Independent Health Facility. Dr. Denys's daughter is the sole shareholder of the corporation that holds the license to operate this Independent Health Facility.

Dr. Denys is also the Quality Advisor and the main interpreting physician for pulmonary function tests at a pulmonary function and diagnostic imaging facility known as Essex County Diagnostic Services, an Independent Health Facility. One of the daughters is the sole shareholder of the corporation that holds the license to operate this Independent Health Facility.

In addition, Dr. Denys's brother is the sole shareholder of the corporation known as Denys Sleep Supplies and Services Inc., which is operated from the same location as the Windsor Sleep Disorders Clinic and which is described as a "Patient liaison to facilitate the purchase of sleep equipment and sleep supplies for treatment of sleep apnea".

Failure to Maintain the Standard of Practice of the Profession

The College retained Dr. Raymond Gottschalk, a respirologist who practises both sleep medicine and respirology, to opine on Dr. Denys's care and treatment of patients at the Windsor Sleep Disorders Clinic. Dr. Gottschalk conducted a review of 50 patient charts of patients from the Windsor Sleep Disorders Clinic, along with those patients' OHIP data, and interviewed Dr. Denys on August 17, 2017. His report was received by the College on August 30, 2017.

Dr. Gottschalk noted that in almost every chart reviewed, patients were booked for a pulmonary function test immediately upon referral to the Windsor Sleep Disorders Clinic. Dr. Gottschalk opined that there was no clinical indication for such testing evident on the face of the referral nor had the patient been evaluated in person by Dr. Denys. In addition, although routine pulmonary function tests were booked on almost all patients, Dr. Gottschalk opined that the results of such testing were not addressed in the consultation reports to the referring physicians nor were abnormalities identified or treatments recommended.

In addition, Dr. Gottschalk opined that there were other significant areas of concern with Dr. Denys's sleep medicine practice, including that:

- There was no effective initial triage process to distinguish between severe patients and routine patients. All patients appeared to be treated with the same strategy without evaluating the severity of the condition for which they were referred;
- There was a failure to report unsafe drivers to the Ministry of Transportation or to recommend to patients that they not drive;
- The presenting complaint was not addressed in the consultation report provided by Dr.
  Denys to the referring physician;
- There was no effective triage following sleep studies, with the result that some patients with extremely severe sleep apnea experienced 6-9 month delays in getting treatment;
- The quality of the sleep study reports and consultation reports provided to the referring physician was poor, with nearly identical assessments and

recommendations regardless of the issues or severity of concerns identified in the sleep study;

- In some cases there was no evidence that the patient had attended for a consultation with Dr. Denys following the sleep study, nor any evidence that attempts had been made to contact the patient or that the referring physician was advised that the patient did not attend for the consultation.

Dr. Gottschalk opined that Dr. Denys failed to meet the standard of practice of the profession in his care and treatment of patients in 45 of the 50 patient charts reviewed, that Dr. Denys demonstrated a lack of knowledge, skill and/or judgment in 44 of the 50 patient charts reviewed, and that Dr. Denys's clinical practice exposed, or was likely to expose, patients to a risk of harm in 25 of the 50 patient charts reviewed.

Dr. Denys provided responses outlining the changes to his practice to address the concerns of Dr. Gottschalk. Dr. Gottschalk reviewed Dr. Denys's responses, with reference to the specific patient charts, and delivered addendum reports dated November 24, 2017 and January 7, 2018.

Disgraceful, dishonourable and unprofessional conduct

As indicated in the reports of Dr. Gottschalk, Dr. Denys ordered pulmonary function tests without appropriate clinical indication. Dr. Denys's daughters own the licenses of Essex County Respiratory Services and Essex County Diagnostic Services, the Independent Health Facilities where the pulmonary function tests were performed, and Dr. Denys is the main interpreting physician for pulmonary function tests at both facilities.

Referring patients for testing without appropriate clinical indication and from which he and his family members received a benefit constitutes disgraceful, dishonourable and unprofessional conduct. In addition, Dr. Denys failed to comply with conflict of interest requirements, which also constitutes disgraceful, dishonourable and unprofessional conduct.

Dr. Denys failed to inform the College of his conflicts of interest in respect of Windsor Sleep Disorders Clinic, Essex County Respiratory Services, Essex County Diagnostic Services and Denys Sleep Supplies and Services Inc. until he submitted the Conflict of Interest declaration forms on August 16, 2017.

Interim Undertaking

On March 6, 2018, the ICRC directed that Dr. Denys enter into an Undertaking in lieu of imposing an Order pursuant to s. 25.4(1) of the Code (the "Section 25.4 Undertaking"). The Section 25.4 Undertaking provides that Dr. Denys must practise sleep medicine under the supervision of a Clinical Supervisor until the disposition of the allegations referred to the Discipline Committee.

On April 12, 2019, Dr. Denys entered into an Undertaking with the College in which he agreed to cease practising sleep medicine in all jurisdictions and to never resume doing so.

Disposition

On May 13, 2019, the Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Denys's certificate of registration for a period of four (4) months, commencing from May 14, 2019 at 12:01 a.m.
- the Registrar place the following terms, conditions and limitations on Dr. Denys's certificate of registration:
  - Dr. Denys will participate in and pass the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals (CPEP), with a report or reports to be provided by CPEP to the College regarding Dr. Denys's progress and compliance. Dr. Denys will complete this requirement within 6 months, or, if it is not possible to do so within 6 months, at the first available PROBE Ethics & Boundaries program for which Dr. Denys is eligible.
- Dr. Denys attend before the panel to be reprimanded.
- Dr. Denys pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

5. Dr. S. J. Goldstein

Name:	Dr. Sol Julian Goldstein
Practice:	Psychiatrist
Practice Location:	Toronto
Hearing:	Statement of Uncontested Facts and Plea of No Contest Penalty – Joint Submission
Finding/Penalty Decision Date:	June 19, 2019
Written Decision Date:	August 2, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Goldstein is an 80-year-old psychiatrist practising in Toronto, Ontario, who received his certificate of registration authorizing independent practice in 1968.

On the basis of information received from the Health Services Branch of the Ontario Ministry of Health and Long-Term Care (the "Ministry") identifying concerns with Dr. Goldstein's recordkeeping and billing practices, as well as other information, the

College commenced an investigation under section 75(1)(a) of the Health Professions Procedural Code to obtain a broader view of Dr. Goldstein's psychiatry practice.

Investigation of Dr. Goldstein's Practice

The College retained Dr. Ahmed Boachie ("Dr. Boachie"), a psychiatrist and Assistant Professor in the Department of Psychiatry at the University of Toronto, to opine on Dr. Goldstein's psychiatry practice including his documentation and billing practices. Dr. Boachie reviewed 24 patient charts, the associated OHIP billing for 21 patients, and certain other information.

Dr. Boachie opined that Dr. Goldstein's documentation practices fell below the standard of practice of the profession in all 24 of the charts reviewed. In particular, he noted that:

> There is a clear pattern for concern regarding Dr. Goldstein's assessment, documentation, and billing practices. It is practically ubiquitous that:
>
> a) Notes are handwritten and difficult to decipher...;
> b) Notes are very short, or sometimes there is no note at all, but only a date and time period for the appointment; and
> c) Although Dr. Goldstein can clearly assess and formulate mental health disorders, as is evident when he writes letters regarding patients for insurance or legal purposes, there are no assessment notes or formulations written in the chart notes. Nor are there treatment plans.
>
> These practices would make it very difficult for another psychiatrist to take over care of one of Dr.Goldstein's patients, should he be unavailable to them. These documentation practices do not meet minimum standards of care.

Dr. Boachie also opined that Dr. Goldstein's billing practices failed to meet the standard of practice of the profession. He noted:

> With regard to billing practices, there were numerous cases in which dates of treatment that were billed to OHIP did not have corresponding dates and/or chart notes in the patients' files. In some cases, billing dates were not in sequence, not even roughly in sequence, but all over the place. These concerns require further investigation.

Dr. Boachie interviewed Dr. Goldstein and submitted a further report following that interview. He noted that:

> Dr. Goldstein appeared to have a very good memory of events when prompted, but because of inadequate documentation there were still certain cases where we could not get a clear idea why many decisions were made. He could also

> not give any appropriate explanation for the discrepancies in OHIP billing described in my first report.

Dr. Boachie, in his reports, raised certain issues with regard to Dr. Goldstein's patient charts in assessments conducted for use in family court or in cases of family conflict. As Dr. Boachie did not practice in this area, the College retained Dr. Anthony Pignatiello, the Associate Psychiatrist-in-Chief at the Hospital for Sick Children, to review certain patient records previously reviewed by Dr. Boachie. Dr. Pignatiello reviewed five patient charts and interviewed Dr. Goldstein.

As with Dr. Boachie, Dr. Pignatiello's review identified issues related to Dr. Goldstein's documentation and billing. In particular, in his report Dr. Pignatiello commented:

> The patient files of Dr. Goldstein reviewed were consistently very disorganized, unclear, vague, often times with scant information provided. In some sections dates of service were identified; however, no content was written. Two of the files had beginning elements of an assessment note whereas with others there was no evidence of any assessment. There was no clear approach to an impression, formulation or clear management plan, nor was there any periodic review of the service provided or further plans of action… There was also unclear documentation required for billing purposes

Dr. Goldstein's inadequate documentation and billing as set out in the reports of Dr. Boachie and Dr. Pignatiello is unprofessional.

Relevant History

On August 27, 1999, the General Manager of the Ontario Health Insurance Plan ("OHIP"), based on the recommendation of the Medical Review Committee of the College (the "MRC"), directed Dr. Goldstein to reimburse OHIP for billing in the amount of $54,705.49.

In 2013, the Health Services Branch of the Ontario Ministry of Health and Long-Term Care (the "Ministry") requested repayment by Dr. Goldstein of certain OHIP claims in the amount of $10,740, comprising those claims without any corresponding patient record for the encounter billed, and those claims where the records were created months after the patient encounter.

Dr. Goldstein repaid approximately $7,500, comprising only those claims without any corresponding patient record for the encounter billed.

Disposition

The Discipline Committee ordered that:

- Dr. Goldstein attend before the panel to be reprimanded.

- The Registrar suspend Dr. Goldstein's certificate of registration for a period of three (3) months, commencing from June 27, 2019 at 12:01am.
- The Registrar place the following terms, conditions and limitations on Dr. Goldstein's certificate of registration:
  a. Dr. Goldstein shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "A" to this Order;

  PROBE Program

  b. Dr. Goldstein shall participate in and unconditionally pass the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, with a report or reports to be provided by the provider to the College regarding Dr. Goldstein's progress and compliance. Dr. Goldstein shall complete this requirement within six (6 months) of the date of this Order.

  Clinical Supervision

  c. Within twenty (20) days of this Order, Dr. Goldstein shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor") with respect to his psychiatry practice, who has signed an undertaking in the form attached hereto as Schedule "B".
  d. For a period of twelve (12) months commencing on the date that Dr. Goldstein resumes practice following the suspension of his certificate of registration, Dr. Goldstein may practise psychiatry only under the supervision of the Clinical Supervisor ("Clinical Supervision"), who shall facilitate the education program set out in the Individualized Education Plan ("IEP"), attached hereto as Schedule "C"; as follows:
  e. For an initial period of two (2) months, Dr. Goldstein will meet with the Clinical Supervisor every week, at which meetings the Clinical Supervisor will:
     i. review a minimum fifteen (15) of Dr. Goldstein's patient records, to be selected at the sole discretion of the Clinical Supervisor, and the associated OHIP claims submissions or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Goldstein;
     ii. make recommendations to Dr. Goldstein for practice improvements and ongoing professional development, and inquire into Dr. Goldstein's compliance with the recommendations; and
     iii. keep a log of all patient charts reviewed along with patient identifiers.
  f. After the initial period of two (2) months, if the Clinical Supervisor is satisfied that Dr. Goldstein's patient records and associated OHIP billings reflect the knowledge, skills and judgment necessary for Dr. Goldstein to

practise in a less highly supervised environment, the Clinical Supervisor may recommend to the College that supervision be reduced for the balance of the Clinical Supervision period of twelve (12) months.

g. Upon the recommendation of the Clinical Supervisor and approval of the College of a reduction in supervision, Dr. Goldstein will meet with the Clinical Supervisor every month, at which meetings the Clinical Supervisor will:

   i. review a minimum fifteen (15) of Dr. Goldstein's patient records, to be selected at the sole discretion of the Clinical Supervisor, and the associated OHIP claims submissions or planned OHIP claims submissions, and discuss any issues or concerns arising from this review with Dr. Goldstein;

   ii. make recommendations to Dr. Goldstein for practice improvements and ongoing professional development, and inquire into Dr. Goldstein's compliance with the recommendations; and

   iii. keep a log of all patient charts reviewed along with patient identifiers.

Other Elements of Clinical Supervision

h. Throughout the period of Clinical Supervision, Dr. Goldstein shall abide by all recommendations of his Clinical Supervisor regarding his recordkeeping and OHIP billing, practice improvements, and ongoing professional development.

i. The Clinical Supervisor shall submit written reports to the College at least once every month, or more frequently if the Clinical Supervisor has concerns about Dr. Goldstein's standard of practice.

j. If a person who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its provisions, Dr. Goldstein shall, within twenty (20) days of receiving notice of the same, ensure that an executed undertaking is delivered to the College in the same form from a similarly qualified person who is acceptable to the College.

k. If Dr. Goldstein is unable to obtain a Clinical Supervisor as set out in this Order, he shall cease practising medicine until he has obtained a Clinical Supervisor acceptable to the College.

l. If Dr. Goldstein is required to cease to practise medicine as a result of section (5)(k) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register.

Reassessment of Practice

m. Approximately six (6) months after the completion of Clinical Supervision, Dr. Goldstein shall undergo a reassessment of practice by a College-appointed assessor (the "Assessor"). The re-assessment shall include a review of Dr. Goldstein's patient charts and associated OHIP claims

submissions or planned OHIP claims submissions. The results of the re-assessment shall be reported to the College.

n. Dr. Goldstein shall consent to such sharing of information among the Assessor, the Clinical Supervisor, and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

Monitoring

o. Dr. Goldstein shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

p. Dr. Goldstein shall cooperate with unannounced inspections of his practice, patient charts and OHIP claims submissions by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

q. Dr. Goldstein shall consent to the College's making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.

r. Dr. Goldstein shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Goldstein pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

6. Dr. R. Kumra

Name:	Dr. Rajiv Kumra
Practice:	Family Physician
Practice Location:	Toronto
Hearing:	Statement of Facts and Plea of No Contest Penalty – Joint Submission
Finding/Penalty Decision Date:	June 17, 2019
Written Decision Date:	July 22, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- conduct unbecoming a physician – **withdrawn**
- incompetence - **withdrawn**

Summary

Dr. Kumra is a 55 year old family physician practising in Toronto, Ontario who received his certificate of registration authorizing independent practice from the College on June 27, 1989.

At the relevant time, Dr. Kumra practised in the greater Toronto area at the following locations:

(a) Six Points Plaza Clinic ("Six Points Clinic");
(b) Tretheway Clinic;
(c) Lawrence Avenue Clinic; and,
(d) Pickering Clinic.

Disgraceful, Dishonourable or Unprofessional Conduct - OHIP Billing

Between 2012 and 2017, Dr. Kumra engaged in disgraceful, dishonourable or unprofessional conduct by billing the Ontario Health Insurance Plan ("OHIP") and receiving remuneration for services he did not provide. When a single patient attended Dr. Kumra's office he directed his staff to register as patients, and bill OHIP, for all the members of the individual's family or household (i.e. residing at the same address), notwithstanding that Dr. Kumra did not provide treatment to the family and/or household members at that attendance.

The College's investigation revealed facts including the following:

- On January 14, 2017, Patient A attended Six Points Clinic alone. Her children were not seen by Dr. Kumra on that date. On that date, Dr. Kumra billed OHIP and was paid for services in respect of Patient A and her three children.
- On August 20, 2016, Patient B attended Six Points Clinic alone. Her children were not seen by Dr. Kumra on that date. On that date, Dr. Kumra billed OHIP and was paid for services in respect of Patient B and her five children. Patients B's eldest child attended Dr. Kumra's office on two occasions in August 2016. However, Dr. Kumra billed OHIP and was paid for services in respect of this child on August 14, 20 and 22, 2016.
- On August 27, 2016, Patient C attended Six Points Clinic alone. His children were not seen by Dr. Kumra on that date. On that date, Dr. Kumra billed OHIP and was paid for services in respect of Patient C and his six children.
- On January 14, 2017, Patient D attended Six Points Clinic alone. Her five children were not seen by Dr. Kumra on that date. On that date, Dr. Kumra billed OHIP and was paid for services in respect of Patient D and her five children.
- Patient E attended Six Points Clinic on one or two occasions. Dr. Kumra billed OHIP and was paid for services in respect of Patient E on fifteen occasions between February 28, 2014 and November 1, 2016. On August 20, 2016, Patient E was not seen by Dr. Kumra nor were her six siblings. On that date, Dr. Kumra billed OHIP and was paid for services in respect of Patient E and her six siblings.
- Patient F attended Dr. Kumra's clinic typically one time per year. None of Patient F's ten children attended Dr. Kumra's clinic more than once per year. Dr. Kumra billed OHIP and was paid for services in respect Patient F on 12 occasions between November 24, 2012 and November 14, 2014. On 11 of those 12 occasions, Dr. Kumra billed OHIP and was paid for services in respect of at least ten other members of his household. Patient F's daughter accompanied her father

on one occasion when he visited Dr. Kumra's office. She was not seen or assessed by Dr. Kumra at any time. Dr. Kumra billed OHIP and was paid for services in respect of Ms. F on fourteen occasions between February 1, 2012 and August 28, 2015.

- Patient G has not had more than three patient encounters with Dr. Kumra. None of her six children who reside at the same household had more than a single patient encounter with Dr. Kumra. Dr. Kumra billed OHIP and was paid for services in respect of Patient G on nine occasions between June 10, 2012 and April 2, 2014. Dr. Kumra billed OHIP and was paid for services in respect of five of her children on six dates between June 10, 2012 and April 2, 2014.

The College retained Investigative Research Group ("IRG") to conduct surveillance on Dr. Kumra's medical practices at the Six Points Clinic and the Tretheway Clinic. The information gathered by IRG was reconciled against Dr. Kumra's OHIP billing data for the service dates on which surveillance was carried out. The reconciled data shows that Dr. Kumra billed OHIP and was paid for assessment-based services for individuals who did not attend either clinic and who did not receive assessment-based services from Dr. Kumra.

Surveillance conducted on August 20, 2016 at Six Points Clinic and Tretheway Clinic established:

- A total of 84 individuals were observed entering the two practice locations. Only 67 individuals remained in a practice location for more than three minutes. However, on the same date, Dr. Kumra billed OHIP and was paid for assessment-based services in respect of 97 individuals.
- A total of 19 individuals under the age of 19 were observed entering the two practice locations. However, on the same date, Dr. Kumra billed OHIP and was paid for assessment-based services in respect of 53 individuals 19 years of age or younger.
- A total of 33 males were observed entering the two practice locations. Only 22 remained in a practice location for more than three minutes. However, on the same date, Dr. Kumra billed OHIP and was paid for assessment-based services in respect of 46 males.

Surveillance conducted on September 3, 2016 at Six Points Clinic and Tretheway Clinic established:

- A total of 70 individuals were observed entering the two practice locations. Only 62 remained in a practice location for more than three minutes. However, on the same date, Dr. Kumra billed OHIP and was paid for assessment-based services in respect of 93 individuals.
- A total of 10 individuals under the age of 19 were observed entering the two practice locations. However, on the same date, Dr. Kumra billed OHIP and was paid for assessment-based services in respect of 46 individuals 19 years of age or younger.

- A total of 30 males were observed entering the two practice locations. Only 27 remained in a practice location for more than three minutes. However, on the same date, Dr. Kumra billed OHIP and was paid for assessment-based services in respect of 47 males.

Disgraceful, Dishonourable or Unprofessional Conduct - Special Diet Allowance Forms

The Special Diet Allowance ("SDA") program, administered through Ontario Works, provides additional financial assistance to assist individuals with the costs of a special diet that is required due to an approved medical condition, as confirmed by a healthcare professional, including physicians. Physicians completing SDA forms must satisfy themselves that the patient has the specified condition upon which the special diet allowance is based.

Dr. Kumra engaged in disgraceful, dishonourable or unprofessional conduct by improperly accepting cash from patients in exchange for executing SDA forms and by executing SDA forms without sufficiently assessing the patient, and satisfying himself that the patient has the specified condition upon which the special diet allowance is based.

Between 2010 and 2016, Dr. Kumra improperly charged patients $50 to complete each SDA form in addition to billing OHIP for the same service. In 2016, Dr. Kumra charged patients $100 to complete each SDA form in addition to billing OHIP for the same service.

On two separate occasions between 2013 and 2016, Patient A paid $350 cash for herself and her three children to obtain the completed SDA forms from Dr. Kumra.

In or around September of 2014, because Ontario Works began rejecting SDA forms signed by Dr. Kumra, Dr. Kumra arranged for a physician friend to attend at his clinic once a week to sign SDA forms. Dr. Kumra and his physician friend shared the cash paid by the patients to obtain the SDA forms. This continued for approximately nine months until May of 2015. Around that time, social services resumed accepting SDA forms signed by Dr. Kumra.

Disgraceful, Dishonourable or Unprofessional Conduct - Medical Records

Despite multiple attempts by the College between 2013 and 2017 to obtain Dr. Kumra's patient records, Dr. Kumra failed to produce and maintain complete patient medical records as required under Part V of Ontario Regulation 114/94, made under the *Medicine Act, 1991*. According to Dr. Kumra:

- separate servers have been stolen on at least two occasions, including on one occasion by another physician with whom he shared office space;
- his computer has been hacked at least three times; and,

- separate servers/computers have gone missing on at least three occasions without any explanation (other than one occasion in which Dr. Kumra falsely suggested that the College took it).

Dr. Kumra's claims were not consistent with evidence obtained by the College.

April 24, 2013 Records Request

On April 24, 2013, College investigators attended at Dr. Kumra's Six Points Clinic to obtain 26 patient charts. Dr. Kumra produced only 18 of the requested charts.

Dr. Kumra maintained that the 18 charts obtained by the College were incomplete. He claimed that his EMR server was stolen on May 27, 2012 and his replacement computer had been "hacked" on three occasions. He asserted that he was no longer able to access patient records pre-dating May 28, 2012.

Dr. Kumra's claims were not consistent with evidence obtained by the College. A staff member working for Dr. Kumra in May 2012 specifically recalled that after the purported theft of the EMR server, patient records reappeared on the computer system. In addition, subsequent forensic analysis of Dr. Kumra's server systems retrieved multiple records predating May 28, 2012.

February 17, 2015 Records Request

On February 17, 2015, College investigators attended at Dr. Kumra's Six Points Clinic to obtain a variety of information, including electronic medical records. A server was retrieved by the College from the Six Points Clinic at this visit. Dr. Kumra advised College investigators that the complete medical records could be obtained from the Lawrence Avenue Clinic server.

The College investigators attended at the Lawrence Avenue Clinic later on February 17, 2015, and removed two pieces of computer hardware. However, neither was found to contain an active EMR database or patient records, contrary to the information Dr. Kumra had provided to College investigators.

Prior to College investigators arriving at Lawrence Avenue Clinic, Dr. Kumra took steps to have the EMR server removed from the Lawrence Avenue Clinic.

In an interview with the College on June 22, 2017, Dr. Kumra falsely suggested that during the February 17, 2015 attendance, College investigators removed the "missing" EMR server that purportedly contained the records.

October 6, 2016 Records Request

On October 6, 2016, College investigators attended at the Six Points Clinic to obtain patient records. Dr. Kumra had prior knowledge that the College would be attending the clinic on this date.

At the site visit, the College investigator provided Dr. Kumra with a letter requesting thirty specific patient records. Dr. Kumra advised the College that the EMR server had been stolen and that he does not have a back-up system for his electronic medical records, despite having been previously advised by his EMR provider to implement a backup solution. The College was unable to obtain any patient records.

July 7, 2017 Records Request

On July 7, 2017, College investigators and the College's independent forensic expert attended at Dr. Kumra's Pickering Clinic to obtain thirty specific patient records. Dr. Kumra was not present but College investigators communicated with Dr. Kumra's counsel who was apprised of the College's attendance and activities.

While present at the Pickering Clinic, the College investigators and the independent forensic expert observed from a computer terminal in the Clinic that Dr. Kumra's EMR application was actively connected to an EMR server. College investigators and the independent forensic expert began to search for the EMR server. While present in the Pickering Clinic, the College investigators and the independent forensic expert then observed from a computer terminal, in real time, that the EMR server had been remotely disconnected and taken offline.

The Pickering Clinic is housed in the same building as Pickering Medical Imaging, a facility owned by Dr. Kumra's wife. After the server connection was lost, in an attempt to physically locate the server which had suddenly been disconnected, College investigators went outside the building to a utility closet within Pickering Imaging. The College investigators observed the receptionist from Pickering Medical Imaging standing at the utility closet with a cellphone to her ear, carrying a large bag. The College investigators were not given access to observe the contents of the large bag. The receptionist initially denied, but later admitted, that she was speaking with Dr. Kumra on her cellphone. The College investigators were not able to locate the EMR server.

Dr. Kumra directed the receptionist to disconnect the EMR server while the College was in attendance and to remove it from the premises.

Dr. Kumra claimed he was ill and therefore unable to attend at the office on July 7, 2017 when College investigators (and patients) were waiting. He also claimed that he was too ill to return telephone calls. However, a subsequent review of cellphone and internet records indicates that Dr. Kumra was actively using his phone and was mobile during this time period.

July 8, 2017 Records Request

On July 8, 2017, College investigators attended at the Six Points Clinic and Tretheway Clinic to collect 167 patient records. Dr. Kumra had purportedly treated 26 patients that

morning. Dr. Kumra advised College investigators that he created rough notes for these patient encounters but was unable to produce a single note for these 26 patient encounters.

Failure to Maintain the Standard of Practice of the Profession

On July 19, 2016, the College retained Dr. Jeff Bloom, Family Physician-in-Chief, University Health Network, to provide an opinion as to whether Dr. Kumra maintained the standard of practice of the profession.

Dr. Bloom was provided with records the College was able to obtain from Dr. Kumra's practice and related to Dr. Kumra's patients. These included:

- Patient records obtained in April 2013 from Six Points Clinic;
- EMR records forensically retrieved from Dr. Kumra's server at Six Points Clinic obtained on February 17, 2015;
- Patient records obtained from other health care providers;
- OHIP billing records; and
- SDA forms obtained from Ontario Works.

Dr. Bloom delivered his report dated February 16, 2018. Dr. Bloom reviewed the care and treatment provided in 27 cases and opined that Dr. Kumra failed to maintain the standard of practice of the profession and displayed a lack of judgment including with respect to the completion of SDA forms, his billing practices and his administrative/managerial oversight of his EMR and office practices.

- In many cases, there was no documentation to support the conditions identified on patients' SDA forms;
- Dr. Kumra completed SDA forms for food allergies and intolerances where contradictory medical records existed;
- In many cases, there was no documented history or physical exam to support the significant number of medical imaging studies ordered by Dr. Kumra;
- In some instances, there were multiple versions of documentation for the same visit and/or templated documentation identical to the documentation in other charts;
- There were submissions for OHIP for which there were no patient records; and/or insufficient documentation to support intermediary assessments billed to OHIP; and,
- Dr. Kumra's completion of Mandatory Special Necessities Benefit forms were not substantiated by the pattern of care he provided prior and subsequent to completing the form.

Undertaking with the College

On April 26th, 2019, Dr. Kumra signed an undertaking to resign from the College effective immediately and agreed not to apply or re-apply for registration as a physician

to practise medicine in Ontario or any other jurisdiction in Canada.

Disposition

On June 17, 2019, the Discipline Committee ordered and directed that:
- Dr. Kumra attend before the panel to be reprimanded.
- Dr. Kumra pay costs to the College in the amount of $6,000.00 within thirty (30) days.

7. Dr. M. Savic

Name:	Dr. Mile Savic
Practice:	Family Medicine
Practice Location:	Belleville
Hearing:	Allegations – Contested Penalty- Contested
Finding Decision Date:	December 18, 2018
Penalty Decision Date:	August 23, 2019
Written Decision Date:	August 23, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- contravened a term, condition or limitation on certificate of registration - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence - **withdrawn**

Summary

Dr. Savic is a family physician who formerly practised in Belleville, Ontario. Dr. Savic signed an undertaking with the College in November 2010 in exchange for the College agreeing to withdraw a referral to the Discipline Committee and to terminate a College investigation. As part of the undertaking, Dr. Savic agreed to voluntarily relinquish his prescribing privileges in respect of narcotic drugs, narcotic preparations, controlled drugs and benzodiazepines, and other targeted substances.

The College received information that Dr. Savic may have been in breach of his prescribing restriction and, in February 2016, it requested prescribing data from the Ministry's Narcotics Monitoring System (NMS) for the period from January 2010 to that time. The NMS data that it provided identified instances in which Dr. Savic wrote or authorized prescriptions for clobazam (a benzodiazepine) for Patient C, Vyvanse (an amphetamine derivative and thus a controlled drug) for Patient D, phenobarbital (a controlled drug) for Patient E, and oxazepam (a benzodiazepine) for Patient F. Dr. Savic was specifically prohibited from prescribing each of these medications by the terms of his undertaking.

The Committee found that Dr. Savic prescribed or authorized prescriptions for four drugs after he had entered into an undertaking with the College that prohibited him from doing so and therefore, breached his November 2010 undertaking with the College and contravened a term, limitation or condition on his certificate of registration.

Failed to Maintain the Standard of Practice of the Profession

Prescribing for Patients A and B

Regarding prescribing to Patient A, the College-retained expert stated:

- Dr. Savic displayed a lack of skill in writing prescriptions in that his handwriting was poor and there was a discrepancy between his intended dose and the actual dose prescribed;
- Dr. Savic failed to meet the standard of practice in that he prescribed a third-line antibiotic without any documented reason;
- Dr. Savic showed a lack of knowledge in respect of proper antibiotic dosing and duration of treatment, and failed to meet the standard of practice by prescribing a higher dose for a longer course than what was proposed in guidelines;
- Dr. Savic's prescribing exposed Patient A to the possibility of receiving an ineffective medication or an overdose of medication.

The Committee accepted expert's opinion that Dr. Savic's choice of antibiotic was inappropriate in that Dr. Savic provided no documentation of why he chose a third-line antibiotic. The Committee therefore found that Dr. Savic failed to maintain the standard of practice of the profession in his prescribing to Patient A.

Regarding Patient B, the College retained expert opined that Dr. Savic's prescribing for Patient B displayed a lack of judgment in that he wrote ongoing prescriptions for gabapentin at escalating doses without any comprehensive assessment, management plan, or documented reasons for the choice of gabapentin or increasing doses. In these actions, Dr. Savic exposed Patient B to a risk of harm such as the use of inappropriate medication, interactions with other medications, and side effects such as drowsiness. The Committee accepted Dr. Law's opinion, and found that Dr. Savic failed to maintain the standard of practice of the profession in his prescribing to Patient B.

Ordering of Diagnostic Testing

A second College-retained expert reviewed Dr. Savic's ordering of diagnostic testing. The expert reviewed 25 patient charts and interviewed Dr. Savic.

Holter Monitor Testing

In reaching her opinion, the expert relied on her clinical experience, the ACC/AHA Guidelines for Ambulatory Electrocardiography, published in 1999, and the British Columbia Guidelines on Ambulatory ECG Monitoring (Holter Monitoring and Patient-Activated Event Recorder), dated April 15, 2013. The expert pointed out that the ACC/AHA guidelines explicitly state that Holter monitor testing is not useful for routine

screening of asymptomatic patients, or in the initial evaluation of chest pain patients who can exercise, and it may be harmful in some cases.

In only one of 24 charts did Dr. Savic document any reason for ordering Holter monitor testing, and often there was no documentation that it had even been ordered until the patient returned for follow-up. In just six patient charts did the expert find any medical evidence that might represent an indication for Holter monitor testing. There was no supporting medical evidence or documented reason in the instances in which Dr. Savic ordered repeated Holter monitor testing.

The Committee accepted the expert's opinion that Dr. Savic displayed a lack of knowledge in that he ordered Holter monitor and other tests without appropriate indication or documentation. Dr. Savic ordered Holter monitor testing outside accepted guidelines for a large majority of the patients reviewed, not simply for a few patients whose circumstances might have been unusual. Further, there was virtually no documentation in Dr. Savic's charts of any reasons that would support his clinical judgement in ordering Holter monitor testing for individual patients outside accepted guidelines.

Ordering of Other Tests

The expert opined that Dr. Savic's ordering of EKGs and stress tests lacked any acceptable indication for the most part. As with Holter monitor testing, Dr. Savic stated to the expert that the typical reason he ordered the tests was screening.

The expert expressed strong concern about a recurrent practice of Dr. Savic seeing patients for an EKG just days after a normal stress test. Dr. Savic acknowledged to her that he had no justification, and that such testing represents a duplication of service in that the patients would have had an EKG prior to their stress test.

In respect of Dr. Savic's ordering of tests, the expert described a "cascade" of unnecessary cardiac testing in a patient with no cardiac concerns and no cardiac findings on physical examination.

The Committee found that Dr. Savic displayed a lack of knowledge and failed to maintain the standard of practice of the profession in his ordering of Holter monitor testing, EKGs, and stress tests without appropriate indication or documented justification.

Record Keeping

The expert opined that Dr. Savic's documentation in relation to ordering Holter monitor testing fell significantly below the standard of practice. She noted that Dr. Savic displayed a lack of skill in terms of the completeness of his documented histories and examinations, and a lack of judgment in failing to document a proper evaluation in patients presenting with potentially significant symptoms. The Committee accepted her

opinion that Dr. Savic failed to maintain the standard of practice in respect of his documentation in multiple charts reviewed.

With respect to Patient A, there was no indication in the documented history and examination that Patient A's symptoms were severe. With respect to Patient B, there was no documentation of history, examination, investigation or management plan over an extended period. The Committee found that Dr. Savic failed to maintain the standard of practice of the profession in his record-keeping for Patients A and B.

Overall Management

The Committee considered Dr. Savic's overall management of patients. The College-retained expert opined that Dr. Savic's care of patients fell below the standard of practice of the profession in respect of additional aspects of his care. In general, the expert commented on Dr. Savic's:

- failure to recognize and/or take appropriate action based on Holter monitor test results (patients #14, #1A, #4A);
- failure to properly investigate patients with cardiac symptoms or findings (patients #14, #3A, #4A, #6A). Among the patients for whom Dr. Savic ordered Holter monitor testing, other cardiac testing would have been more appropriate for the few who presented with cardiac symptoms;
- failure to properly investigate and/or follow up on patients who presented with non-cardiac symptoms (patients #5, #12, #1A, #2A); and
- failure to maintain an adequate referral system so that patients who Dr. Savic refers to specialists were in fact seen within an appropriate time (patients #8 and #14).

The expert opined that Dr. Savic's knowledge was below standard and expressed "very serious concerns regarding the competence of [his] practice." She identified "a marked and consistent lack of thoroughness in his case management, with frequent evidence of insufficient history, physical exam, inappropriate investigation, and incomplete follow up."

With respect to Dr. Savic's care of Patient A, Dr. Savic displayed a lack of knowledge and judgment and failed to meet the standard of practice in not obtaining a throat swab or rapid antigen testing, in assessing the severity of Patient A's illness, and in his rationale for management. With respect to Dr. Savic's care of Patient B, there was no proper history, examination, investigations or comprehensive management plan of a patient with chronic pain. Dr. Savic displayed a lack of knowledge, skill and judgment in his care of Patient B.

The Committee found that Dr. Savic failed to maintain the standard of practice of the profession in his overall management of patients.

Disgraceful, Dishonourable or Unprofessional Conduct

Dr. Savic ordered unnecessary diagnostic testing without clinical indication or justification. In doing so, he exposed his patients to the stress, discomfort, inconvenience, and personal costs associated with medical testing. Further, he exposed patients to the risk that an important diagnosis would be missed because they did not get the appropriate test. He also exposed patients to the risk of receiving a false positive result to the Holter monitor test. A false positive result could lead to additional tests being recommended that were unnecessary. The additional tests would have their own risk of complications. Dr. Savic has violated the trust patients have that he as a medical professional will act with competence, integrity, and in his patients' best interests. This conduct is disgraceful, dishonourable and unprofessional.

Dr. Savic billed OHIP for services relating to the unnecessary testing he ordered. In doing so, he diminished the public funding that could otherwise have been directed to appropriate health care services. Thus, Dr. Savic has failed in his stewardship of our limited health care resources and his responsibilities to the profession and society at large.

The Committee found that, in his ordering of unnecessary tests and billing for related services, Dr. Savic has engaged in conduct or an act or omission that would reasonably be regarded by the members of the profession as disgraceful, dishonourable and unprofessional.

Disposition

On August 23rd, 2019, the Discipline Committee released its decision on penalty. The Committee ordered and directed that:

- Dr. Savic appear before the panel to be reprimanded;
- The Registrar revoke Dr. Savic's certificate of registration effective immediately; and
- Dr. Savic pay the College costs in the amount of $30,730.00 within thirty (30) days of the date of this Order.

8. Dr. B. Takhar

Name:	Dr. Baldeep Takhar
Practice:	Family Physician
Practice Location:	Cambridge and Kitchener
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding Date:	May 24, 2019
Penalty Decision Date:	May 27, 2019
Written Decision Date:	July 16, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **withdrawn**
- incompetence - **withdrawn**

Summary

Dr. Takhar, a 52 year old family physician practising in Cambridge and Kitchener, Ontario, received her certificate of registration authorizing independent practice in 1977.

In November 2013, Dr. Takhar, along with three other doctors, created the Franklin Family Health Organization ("FHO"). Dr. Takhar assumed the role of "Lead FHO Physician." Dr. Takhar had previously been a signatory member at another FHO, the Canamera FHO, since 2011.

Between December 2013 and December 2015, the practices of Dr. Takhar and the Associate Lead Physician, Dr. Jodie Wang, grew quickly. The Franklin FHO's total patient enrolment count grew from 8,774 to 18,123 patients. Patients were rostered under approximately seven member physicians, but some member physicians left the FHO and most patients came to be rostered under Dr. Takhar or Dr. Wang. During this time period, Dr. Takhar's individual patient enrolment count increased from 4,453 patients to 7,282 patients.

Dr. Takhar practised at two locations of the Franklin FHO in Kitchener, and at one location in Cambridge. A further location opened in Guelph in 2014, which was run by two other member physicians.

The FHO was staffed by both signatory physicians (who were members of the FHO) and locum physicians who were paid by the hour, as well as other staff such as physician assistants, nurse practitioners, registered practical nurses, and office staff.

Patients enrolled with the Franklin FHO were rostered to an individual physician. However, the Franklin FHO used a "shared care model", in which each patient could book an appointment to see any of the physicians on staff or walk in on the weekend to do so. The rapid growth of the Franklin FHO and the problems that arose in implementing the "shared care model" contributed to Dr. Takhar's failure to maintain the standard of practice of the profession, as outlined below.

After receiving information of concern regarding Dr. Takhar's clinical and administrative practices, the College commenced an investigation into her family practice in September 2014. An expert was retained who reviewed twenty-two family practice charts and related records, and interviewed Dr. Takhar. The College expert opined in reports in March and October 2016 that Dr. Takhar had failed to maintain the standard of practice of the profession with respect to record keeping, practice management, and clinical management of patients.

In the period reviewed by Dr. Cohen (i.e. 2005 through January 2015), Dr. Takhar failed to maintain the standard of practice of the profession as set out below.

In terms of clinic management, Dr. Takhar rostered too many patients at the Franklin FHO and personally to herself, without ensuring that continuity of care could be provided to rostered patients.

The Franklin FHO used an electronic medical records system ("EMR"). However, the system in place for physicians to be alerted as to test results or possible charting errors did not reliably reflect whether a result entered into the system had been reviewed by a physician, whether a patient had taken a test that had been ordered, or whether a test result was lost. There was no clear policy or procedure administratively on who should receive this information or follow up in this regard. It was also difficult to determine who was the "most responsible physician" for the patient. This resulted in inconsistent follow-up, and in necessary follow-up sometimes being missed.

In terms of medical record keeping, issues were identified with Dr. Takhar's charting practices in a number of the charts reviewed:

- Information was missing in the comprehensive patient profiles of patients rostered to her, including regarding social history, past medical history, preventive health history, and immunizations;
- Progress notes were frequently incomplete or vague as to history, physical examination, diagnosis, plan, and follow-up;
- Patient charts lacked appropriate diabetes care documentation regarding a diabetic patient and a potentially diabetic patient whose care was reviewed; and
- The patient charts did not document the clinical indication for tests Dr. Takhar ordered or medications she prescribed.

In terms of clinical care, following review of the patient charts from this same period, the College's expert opined that Dr. Takhar's clinical care of patients did not meet the standard of practice of the profession in the following ways:

- Letters referring patients to specialists for consultation did not set out all the necessary clinical details;
- Follow-up on test results for rostered patients and patients for whom she had ordered tests was inconsistent, and necessary follow-up was sometimes delayed or missed;
- Follow-up for her patients regarding recommended preventive healthcare was inconsistent, including for Pap smears, mammograms, faecal occult blood tests, and immunizations;
- Vitamin B12 injections were given without documented clinical indication, and the chart did not indicate why oral B12 had not been given instead;
- Testing was ordered that appeared to be excessive and lacking documented clinical indication in some cases, including blood work and ECHO cardiograms;
- Necessary physical examinations were not always documented;

- Follow-up for patients with hypertension was sometimes not carried out;
- Antibiotics were prescribed to some patients without noting clinical indication in the chart, and in one instance there was no indication why primary care guidelines were not followed regarding otitis media (ear infection) in children; and
- Medications were prescribed to some patients without noting a clear clinical indication in the chart.

Disposition

On May 27, 2019, the Discipline Committee ordered that:

- Dr. Takhar attend before the panel to be reprimanded.
- The Registrar to place the following terms, conditions and limitations on Dr. Takhar's certificate of registration:
  - Dr. Takhar shall attend the entirety of Pri-Med Canada, or the College of Family Physicians of Canada's Family Medicine Forum, or another similar family medicine program or conference acceptable to the College. Dr. Takhar shall complete this requirement within seven (7) months of the date of this Order or, if no such program or conference is available within that time, as soon thereafter as one is available. Dr. Takhar shall provide proof of her attendance to the College within one (1) month of completion, including the number of credits received;
  - Dr. Takhar shall attend and successfully complete the course, "Effective Team Interactions," offered by SAEGIS. Dr. Takhar shall complete this requirement within six (6) months of the date of this Order and shall provide her certificate of attendance to the College within one (1) month of completion, including the number of credits received. If the program is unavailable within that time, Dr. Takhar may fulfill this requirement by completing another program related to this topic acceptable to the College within the same time period and forthwith providing proof of completion to the College;
  - Dr. Takhar shall participate in and unconditionally pass the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, with a report or reports to be provided by the provider to the College regarding Dr. Takhar's progress and compliance. Dr. Takhar shall complete this requirement within six (6) months of the date of this Order;
  - Within approximately twelve (12) months of the date of this Order, Dr. Takhar shall submit to an assessment of her family medicine practice by an assessor or assessors selected by the College (the "Assessment"). The Assessment may include chart reviews, direct observation of Dr. Takhar's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the Assessor. The results of the Assessment will be reported to the College and may form the basis of further action by the College; and

- Dr. Takhar shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Takhar pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of this Order.

9. Dr. A. Taniguchi

Name:	Dr. Alan Taniguchi
Practice:	Palliative Care
Practice Location:	Hamilton
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	May 10, 2019
Written Decision Date:	June 24, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- incompetence – **withdrawn**

Summary

Dr. Taniguchi is a 54-year old palliative care physician practising in Hamilton, Ontario. He received his certificate of registration authorizing independent practice in 1991

In addition to his clinical practice, Dr. Taniguchi is an Assistant Clinical Professor at McMaster University, and the Program Director of McMaster's Family Medicine Palliative Care Residency Program. At the time of the events at issue, in addition to his clinical duties, Dr. Taniguchi had significant teaching, academic, and administrative responsibilities.

Failure to comply with SCERP

On July 15, 2016, the Quality Assurance Committee of the College of Physicians and Surgeons of Ontario ("the College") required Dr. Taniguchi to participate in a specified continuing education or remediation program ("SCERP") consisting of:

- a review and written summary of a College policy, and a section of the Practice Guide;
- a period of clinical supervision, in which Dr. Taniguchi was required to meet with a supervisor monthly for six months and review 10 charts at each meeting; and
- a reassessment of his practice.

Dr. Taniguchi was notified of the Committee's decision on August 5, 2016. He was required to retain a clinical supervisor within 30 days of receiving the decision.

Dr. Taniguchi did not retain a clinical supervisor, or undergo a reassessment, pursuant to the SCERP. Dr. Taniguchi failed to respond to correspondence from the College on August 16, 2016, November 22, 2016 and January 2, 2017 with respect to his compliance with the SCERP.

Dr. Taniguchi submitted the required written summary on June 23, 2017.

Breach of Order

On May 10, 2017, the QAC made an Order imposing terms, conditions, and limitations on Dr. Taniguchi's certificate of registration. Under the Order, Dr. Taniguchi was required to obtain a clinical supervisor acceptable to the College within 14 days of the Order, and meet with the clinical supervisor monthly to review 10 long-term care patient charts. The Order was to remain in effect until May 9, 2018. If Dr. Taniguchi was unable to retain a clinical supervisor as required by the Order, he was required to cease practicing long-term care until such time as he had done so.

On May 25, 2017, Dr. Taniguchi proposed that Dr. David Chan be approved as his supervisor. On May 31, 2017, the College confirmed that Dr. Chan was approved. On June 7, 2017, the College advised Dr. Taniguchi that it had received Dr. Chan's executed undertaking, and that Dr. Taniguchi was permitted to return to practice.

Dr. Taniguchi had his first and only meeting with Dr. Chan on September 8, 2017:

- there were "no deficiencies identified" in Dr. Taniguchi's charts; and
- "Dr. Taniguchi has made a lot of progress. His documentation is excellent and in my opinion meets the standard of documentation in a [long-term care] setting".

Although Dr. Chan's initial report was favorable, Dr. Taniguchi states that he felt overwhelmed. He failed to arrange follow-up meetings with Dr. Chan. Dr. Chan emailed Dr. Taniguchi twice after their first meeting to encourage Dr. Taniguchi to schedule their next meeting, but Dr. Taniguchi did not respond.

On January 26, 2018, Dr. Taniguchi was notified that he was in breach of the Order, and was advised to meet with Dr. Chan and review 40 charts with him by February 8, 2018 to bring himself back into compliance. Dr. Taniguchi failed to do so.

On February 12, 2018, Dr. Chan advised the College that he had not heard from Dr. Taniguchi, and withdrew as Dr. Taniguchi's clinical supervisor. Dr. Taniguchi ceased practicing long-term care in February 2018.

Section 75 Investigation

In addition to making the Order described above, the QAC also disclosed to the ICRC Dr. Taniguchi's name, as well as the allegations that he may have committed an act of professional misconduct, including but not limited to lack of governability, or that he may be incompetent or incapacitated. The Registrar appointed investigators to investigate whether Dr. Taniguchi, in his general medicine practice, including his long-term care and palliative care, had engaged in professional misconduct or was incompetent.

Dr. Taniguchi was notified of the investigation on July 13, 2017. The investigator asked Dr. Taniguchi to complete a Physician Practice Questionnaire and an Electronic Records Questionnaire, and return them to the College within 10 business days. Dr. Taniguchi did not respond. The investigator sent several further requests for Dr. Taniguchi's completed questionnaires between October 2017 and February 2018, to which Dr. Taniguchi did not respond. The College did not receive Dr. Taniguchi's completed questionnaires.

The College retained Dr. Benoit Robert to opine on Dr. Taniguchi's care of 25 patients in both palliative care and long-term care practices.

On April 16, 2018, the investigator wrote to Dr. Taniguchi advising him that Dr. Robert had requested to interview Dr. Taniguchi for the purposes of preparing his opinion. Dr. Taniguchi did not respond to this letter, and did not attend for an interview with Dr. Robert.

With respect to Dr. Taniguchi's palliative care practice, Dr. Robert opined:

- Dr. Taniguchi's pattern of documentation was consistent with a physician who practiced "at a distance". It was unclear from much of the documentation provided whether Dr. Taniguchi had direct contact with patients. Although Dr. Taniguchi was a consultant in a teaching setting, his charting pattern was suggestive of not being available on a consistent basis;
- Dr. Taniguchi's documentation of encounters did not follow a "SOAP" format, or a problem-based approach. His notes contained minimal subjective and objective data, and his assessments and plans were cursory. There was limited evidence of physical examinations;
- Dr. Taniguchi demonstrated a significant lack of knowledge of appropriate documentation. The paucity of charting and documentation interfered with Dr. Robert's ability to opine on Dr. Taniguchi's knowledge with respect to palliative care. The lack of documentation also precluded an accurate assessment of Dr. Taniguchi's skill; and
- Dr. Taniguchi was not readily available to assess patients in a timely fashion. While Dr. Taniguchi's clinical practice was unlikely to expose patients to harm or injury, this was due to the rapid available backup by other qualified palliative care physicians on days on which Dr. Taniguchi is not available.

With respect to Dr. Taniguchi's long-term care practice, Dr. Robert opined:

- It was not clear from Dr. Taniguchi's documentation in 2015 and 2016 that he was performing admission physicals, nor was it clear that he was performing annual physicals. There were a number of occasions on which these physicals were not documented. Dr. Taniguchi's extensive use of PRN orders in the order sets in some charts also suggested that his approach to those residents' care was not personalized;
- There was a significant improvement in Dr. Taniguchi's long-term care documentation after mid-2017, with respect to his use of SOAP notes, and

the documentation of admission and annual exams, and care conferences;
- Dr. Taniguchi's knowledge and skill were difficult to ascertain from his charts. However, there were instances in which Dr. Taniguchi's charting suggested a lack of knowledge and/or skill. In one case, Dr. Taniguchi failed to follow through on a psychiatry note outlining the need for quarterly monitoring of the patient's liver function tests. In another case, Dr. Taniguchi failed to address rising creatinine levels in an elderly patient who was prescribed Ramipril, and who later developed acute-on-chronic renal failure; and
- Dr. Taniguchi was not readily available to assess his patient load, and his lack of availability was concerning. His practice of attending on patients only every two weeks allowed for conditions to aggravate between visits. It also appeared that he was not available between visits. The use of email did not seem to expedite communication. It also was not clear that the email channels used were secure, and Dr. Taniguchi's email correspondence at times comingled patients' personal health information.

Section 25.4 Order

On November 8, 2018, the Inquiries, Complaints and Reports Committee made an Order under s. 25.4 of the Health Professions Procedural Code ("s. 25.4 Order"), requiring, among other things, that Dr. Taniguchi practice under the guidance of a clinical supervisor.

On November 23, 2018, Dr. Anne Woods was approved as Dr. Taniguchi's clinical supervisor. Since that time, Dr. Taniguchi has been fully cooperative with the College, and has been meeting with Dr. Woods on a regular basis to review patient charts from his palliative care practice pursuant to the s. 25.4 Order. Dr. Woods's reports have been positive, and indicate that Dr. Taniguchi's care has been appropriate.

As Dr. Woods has noted in her reports:
- "Once aware of the requirements for charting, Dr. Taniguchi's notes have met all requirements, have addressed concerns raised in the previous audit, and reflect a care that is exemplary. I have made only one recommendation: 'Ensure the documented physical exam reflects all major concerns noted as issues that day.'"
- "Dr. Taniguchi's notes consistently reflect a high quality of care, supervision, education, collegiality, and graciousness"; and
- "Dr. Taniguchi has the reputation in the wider palliative medicine community as being the doctor's doctor, the one physicians would choose to have look after them. He is known for his unremitting respect for other physicians, his knowledge, and his hard work".

Dr. Taniguchi states that, between 2016 and 2018, he was feeling overwhelmed by his professional responsibilities, and was struggling to cope, and that this contributed to his failure to comply with the SCERP, and his failure to be responsive to the College.

In order to address the issues that contributed to his conduct in this case, Dr. Taniguchi is working to reorganize his workload. He has stepped down from some of his academic

responsibilities, and has recently moved to a lower-volume clinical environment. Dr. Taniguchi has also seen a counsellor, to help him develop his stress management and coping skills.

On May 8, 2019, Dr. Taniguchi entered into an undertaking with the College by which he agreed to, among other things:

- practise under the guidance of a Clinical Supervisor acceptable to the College for 6 months;
- engage in professional education in professional responsibilities in post-graduate medical education, and medical ethics; and
- undergo a reassessment of his practice by an assessor selected by the College within 6 months of the end of the period of Clinical Supervision.

Disposition

On May 10, 2019, the Discipline Committee Ordered that:

- Dr. Taniguchi attend before the panel to be reprimanded.
- The Registrar suspend Dr. Taniguchi's certificate of registration for a period of two (2) months.
- Dr. Taniguchi pay costs to the College in the amount of $6,000.00 within thirty (30) days from the date of this Order.

Found Guilty of Offence Relevant to Suitability to Practise – 2 cases

1. Dr. J. Hwang

Name:	Dr. Joshua Hwang
Practice:	PGY1 Resident, Family Medicine
Practice Location:	Toronto
Hearing:	Statement of Uncontested Facts Penalty – Joint Submission
Finding/Penalty Decision Date:	June 17, 2019
Written Decision Date:	July 24, 2019

Allegations and Findings

- found guilty of offence relevant to suitability to practise - **proven**
- conduct unbecoming a physician – **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Joshua Hwang is 32 years old. Between October 2016 and July 2017, Dr. Hwang was a PGY1 resident in the Family Medicine residency training program at Western University. He had a certificate of registration authorizing postgraduate education. On July 1, 2017, Dr. Hwang was placed on a leave of absence from his residency program. On August 24, 2017, Dr. Hwang was suspended from that program, and was never reinstated. Dr. Hwang's certificate of registration expired on June 30, 2018.

CPSO Investigation

In June 2017, Dr. Hwang was living in London, Ontario. On June 21, 2017, Dr. Hwang travelled to attend a conference in a different city. He made arrangements to stay with two of his friends, Dr. A and his wife, Dr. B, at their apartment.

Dr. A and B's apartment had 2 bedrooms and 2 bathrooms. Dr. A and B used the master bedroom and en suite master bathroom. Dr. Hwang was given the guestroom to stay in, and a separate bathroom in the common area to use.

On June 21, 2017, Dr. Hwang installed a video and audio recording device ("the Recording Device") in his friends' en suite master bathroom by plugging it into an electrical wall outlet facing their shower and toilet. The Recording Device was concealed as a USB charger. Using the Recording Device, Dr. Hwang surreptitiously recorded Drs. A and B naked and partially naked in their bathroom, including when they were using the toilet and showering.

After Dr. B noticed the Recording Device plugged into the electrical outlet in the en suite bathroom, Dr. A questioned Dr. Hwang about it. Dr. Hwang acknowledged that the Recording Device belonged to him, but falsely denied knowing that it was a camera or that it had recording capabilities. Dr. Hwang told Dr. A that he thought the Recording Device was merely a USB charger; that he had purchased it on the internet; that he had been trying to use it to charge his cell phone; but that he had had to plug it in in the en suite master bathroom because it had not been working in other outlets in his friends' apartment. This explanation was false.

Dr. Hwang also falsely told Dr. A that he could provide an e-mail receipt to prove that the device he had ordered was supposed to be a USB charger. Dr. Hwang forwarded to Dr. A an email receipt dated November 30, 2012 that related to Dr. Hwang's purchase of a USB wall charger. The USB wall charger that Dr. Hwang had purchased was not the Recording Device that Dr. Hwang installed in his friends' en suite bathroom in June 2017 that he had used to surreptitiously record them.

In addition to surreptitiously video recording Drs. A and B in their bathroom, Dr. Hwang also used the Recording Device to surreptitiously record:

- a clinical encounter between Dr. Hwang and a female patient, taken on June 19, 2017, at clinic where Dr. Hwang was practicing as part of his residency. The camera was positioned to face the exam table. The patient was off camera during most of the encounter. Dr. Hwang is visible throughout the recordings. Dr. Hwang can be seen taking the patient's blood pressure reading, and speaking to the patient. Another video captures further discussion between Dr. Hwang and the patient. Dr. Hwang can also be seen removing the camera from the electrical wall outlet. The patient was unaware that Dr. Hwang had recorded her patient encounter. She did not consent to Dr. Hwang's recording the appointment; and
- two females in bedrooms in Dr. Hwang's home. Both of them were, at times, in a state of nudity. In one of the recordings, a female was engaged in intimate sexual activity. The recordings were made surreptitiously. Neither of these two individuals was aware that Dr. Hwang video recorded them, nor did they consent to the recording. One of the individuals described it as an "invasion of privacy" when she was told of the recording.

Dr. Hwang made the recordings referred to above so that he could later watch them for his sexual gratification.

Criminal Proceedings

On August 4, 2017, Dr. Hwang was charged with committing voyeurism against Drs. A and B, contrary to s. 162 of the *Criminal Code of Canada*, and specifically that:

> On or about the 21st day of June in the year 2017 at the City of Ottawa in the East/De L'Est Region did, without lawful excuse, surreptitiously make a visual recording of a person who was in circumstances that gave rise to a reasonable

expectation of privacy when that person was in a place in which that person could reasonably be expected to be nude, to be exposing his or her genital organs or anal region or exposing her breasts or be engaged in explicit sexual activity, namely the victim's bathroom, and thereby commit an offence under Section 162, subsection (1), clause (a) of the Criminal Code, contrary Section 162, subsection (5) of the Criminal Code of Canada.

Dr. Hwang pleaded guilty to, and was convicted, of this offence on February 17, 2018. On June 29, 2018, Dr. Hwang was sentenced to six months' house arrest, followed by two years' probation. The Ontario Court of Justice transcripts of Dr. Hwang's conviction and sentencing are attached at Tabs 2 and 3 to the Statement of Uncontested Facts

Disposition

On June 17, 2019, the Committee ordered that:

- The Registrar revoke Dr. Hwang's certificate of registration effective immediately.
- Dr. Hwang attend before the panel to be reprimanded.
- Dr. Hwang pay costs to the College in the amount of $6,000.00 within six (6) months from the date of this Order.

2. Dr. R. T. Shenava

Name:	Dr. Ravishankar Thimmangur Shenava
Practice:	Psychiatry
Practice Location:	Windsor
Hearing:	Agreed Statement of Facts on Liability Penalty – Joint Submission
Finding/Penalty Decision Date:	June 18, 2019
Written Decision Date:	August 12, 2019

Allegations and Findings

- found guilty of offence relevant to suitability to practise - **proven**
- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse of a patient- **withdrawn**

Summary

Dr. Shenava is a 68-year-old psychiatrist practiising in Windsor, Ontario who received his certificate of registration authorizing independent practice in Ontario in 1988 and his specialist qualification in psychiatry in 1987.

Guilty of Offence Relevant to Dr. Shenava's Suitability to Practice

On September 6, 2018, Dr. Shenava pleaded guilty and was found guilty of three counts of assault contrary to s.266 of the Criminal Code of Canada in proceedings before Thomas J., Superior Court of Justice at Windsor, Ontario. The findings of guilt pertain to Patients F, K and L in the Notice of Hearing.

Disgraceful, Dishonourable or Unprofessional Conduct

Dr. Shenava admits that, based on the facts admitted at the criminal proceedings, he engaged in disgraceful, dishonourable or unprofessional conduct towards Patients F, K and L.

With respect to the remaining patients in the Notice of Hearing, Dr. Shenava engaged in disgraceful, dishonourable or unprofessional conduct in the following ways:

- hugging patients without consent, asking for hugs from patients, touching patients' legs, backs and arms;
- failing to maintain spatial boundaries, including by sitting too close to patients and making patients uncomfortable with his proximity to them;
- making inappropriate personal comments to some patients.

Failure to Maintain Standard of Practice

As part of an investigation into whether Dr. Shenava failed to maintain the standard of practice, the College retained Dr. David Cochrane, psychiatrist.

Dr. Cochrane provided a report dated February 28, 2019. Dr. Cochrane found that in all twenty-two of twenty-two (22/22) charts he reviewed, Dr. Shenava failed to maintain the standard of practice in his clinical documentation, clinical care and the management of boundaries and transference enactments.

Disposition

On June 18, 2019, the Committee ordered that:

- The Registrar revoke Dr. Shenava's certificate of registration, effective immediately.
- Dr. Shenava attend before the panel to be reprimanded.
- Dr. Shenava pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of this Order.

Disgraceful, Dishonourable or Unprofessional Conduct – 5 Cases

1. J. K. Chadda

Name:	Dr. Jasjot Kaur Chadda
Practice:	Psychiatry
Practice Location:	Toronto
Hearing:	Agreed Statement of Facts Penalty – Joint Submission
Finding/Penalty Decision Date:	May 24, 2019
Written Decision Date:	July 16, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- failed to maintain standard of practice of the profession – **withdrawn**
- incompetence - **withdrawn**

Summary

Dr. Chadda received her certificate of registration authorising independent practice from the College on July 5, 1991 and began practising as a family physician. In 1997, she completed training in psychiatry and commenced practising as a psychiatrist. Dr. Chadda practises psychiatry as a sole practitioner in Toronto.

Patient A

Patient A was a patient of Dr. Chadda's from August 2013 until the end of 2014. She sought treatment for her depression from Dr. Chadda. Dr. Chadda provided psychotherapy to her. During the course of her treatment of Patient A, Dr. Chadda suggested that she join what Dr. Chadda described as a "meditation retreat" that she was organizing in Italy in July 2014 (the "Italy Retreat"). Patient A agreed to attend the Italy Retreat. Dr. Chadda charged Patient A $5295 plus HST for the retreat, exclusive of airfare and other expenses, which Patient A was required to pay in addition to the fee charged by Dr. Chadda.

Following the Italy Retreat, during one of her sessions with Patient A, Dr. Chadda requested that Patient A do a video testimonial for Dr. Chadda's website to promote the Italy Retreat. Dr. Chadda told Patient A that she would have her hair and makeup done at Dr. Chadda's house. Patient A told Dr. Chadda she needed to think about it, but ultimately declined. Despite Patient A's refusal, Dr. Chadda brought it up again during therapy sessions, until Patient A asked that Dr. Chadda not raise it again. Dr. Chadda's requests for a testimonial made Patient A uncomfortable.

In October 2015, Patient A complained to the College about various concerns she had about Dr. Chadda's "care and conduct," including the following:

- Patient A stated that she felt Dr. Chadda “blurred boundaries” with her and that she was often confused during her relationship with Dr. Chadda as to whether they were friends or whether Dr. Chadda was just her doctor;
- Patient A also complained that Dr. Chadda charged her a fee per session in addition to billing OHIP;
- Dr. Chadda failed to transfer her records, despite repeated requests from her and from Patient A’s subsequent care provider.

The College retained the services of a psychiatrist, Dr. Greg Chandler, to review Dr. Chadda’s care of Patient A and provide an independent expert opinion. Dr. Chandler opined as follows:

> *Patient A participated in a meditation retreat organized by Dr. Chadda*
>
> During our training as physicians, we are taught about maintaining proper boundaries between ourselves and our patients. The principle is that by altering the relationship from a purely physician-patient one, we could adversely affect the care provided. In some circumstances, due to the limited scope of certain clinical encounters or with the passage of time after treatment has ended, some nonclinical relationships have been considered acceptable between physicians and patients. However, in our training as psychiatrists, we are taught that significant non-clinical relationships, including but not limited to romantic ones, would never be acceptable if a psychiatrist-patient relationship has ever existed; this includes when there has been only one meeting or after the clinical relationship has terminated. The rationale is that as part of the clinical encounters themselves, psychiatrists will make specific efforts to understand our patients' ways of thinking, anxieties, motivations and vulnerabilities. This makes psychiatrists more able to affect our patients' thinking and behaviour; in fact, this is generally the goal of psychotherapy and the mechanism of it working. This context also makes psychiatrists more at risk for taking advantage of our patients' vulnerabilities, even if done unintentionally. Furthermore, patients will usually be seeing psychiatrists because they feel psychologically vulnerable. When this is the case, it can feel especially important for patients to ensure good relationships with their psychiatrists. As such, when a psychiatrist asks something of a patient, the patient may comply because they do not want to risk the psychiatrist's disapproval, with the ultimate feared risk being the termination of the therapy. This could lead patients to compromise their own best interests in an attempt to please their psychiatrists.
>
> The CPSO’s policy Physician Behaviour in the Professional Environment states, "The physician's primary responsibility is to act in the best interests of the individual patient." As per the CPSO's policy statement Maintaining Appropriate Boundaries and Preventing Sexual Abuse,

"Physicians must establish and maintain appropriate professional boundaries with patients." As the dominant individual in the relationship, the CPSO advises that it is the physician's responsibilities to maintain boundaries. As mentioned, while maintaining clear boundaries is crucial in any physician-patient relationship, it is thought to be even more important in a psychotherapy relationship.

When a physician makes an offer that involves finances, it introduces the possibility that a physician could be in conflict of interest between their role as a business person and their role as a physician. This would include selling a patient a product or service unrelated to their medical care. In this particular case, there is a foreseeable risk that Patient A could feel pressure to purchase Dr. Chadda's product (the meditation retreat), with the worry that not doing so could lead to a change in the relationship, or even the termination of therapy. This would mean that even if the psychiatrist did not realize this service could be undesired by the patient, the patient may feel hesitant to raise this and/or refuse the offer. Furthermore, even if the patient wanted the product, coming from a trusted psychiatrist, the patient would be unlikely to conduct themselves in the same way they would in other business decisions, possibly compromising their needs. Dr. Chadda stated that she did not "persuade" Patient A to join the retreat, however it does not reasonably exclude the possibility of a perceived pressure. Even if Patient A had raised the possibility of joining the retreat, Dr. Chadda should have declined. After paying over $5000 to participate, Patient A was dissatisfied with the quality of the meditation retreat; Patient A' complaint to the College seems to be motivated in part by this. Whether others would agree with Patient A's assessment that the retreat did not deliver what was advertised is not relevant. Rather, the possibility that this sort of tension could foreseeably occur illustrates why the relationship should not be entered into in the first place.

As such, in selling a product to a patient she had worked with extensively,…[in] not considering the aforementioned ways this could affect the psychotherapeutic relationship, it also demonstrated a lack of skill and judgment as a psychiatrist. The risks of entering into a significant financial relationship should have been foreseeable to Dr. Chadda. In this case, it caused harm to the patient in that it contributed to the termination of a therapeutic relationship. The degree to which the loss of this or a future therapeutic relationship is harmful would depend on the nature of the relationship and severity of patient illness.

Dr. Chadda asked Patient A to provide a video testimonial for her business

For similar rationale to 1, psychiatrists should not ask patients to perform tasks that are meant to serve the physician's benefit, rather than the

patient's. In Dr. Chadda asking Patient A to provide a testimonial for her meditation retreat to post on her website, she is hoping that Patient A will increase the appeal of her retreat. As Dr. Chadda states, "the website is not related to my medical practice". Dr. Chadda is thus asking her patient to help generate revenue for her. There is always some pressure on a patient to appease a doctor with whom they want to maintain a relationship. Whether the patient ultimately accepts or not, the request has the potential to introduce tension into the relationship.

As such, in making this request of a patient she had worked with extensively,...[i]n not considering the ways this could affect the therapeutic relationship, it also demonstrated a lack of skill and judgment as a psychiatrist. While this issue did not seem to cause significant distress in this particular case - Dr. Chadda's easy acceptance of the refusal likely helped mitigate this - the risk of disruption was certainly present. As in 1, the degree to which the loss of a therapeutic relationship is harmful would depend on the nature of the relationship and severity of patient illness.

Billing, including charges for missed sessions

The CPSO Policy Statement “Block Fees and Uninsured Services”… states "Physicians are entitled to charge patients for uninsured services, which take physician time and resources". As per this policy, physicians are permitted to charge patients for uninsured services in recognition of non-insured activities that take their time. This policy states "Physicians offering a block fee must ensure the fee covers a period of not less than three months and not more than 12". While there was no agreement about block fees in the patient's chart. Given that upon request for additional documentation, Dr. Chadda later provided it and it bears her name and address, I will assume that the "Block fees for services not provide by OHIP" form is also used by her. On this form, it appropriately lays out what services are covered by the fees. However, this form indicates that the fees are charged per session, as opposed to the policy's 3-12 month period. As such, these fees are essentially a supplemental charge. The OHIP rate for 1 hour (or 2 units) of psychiatric care (billing code K198) is $160. Dr. Chadda's additional fee of $65 per session amounts to an extra 40% per session charge. The OHIP rate for a half session of 30 minutes (or 1 unit) of psychiatric care is $80; Dr. Chadda's additional fee of $45 per session amounts to a 55% extra charge. Given that Dr. Chadda runs a psychotherapy practice, she would often be seeing her patients several times per month. It is difficult to imagine what services could be provided to make these fair and reasonable amounts. Per the OHIP billing, Dr. Chadda and Patient A met an average of twice per month. This would mean a supplemental charge of over $1500 annually if most hourly sessions were held.

> These charges would not seem to meet the policy criteria of ensuring the amounts charged are "reasonable in relation to the services provided". They would furthermore "pose a barrier to accessing health care services" for those who could not afford such a large amount, in contradiction with this policy and as such cause harm to potential patients by making care inaccessible. The amount of supplemental billing…demonstrates a lack of professionalism by Dr. Chadda.
>
> *Continuity of Care*
>
> Not providing a patient's medical records to their current treatment provider on a timely basis…demonstrates poor judgment and/or unprofessionalism, depending on Dr. Chadda's degree of intentionality.
>
> Not providing the information on a timely basis (at least 7 weeks) would demonstrate poor judgment on Dr. Chadda's part. By not providing Patient A's clinical information to her GP, it exposed Patient A to substandard medical care. In this case, it seems that Dr. King was aware of Patient A's antidepressant regimen, which was uncomplicated, which mitigated the potential harm. However, if this were done with a patient with a more complicated treatment patter, it could expose them to significant harm, either by prescribing medications that interact with medications the MD would be unaware of, incorrect dosing, or omission of necessary medications.

Patient B

Patient B was a patient of Dr. Chadda's from July to October 2016. Dr. Chadda provided psychotherapy to Patient B. Dr. Chadda charged Patient B $75/session in addition to billing OHIP. Dr. Chadda did not offer Patient B a block fee option. After Patient B terminated therapy with Dr. Chadda, she requested receipts, for income tax purposes, for the amounts that Dr. Chadda had billed her in excess of the OHIP schedule of benefits. Dr. Chadda provided a receipt to Patient B on April 3, 2017.

In January 2017, Patient B complained to the College about Dr. Chadda's billing practices, "misuse of uninsured services," and her failure to provide receipts upon request.

Dr. Greg Chandler was again retained by the College to review this matter and provide an independent expert opinion. Dr. Chandler opined as follows:

> *Additional fees being charged by Dr. Chadda to Patient B*
>
> According to the CPSO Policy Statement Block Fees and Uninsured Services, "Physicians are entitled to charge patients for uninsured services, which take

physician time and resources". As such, Dr. Chadda is permitted to charge for non-clinical activities. The agreement signed by Patient B, entitled "Block fees for services not provide by OHIP", appropriately lays out what services are covered by the fees. However, the CPSO policy deems that an insured service is comprised of several "constituent elements" which are not eligible to be separately charged for. This would include at least three items listed on Dr. Chadda's form, including:

- Referring patients to other health care professionals as needed,
- Writing prescriptions (separate from what is noted as "phone calls for prescription refills")
- Having phone calls with hospital staff if the patient is referred to the emergency department.

These items are clearly part of the standard clinical care of a patient. By including them on the agreement, a patient would have to assume they are part of the extra service and thus would not be included without payment.

The CPSO states "Physicians must ensure that the fees charged for uninsured services are reasonable" in relation to the services provided. As per the OHIP payment schedule provided, most of Ms K's sessions lasted one hour, which constitutes two units of psychotherapy; this is a typical length of individual psychotherapy sessions. The OHIP rate for 2 units of psychotherapy is $160 (Schedule of Benefits for Physician Services under the Health Insurance Act, billing code K197). Dr. Chadda's additional fee of $75 per session amounts to a 47% extra per session charge; for context, OHIP pays $80 for 30 minute sessions, or one unit, of psychotherapy. Essentially, an additional 30 minutes of care is being charged for every one hour session. Four sessions were conducted in each of July and October, three in September and two in August. It is difficult to imagine what services could be provided per session that would meet the Policy's requirement of being considered reasonable in relation to the services provided. I would note that I would consider this to be the case even if this particular patient had used some extra services i.e. the fact that this patient did not receive additional services is not what proves the excess of the charge.

The policy also requires that the amounts charged would not “pose a barrier to accessing health care services” for those who could not afford them. The amounts involved here would be in contravention of this policy if paying them were a condition of receiving care. As such, it would potentially cause harm by making care inaccessible to certain people in need of psychiatric care. The agreement used does not state that these *fees are* optional and that not agreeing to them would not exclude this patient from this doctor's care. If Dr. Chadda clearly indicates to patients that clinical care, including all constituent elements, will be provided regardless of willingness to pay the extra fees, then of course the barrier is removed. If that is the case here, then this would be more of an issue of Dr. Chadda's failure to have the patient clearly understand this. Unclear

communication about the policy would be a much lesser transgression than insisting on payment of
these charges to ensure eligibility for clinical care.

I would note that some confusion likely stems from Dr. Chadda's incorrect use of the term “block fees” for charges related to individual sessions. "A block fee is a flat fee charged for a predetermined set of uninsured services" and "covers a period of not less than three months and not more than 12 months. I do not think this significant in terms of any findings here, but could help reduce future confusion.

Not sending a receipt for fees paid

There seems to be agreement on the facts, which is that Ms. K paid $600 in fees in two installments and Dr. Chadda did not provide receipts for them. As with any payment for services rendered, normal business practice is to issue a receipt immediately upon payment, even without a client asking for it. There is no justification for withholding these receipts upon request.
There would be financial harm to a patient if they did not ultimately receive the receipts, in the full amount if it is covered by a patient's insurance, or a lesser amount if it is being used as a tax deduction.

Summary

I have made assessments for the area of specific complaint about Dr. Chadda's care, as well as others that seemed relevant to an assessment of her practice. Dr. Chadda charges an expensive supplemental fee on top of OHIP billings received for clinical care. This exposes potential patients to harm in that it creates a barrier to services. If agreeing to these fees is not mandatory, then the risk is the same if potential patients are not made aware of this, which is the physician's responsibility. If the intent is for agreement to these charges to be a condition of treatment, then this would be more serious lack of professionalism. For those who have agreed to the policy, the amounts involved here are not reasonable using the relevant CPSO policy on the matter. As a result, they are harmed by the excess amount they pay. Not provided receipts for amounts paid upon a patient’s request also demonstrates a lack of professionalism and causes harm in the proportion to the amount paid.

Section 75(1)(a) Investigation

In February 2017, as a result of concerns raised by Dr. Chandler, the College commenced an investigation under section 75(1)(a) of the Health Professions Procedural Code.

In addition to Patient A, Dr. Chadda took three other patients (Patients C, D and E) on her Italy Retreat. Dr. Chadda charged each of these patients between $5295 and $5695

plus HST for the retreat, exclusive of airfare and other expenses, which the patients were required to pay in addition to the fee charged by Dr. Chadda.

Patient C was Dr. Chadda's patient between 2011 and 2017. Dr. Chadda treated Patient C for depression and prescribed anti-depressants to her. Patient D was a patient of Dr. Chadda's from October 2007 to October 2015. Dr. Chadda diagnosed Patient D as having a recurrent major depression. Dr. Chadda provided psychotherapy and prescribed anti-depressants to Patient D. Patient E was a patient of Dr. Chadda's from April 2007 to October 2016. Dr. Chadda provided psychotherapy to Patient E.

Dr. Chadda charged Patients C, D, and E an additional fee per session in addition to the amount she billed OHIP. Dr. Chadda did not provide any of them with a block fee option.

Dr. Chandler was again retained to review the care provided to Patients C, D and E and provide an independent expert opinion. As part of his review, he interviewed Dr. Chadda in October 2017.

Dr. Chandler opined as follows:

> *The patients participated in a meditation retreat organized by Dr. Chadda*
>
> During our training as physicians, we are taught about maintaining proper boundaries between ourselves and our patients. The principle is that by altering the relationship from a purely physician-patient one, we could adversely affect the care provided. In some circumstances, due to the limited scope of certain clinical encounters or with the passage of time after treatment has ended, some nonclinical relationships have been considered acceptable between physicians and patients. However, in our training as psychiatrists, we are taught that significant non-clinical relationships would never be acceptable if a psychiatrist-patient relationship has ever existed. The rationale is that as part of the clinical encounters themselves, psychiatrists will make specific efforts to understand our patients' ways of thinking, anxieties, motivations and vulnerabilities. This makes psychiatrists more able to affect our patients' thinking and behaviour; in fact, this is generally the goal of psychotherapy and the mechanism of it working. This context also makes psychiatrists more at risk for taking advantage of our patients' vulnerabilities, even if done unintentionally. Furthermore, patients will usually be seeing psychiatrists because they feel psychologically vulnerable. When this is the case, it can feel especially important for patients to ensure good relationships with their psychiatrists. As such, when a psychiatrist asks something of a patient, the patient may comply because they do not want to risk the psychiatrist's disapproval, with the ultimate feared risk being the termination of the therapy. This could lead patients to compromise their own best interests in an attempt to please their psychiatrists.

The CPSO's policy Physician Behaviour in the Professional Environment states, "The physician's primary responsibility is to act in the best interests of the individual patient." As per the CPSO's policy statement Maintaining Appropriate Boundaries and Preventing Sexual Abuse, "Physicians must establish and maintain appropriate professional boundaries with patients." As the dominant individual in the relationship, the CPSO advises that it is the physician's responsibilities to maintain boundaries. As mentioned, while maintaining clear boundaries is crucial in any physician-patient relationship, it is thought to be even more important in a psychotherapy relationship.

When a physician makes an offer that involves finances, it introduces the possibility that a physician could be in conflict of interest between their role as a business person and their role as a physician. This would include selling a patient a product or service unrelated to their medical care. In this particular case, there is a foreseeable risk that a patient could feel pressure to purchase Dr. Chadda's product (the meditation retreat), with the worry that not doing so could lead to a change in the relationship, or even the termination of therapy. This would mean that even if the psychiatrist did not realize this service could be undesired by the patient, the patient may feel hesitant to raise this and/or refuse the offer. Furthermore, even if the patient wanted the product, coming from a trusted psychiatrist, the patient would be unlikely to conduct themselves in the same way they would in other business decisions, possibly compromising their needs. Even if Dr. Chadda does not attempt to persuade patients to join the retreat, it does not reasonably exclude the possibility of a perceived pressure. Even if patients raise the possibility of joining the retreat, the physician should have decline.

As such, in selling a product to three patients she had worked with extensively,…[i]n not considering the aforementioned ways this could affect the psychotherapeutic relationship, it demonstrated a lack of skill and judgment as a psychiatrist. The degree to which patients would be affected would depend on the nature of the relationship and severity of patient illness.

Billing, including charges for missed sessions

According to the CPSO Policy Statement Block Fees and Uninsured Services, "Physicians are entitled to charge patients for uninsured services, which take physician time and resources". The OHIP rate for 1 hour (or 2 units) of psychiatric care is $160, based on the Ministry of Health's Schedule of Benefits (code K198). There was an agreement about block fees in one patient's chart which indicated a charge of $450 for a three month period when patients see her every two weeks. Each of these patients averaged nine sessions per three month period, meaning the per session charge amounts to an extra 30% per session. For these three patients, the amounts documented ranged from $845-1770 in one year periods, so it is less clear if they were all on this block fee arrangement. Nonetheless, it is unclear what services could be provided to make these fair and

reasonable amounts. It is unclear that these charges meet the policy criteria of ensuring the amounts are "reasonable in relation to the services provided". These amounts are substantial enough that they could "pose a barrier to accessing health care services" for many patients, in contradiction and as such causing harm to potential patients by making care inaccessible. The amount of supplemental billing … demonstrates a lack of professionalism by Dr. Chadda.

Summary

I have reviewed the charts of three patients and made assessments for the areas of Dr. Chadda's care that seemed relevant to an assessment of her practice…The three patients were receiving treatment in the form of psychotherapy and two were also receiving pharmacotherapy. All three patients struggled with psychological distress which could result in depressive symptoms…Dr. Chadda…charging an excessive supplemental fee for sessions also exposes patients to harm in that it creates a potential barrier to services.

Disposition:

On May 24, 2019, the Discipline Committee ordered that:

- The Registrar suspend Dr. Chadda’s certificate of registration for a period of six (6) months, commencing from June 15, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Chadda’s certificate of registration:
  - Dr. Chadda will comply with the College Policy #2-07 “Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation”.
  - Dr. Chadda will participate in and unconditionally pass the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, with a report or reports to be provided by the provider to the College regarding Dr. Chadda’s progress and compliance. Dr. Chadda will complete this requirement within 6 months of the date of this Order.
  - Dr. Chadda will agree to the monitoring of her billing practices with respect to uninsured services, at her own expense, for a period of twelve (12) months, which will include a review of Dr. Chadda’s records, if necessary, to ensure that her billing for uninsured services is appropriate.
- Dr. Chadda attend before the panel to be reprimanded.
- Dr. Chadda pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

2. Dr. B.M.K.D. El-Tatari

Name:	Dr. Bassam Mohamed Khalil Darwish El-Tatari
Practice:	Family Medicine
Practice Location:	Windsor
Hearing:	Uncontested Facts and Plea of No Contest Penalty – Joint Submission
Finding/Penalty Decision Date:	April 30, 2019
Written Decision Date:	June 25, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse of a patient - **withdrawn**

Summary

Dr. El-Tatari is a 46 year old family physician who has held a certificate of independent practice with the College of Physicians and Surgeons of Ontario since 2010.

Patient A

Dr. El-Tatari was Patient A's family physician from 2011 to 2014.On a number of occasions, Dr. El-Tatari hugged Patient A before and after her appointments. The hugs made Patient A feel nervous and uncomfortable.

During one appointment, Patient A complained of a pimple on her labia. Without adequate explanation to Patient A, Dr. El-Tatari examined and palpated the pimple on Patient A's labia. This caused Patient A discomfort and upset.

Patient B

Patient B was a patient of Dr. El-Tatari's from 2013 to 2014. On a number of occasions, Dr. El-Tatari hugged Patient B at the end of her appointments. On one occasion, following a clinically indicated breast examination, Dr. El-Tatari hugged Patient B, and told her that she was his "favourite patient." Dr. El-Tatari's conduct made Patient B feel awkward and uncomfortable.

Dr. El-Tatari performed breast examinations on Patient B. Dr. El-Tatari found the examinations difficult due to Patient B's breast implants. Dr. El-Tatari did not provide an adequate explanation of the nature and purpose of the extended examinations. As a result, Patient B was left feeling concerned and upset about the length of those examinations.

Patient C

Patient C was a patient of Dr. El-Tatari from 2011 to 2015. At the end of some medical appointments with Dr. El-Tatari, Dr. El-Tatari hugged Patient C. Dr. El-Tatari told Patient C that she was “one of his special ones.” During one appointment, Dr. El-Tatari hugged Patient C while she was wearing an examination gown. While hugging patient C, Dr. El-Tatari asked her if she liked being hugged. He touched her face with his hand. Dr. El-Tatari’s conduct made Patient C uncomfortable. Patient C made a follow up appointment, but never returned to see Dr. El-Tatari after this appointment.

Patient D

Patient D was a walk-in patient of Dr. El-Tatari in 2014. During an early appointment, Dr. El-Tatari hugged Patient D after she told Dr. El-Tatari that she had a miscarriage. This made Patient D feel awkward. During some appointments, Dr. El-Tatari touched her face with his hand, which made her feel uncomfortable.

Patient E

Patient E was a patient of Dr. El-Tatari in 2014. During one appointment, Dr. El-Tatari conducted a clinically indicated pelvic examination on Patient E. During the examination, without an adequate explanation to Patient E, Dr. El-Tatari asked Patient E to squeeze his finger and commented about the strength of her vaginal muscles. Dr. El-Tatari did not explain to Patient E the purpose of this part of the examination or the reason for his comment.

On another occasion, Dr. El-Tatari also touched her face with his hand, and told her he does that to all his favourite patients. Dr. El-Tatari’s conduct made Patient E uncomfortable.

Patient F

Patient F was a patient of Dr. El-Tatari from 2012 to 2013. During his appointments with Patient F, Dr. El-Tatari regularly hugged Patient F, and told her she was his “favourite patient.” During one appointment in or about July 2013, Dr. El-Tatari kissed Patient F on the cheek and, while hugging her, asked Patient F what she would like him to do. Dr. El-Tatari’s conduct made Patient F uncomfortable. Patient F stopped seeing Dr. El-Tatari after this appointment.

Patient G

Patient G was a patient of Dr. El-Tatari from 2011 to 2013. At the end of appointments with Patient G, Dr. El-Tatari regularly hugged Patient G. Patient G found the hugs “weird.” On one occasion, Dr. El-Tatari commented to Patient G’s boyfriend that he loved Patient G and that Patient G was “like a sister” to him. Patient G found the comment unprofessional.

Patient H

Patient H was a patient of Dr. El-Tatari in 2011 and 2012. On one occasion, during a clinically indicated pelvic examination, while checking her pelvic tone, Dr. El-Tatari commented on the tightness of her pelvic tone. Dr. El-Tatari did not provide an adequate explanation to Patient H as to the reasons for this comment. Patient H felt shocked and upset by the comment.

Disposition

On April 30, 2019, the Discipline Committee ordered that:

- Dr. El-Tatari attend before the panel to be reprimanded.
- The Registrar suspend Dr. El-Tatari's certificate of registration for a period of five (5) months, commencing from May 1, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. El-Tatari's certificate of registration:
  - (i) Dr. El-Tatari shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "A" to this Order;
  - (ii) Dr. El-Tatari shall not engage in any professional encounters of any kind, in person or otherwise, with patients, unless the patient encounter takes place in the presence of a College-approved monitor;
  - (iii) Dr. El-Tatari shall post a sign in each of his examination and consultations rooms that states: "Dr. Bassam Mohamed Khalil Darwish El-Tatari must not have professional encounters, in person or otherwise, with patients, unless in the continuous presence of and under the continuous observation of a practice monitor acceptable to the College of Physicians and Surgeons of Ontario. Dr. El-Tatari must not be alone with patients in any examination or consulting room. Further information may be found on the College website at www.cpso.on.ca;" and
  - (iv) Dr. El-Tatari shall successfully complete the Understanding Boundaries and Managing the Risks Inherent in Doctor-Patient Relationships course offered by the University of Western Ontario at his own expense, with a report or reports to be provided by the provider to the College regarding Dr. El-Tatari's progress and compliance. Dr. El-Tatari will complete this requirement within 6 months of the date of this Order or, if it is not possible to do so within 6 months, at the first available Boundaries course for which Dr. El-Tatari is eligible.
- Dr. El-Tatari pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

3. Dr. K. D. Israel

Name: Dr. Koma Diryawish Israel
Practice: Family Medicine
Practice Location: Hamilton
Hearing: Uncontested Facts and Plea of No Contest
Penalty – Joint Submission
Finding/Penalty Decision Date: May 13, 2019
Written Decision Date: June 28, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse - **withdrawn**

Summary

Dr. Israel is a 64-year-old general physician who practising in Hamilton, Ontario. He received his certificate of registration authorizing independent practice in 2000.

Dr. Israel was Patient A's family doctor between approximately November 2013 and May 2017.

During an appointment with Patient A, Dr. Israel told Patient A that a woman needs a man and that maybe her problem was that she did not have a husband or boyfriend. Dr. Israel also asked Patient A, in an inappropriate and unprofessional manner, whether she was attaining sexual satisfaction by masturbating.

Dr. Israel has no previous history before the Discipline Committee.

Disposition

On May 13, 2019, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Israel's certificate of registration for a period of one (1) month, commencing from May 14, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Israel's certificate of registration:
  - Dr. Israel shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "A" to this Order; and
  - Dr. Israel will participate in and unconditionally pass the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, with a report or reports to be provided by the provider to the

College regarding Dr. Israel's progress and compliance. Dr. Israel will complete this requirement within 6 months of the date of this Order.
- Dr. Israel attend before the panel to be reprimanded.
- Dr. Israel to pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

4. Dr. R. Kakar

Name:	Dr. Ravi Kakar
Practice:	Psychiatrist
Practice Location:	Markham
Hearing:	Agreed Statement of Facts on Liability Penalty - Contested
Finding Decision Date:	November 16, 2018
Penalty Decision Date:	November 16, 2018
Written Decision Date:	May 16, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- found guilty of offence relevant to suitability to practise - **withdrawn**
- failed to maintain the standard of practice of the profession – **withdrawn**
- incompetence **- withdrawn**

Summary

Dr. Kakar is a 59 year old psychiatrist who practises in Markham, Ontario. Dr. Kakar obtained his independent practice certificate from the College in 1993.

Disgraceful, Dishonourable Or Unprofessional Conduct

Third Party Report Concerns

Patient A was referred to Dr. Kakar by her family physician to assess her mental health arising from her adjustment issues and alienation at school. Her family physician noted no history of mental health concerns or hospital admission although Patient A had previously been hospitalized in March of 2016.

Dr. Kakar first met Patient A in July, 2016. Patient A reported to Dr. Kakar a one-day hospitalization in March 2016 for depression resulting from alienation. Dr. Kakar concluded that Patient A was suffering from an adjustment disorder with depressed mood but saw no evidence that Patient A was suffering from psychosis. Dr. Kakar concluded that Patient A was not suffering from an identifiable mental disorder, but he continued to see and monitor Patient A.

Dr. Kakar next saw Patient A in August, 2016, for a follow up appointment. Patient A was a student at a local community college and requested a letter from Dr. Kakar to provide an opinion about whether she was fit to attend school for the fall semester. He provided a report which concluded that she was fit to attend school. Dr. Kakar did not obtain any of Patient A's medical records or additional information about her hospitalization prior to completing the third party report. He continued to treat Patient A with psychotherapy until December 2016.

On August 17, 2016, the College received information from the local community college regarding the psychiatric report prepared by Dr. Kakar on behalf of Patient A.

As a result of the concerns, the College retained Dr. Nicholas Delva as Medical Inspector to provide an opinion on the care Dr. Kakar provided to Patient A and on the third party report that had been prepared by Dr. Kakar on behalf of Patient A. Dr. Delva is a psychiatrist whose primary practice is located in the Department of Psychiatry, Hotel Dieu Hospital, Kingston, Ontario.

In Dr. Delva's opinion, there were no issues with Dr. Kakar's clinical care of Patient A and no concerns about harm or injury to Patient A. Dr. Delva identified, however, deficiencies with Dr. Kakar's third party report and his record-keeping.

Specifically Dr. Delva found that Dr. Kakar's report was not comprehensive and there was inadequate substantiation of facts because: a) Dr. Kakar should have obtained the hospital records reflecting Patient A's hospital admission prior to writing the report; and b) the report should have made it clear that it was based on information obtained directly from Patient A and that Dr. Kakar had failed to independently confirm information obtained from the patient.

Dr. Kakar admits that he was unprofessional in preparing the third party report on behalf of Patient A in that he did not obtain Patient A's hospital records prior to writing his report. Dr. Kakar's conduct is not consistent with professional obligations of a physician as articulated in the College Policy # 2-12, "Third Party Reports".

Breach of February 10, 2016 Undertaking with the College

On February 16, 2016, Dr. Kakar entered into an undertaking with the College in lieu of an Order under (then) s. 37 of the Health Professions Procedural Code in respect of a prior discipline referral. The undertaking required, *inter alia*, that all third party reports authored by Dr. Kakar be reviewed and approved by his Clinical Supervisor before being provided to the third party.

On October 13, 2016, College staff attended at Dr. Kakar's office to monitor his compliance with the terms on his certificate of registration. They identified four forms, for four different patients, from Dr. Kakar which were not approved by his Clinical Supervisor before being provided to the third party.

These four forms were:
- A Psychological Health Medical Update Form dated April 5, 2016 for Patient B;
- An Application for Determination of Catastrophic Impairment Form completed on May 22, 2016 for Patient C;
- A Clinical Information Form dated June 3, 2016 for Patient D; and
- A Medical Follow-Up Form dated October 13, 2016 for Patient E.

All of these four forms constituted Third Party Reports pursuant to the College's Third Party Reports Policy**.**

With respect Patient C, Dr. Kakar subsequent to his completion of the form above, also completed a more comprehensive third part report. This report was sent to his Clinical Supervisor for review and approval.

Dr. Kakar admits that the above four reports were not sent for approval to his Clinical Supervisor.

Disposition

On November 16, 2018, the Discipline Committee ordered and directed that:
- The Registrar suspend Dr. Kakar's certificate of registration for a period of one (1) month, commencing December 15, 2018 at 11:59 p.m.
- Dr. Kakar appear before the panel to be reprimanded.
- Dr. Kakar pay costs to the College in the amount of $10,180.00 within thirty (30) days from the date of this Order.

5. Dr. C. K. Thomas

Name:	Dr. Cholemkeril Kuncheria Thomas
Practice:	Emergency Medicine
Practice Location:	Iroquois Falls
Hearing:	Agreed Statement of Facts and Admission Penalty – Joint Submission
Finding/Penalty Decision Date:	June 19, 2019
Written Decision Date:	August 7 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Thomas is a 64 year old family physician who received his certificate of registration authorizing independent practice from the College in 2001.

Background

On April 19, 2017, the Inquiries, Complaints and Reports Committee of the College (the "**ICRC**") directed that Dr. Thomas attend the College to be cautioned and required that Dr. Thomas complete a specified continuing education and remediation program with the following components:

(a) *Courses*: Attend and complete the next available session of the following courses (with proof of attendance to be provided):

1. The Medical Record-Keeping Course, through a course provider indicated by the College;
2. The Safe Opioid Prescribing Course, through a course provider indicated by the College (three webinars and workshop);
3. ATLS (Advanced Trauma Life Support) (https://www.facs.org/quality-programs/trauma/atls/about); and
4. An Emergency Medicine Review Course (for example, the National Capital Conference on Emergency Medicine at http://www.emottawa.ca/eng/60-nccem.html).

(b) *One-on-one instruction*: Complete one-on-one instruction in collaboration and professionalism (including respect for colleagues and co-workers, punctuality, responsiveness to calls for patient care and responsiveness to requests from the College).

(c) *Self-directed learning with written summaries:* Review and prepare written summaries of up to 2000 words (2-4 pages) of each of the following documents with reference to current standards of practice (where applicable), how it is applicable to Dr. Thomas' situation, as well as how Dr. Thomas has made, or plans to make changes, to his practice. The written summaries were to be submitted within 4 months of receipt of the decision.

- Clinical Practice Guidelines regarding vaginal bleeding during pregnancy;
- Choosing Wisely Canada Recommendations for Emergency Medicine;
- The College's policy on Medical Records;
- The College's policy on Physician Behaviour in the Professional Environment; and
- The College's Practice Guide.

(d) *Clinical Supervision:* Engage a Clinical Supervisor acceptable to the College to engage in focused educational sessions as set out in an Individualized Education Plan. The Clinical Supervisor was required to sign an undertaking with the College within 30 days' of Dr. Thomas' receipt of the April 19, 2017 ICRC Decision. Dr. Thomas was required to meet with the Clinical Supervisor for a period of 12 months, no less than monthly for six months, and then quarterly for six months; and review at least 20 Emergency Department charts at each meeting.

(e) *Reassessment:* Approximately six months following the completion of the education and remediation set out above, Dr. Thomas' Emergency Department practice is to be reassessed.

Dr. Thomas's Failure to Comply With The April 2017 SCERP

On May 16, 2017, the College's Compliance Case Manager wrote to Dr. Thomas' counsel about the implementation of the April 2017 SCERP. The Compliance Case Manager asked that a Clinical Supervisor be identified to him by June 1, 2017.

Dr. Thomas proposed potential Clinical Supervisors on June 12, 2017 and June 27, 2017. The two Clinical Supervisors proposed by Dr. Thomas were not approved by the College.

On July 11, 2017, the Compliance Case Manager advised that he had located a potential Clinical Supervisor for Dr. Thomas. Dr. Thomas confirmed that he would be willing to work with the College's proposed Clinical Supervisor.

On August 2, 2017, the Compliance Case Manager confirmed that the College's proposed Clinical Supervisor ("Clinical Supervisor A") had been approved by the College. The Compliance Case Manager urged Dr. Thomas to contact Clinical Supervisor A shortly to begin the supervision meetings. On August 4, 2017, Clinical Supervisor A signed a Clinical Supervisor Undertaking to the College.

On September 15, 2017, Dr. Thomas, through his counsel, wrote to the Compliance Case Manager requesting an extension for completing the written summaries for the self-directed learning portion of the April 2017 SCERP to October 9, 2017. At the same time, he advised that Dr. Thomas had registered for the Medical Record-Keeping Course, the Safe Opioid Prescribing Course and an Emergency Medicine Review Course. He did not indicate whether Dr. Thomas had registered for a course in ATLS (Advanced Trauma Life Support). The College granted Dr. Thomas' request for an extension for completion of his written summaries to October 9, 2017.

In October of 2017, the Compliance Case Manager contacted Clinical Supervisor A to inquire about the status of her first supervision report, which had yet to be submitted to the College. Between October 17, 2017 and October 27, 2017, in an email exchange and in a telephone conversation, Clinical Supervisor A indicated to the Compliance Case Manager that she had had difficulty connecting and scheduling a meeting with Dr. Thomas.

On November 6, 2017, the Compliance Case Manager reminded Dr. Thomas, through his counsel, that it was Dr. Thomas' responsibility to ensure that he meets monthly with his Clinical Supervisor and that Dr. Thomas is in breach of his undertaking.

On December 7, 2017, Dr. Thomas' counsel wrote to provide an update regarding Dr. Thomas' compliance with the April 2017 SCERP. Dr. Thomas' counsel indicated that Dr.

Thomas had attended the Medical Record-Keeping Course, the Safe Opioid Prescribing Course and an Emergency Medicine Review Course and that he intended to complete a course in ATLS (Advanced Trauma Life Support) in early 2018. He also indicated that Dr. Thomas had completed an initial meeting with his one-on-one instructor, and that he had not yet completed the self-study with written summaries of 5 policies/guidelines (for which he had previously been granted an extension to October 9, 2017), but that these would be completed by December 15, 2017. As well, he indicated that Dr. Thomas had met with his Clinical Supervisor on September 16, 2017 and October 29, 2017.

On December 15, 2017, Dr. Thomas sent several emails to the Compliance Case Manager requesting that he be exempted from preparing written summaries for his self-directed learning as required by the April 2017 SCERP. In response, the Compliance Case Manager reminded Dr. Thomas that he had already been provided with two extensions and stated that the written summaries must be provided to the College by December 22, 2017.

On December 19, 2017, in response to a follow-up email from the Compliance Case Manager, Clinical Supervisor A advised the Compliance Case Manager that the meeting she had been scheduled to have with Dr. Thomas on December 12, 2017 had not occurred due to bad weather. Clinical Supervisor A had suggested that she could spend the day with Dr. Thomas in the emergency room but he had not been willing to do so. Given that Clinical Supervisor A had not been able to meet with Dr. Thomas in accordance with the terms of the April 19, 2017 ICRC Decision, the Compliance Case Manager advised that Clinical Supervisor A was no longer approved to act as Dr. Thomas' Clinical Supervisor.

On December 21, 2017, the Compliance Case Manager wrote to Dr. Thomas' counsel advising that the name of a new proposed Clinical Supervisor should be forwarded to her by January 12, 2018.

On January 3, 2018, the Compliance Case Manager wrote to Dr. Thomas' counsel advising that she had received an email from Dr. Thomas requesting yet another extension of time to complete his self-directed learning written summaries. She advised that she would grant one final extension to January 12, 2018. The Compliance Case Manager also stated that Dr. Thomas was required to have a College-approved Clinical Supervisor by January 12, 2018.

On January 15, 2018, the Compliance Case Manager wrote to Dr. Thomas' counsel and advised that Dr. Thomas had not submitted his self-directed learning written summaries, nor had she received the name of a proposed Clinical Supervisor. In her letter, the Compliance Case Manager indicated that she would grant an extension to January 26, 2018, failing which the matter would be returned to Committee for further direction.

On March 27, 2018, the Compliance Case Manager wrote to Dr. Thomas' counsel informing him that Dr. Thomas' matter would be returning to ICRC on April 3, 2018 for consideration of action due to his failure to complete the terms of the April 2017

SCERP.

As of April 3, 2018, when this matter was referred to the Discipline Committee by the ICRC, Dr. Thomas had failed to complete the terms of the April 2017 SCERP.

Status of Compliance at Date of Referral to the Discipline Committee

In particular, as of April 3, 2018, the status of Dr. Thomas' compliance with the terms of the April 2017 SCERP was as follows:

(a) *Courses:* Incomplete. Dr. Thomas had completed some, but not all, of his coursework.

(b) *One-on-one instruction:* Incomplete. Dr. Thomas had attended an initial meeting with his one-on-one instructor but then failed to attend follow-up sessions.

(c) *Self-directed learning with written summaries:* Incomplete. On multiple occasions, Dr. Thomas had requested and received extensions from the College to submit his written summaries.

(d) *Clinical Supervision:* Incomplete. Clinical Supervisor A ceased being Dr. Thomas' Clinical Supervisor on December 20, 2017, as Dr. Thomas failed to meet with her in accordance with the terms of the April 2017 SCERP. Dr. Thomas failed to identify a new Clinical Supervisor.

(e) *Reassessment:* Incomplete.

Current Status of Dr. Thomas' Compliance with the April 2017 SCERP

Following the ICRC's referral of Dr. Thomas' matter to the Discipline Committee, Dr. Thomas made some further efforts to comply with the April 2017 SCERP. As of June 12, 2019, the status of Dr. Thomas' compliance with the terms of the April 2017 SCERP is as follows:

(a) *Courses:* Complete.

(b) *One-on-one instruction:* Complete.

(c) *Self-directed learning with written summaries:* Complete.

(d) *Clinical Supervision:* Incomplete. Dr. Thomas retained a new Clinical Supervisor in December of 2018.

Dr. Thomas attended Clinical Supervision meetings on the following dates:

- January 12, 2019
- February 17, 2019

- March 16, 2019
- May 10, 2019

Dr. Thomas was scheduled to meet with his Clinical Supervisor in mid-April of 2019. However, Dr. Thomas cancelled the meeting. Therefore, Dr. Thomas did not meet with his Clinical Supervisor in April of 2019.

Dr. Thomas was also scheduled to meet with his Clinical Supervisor on May 31, 2019. However, on May 31, Dr. Thomas requested that the meeting be rescheduled. Thus, the May 31, 2019 meeting was rescheduled to June 2, 2019. On June 2, 2019, Dr. Thomas again requested that the meeting be rescheduled. The meeting was then rescheduled to June 3, 2019. On June 3, 2019, approximately one hour before the scheduled meeting time, Dr. Thomas called the Clinical Supervisor and advised that he forgot the time, would be late, and asked to start the meeting one hour later. Dr. Thomas's Clinical Supervisor was not able to accommodate this third rescheduling request. Dr. Thomas's next meeting with his Clinical Supervisor is scheduled for June 14, 2019.

Subject to any further delays, Dr. Thomas is scheduled to complete his Clinical Supervision in February of 2020.

(e) *Reassessment:* Incomplete. Dr. Thomas' reassessment is to be scheduled approximately 6 months' following completion of Dr. Thomas' Clinical Supervision.

Relevant College History

In June 2014, the Inquiries, Complaints and Reports Committee of the College considered a complaint from a prior employer of Dr. Thomas in Ottawa. That employer complained that Dr. Thomas left his position without any notice or follow-up plans for his patients, did not respond to efforts by clinic staff to contact him, and took some patient records with him. In addition, Dr. Thomas failed to respond to a letter from the College's investigator with questions regarding the matter. The ICRC issued a written caution to Dr. Thomas regarding his lack of appropriate management upon leaving a practice.

Additional Relevant History

In August 1996, a complaint was received by the College of Physicians and Surgeons of Nova Scotia from the Nova Scotia Prescription Monitoring Program that Dr. Thomas failed to respond to their requests for information concerning his prescribing of controlled substances to patient X. After investigation of the matter, Dr. Thomas was counseled with respect to not responding promptly and appropriately to the Prescription Monitoring Program. The Investigation Committee also suggested that he review the organization of his office to ensure that all mail was dealt with appropriately.

Disposition

The Discipline Committee ordered that:

- Dr. Thomas attend before the panel to be reprimanded.
- The Registrar suspend Dr. Thomas's certificate of registration for a period of one (1) month, commencing from July 3, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Thomas's certificate of registration:
    a. Dr. Thomas shall comply with the College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation", a copy of which is attached at Schedule "A" to this Order;

Clinical Supervision

b. For a period of nine (9) months from the date of this Order, Dr. Thomas shall practice medicine only under the supervision of a clinical supervisor approved by the College (the "Clinical Supervision").

c. Within ten (10) days of this Order, Dr. Thomas shall have a College-approved clinical supervisor (the "Clinical Supervisor") sign an Undertaking in the form attached hereto as Schedule "B".

d. Dr. Thomas shall meet with the Clinical Supervisor once in August 2019, once in November 2019, and once in February 2020. At each meeting, the Clinical Supervisor shall:
    i. Review a minimum of twenty (20) patient charts, to be selected by the Clinical Supervisor in accordance with the educational needs identified in the Individualized Education Plan attached hereto at Schedule "C" (the "IEP");
    ii. Discuss with Dr. Thomas any concerns the Clinical Supervisor may have arising from the chart reviews;
    iii. Make recommendations to Dr. Thomas for practice improvements and inquire into Dr. Thomas' compliance with the recommendations; and
    iv. Keep a log of all patient charts reviewed along with patient identifiers.

e. The Clinical Supervisor shall submit written reports to the College promptly after every meeting with Dr. Thomas, or immediately if the Clinical Supervisor has concerns about Dr. Thomas' standard of practice or that Dr. Thomas' patients may be exposed to harm or injury.

f. Dr. Thomas shall fully cooperate with the Clinical Supervision and shall abide by all recommendations of the Clinical Supervisor.

g. If a person who has given an Undertaking in Schedule "B" to this Order is unable or unwilling to continue to fulfill its provisions, Dr. Thomas shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

h. If Dr. Thomas is unable to obtain a Clinical Supervisor as set out in this Order, he shall cease practising medicine until such time as he has obtained a Clinical Supervisor acceptable to the College.

i. If Dr. Thomas is required to cease practise as a result of section 4.(viii) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register.

Reassessment

j. Approximately six (6) months following completion of the Clinical Supervision, Dr. Thomas shall undergo a reassessment of his practice by a College-appointed assessor (the “Reassessment”).

k. The Reassessment shall focus on the educational needs addressed during the period of Clinical Supervision as set out in the IEP and may include a review of Dr. Thomas’s patient charts, direct observations, and interviews with staff and/or patients and any other tools deemed necessary by the College. The Assessor shall report the results of the Reassessment to the College.

Monitoring

l. Dr. Thomas shall inform the College of each and every location where he practices, in any jurisdiction (his “Practice Location(s)”) within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

m. Dr. Thomas shall consent to the sharing of information between the Clinical Supervisor, the Assessor and the College as any of them deem necessary or desirable in order to fulfill their respective obligations.

n. Dr. Thomas shall consent to the College making enquiries of the Ontario Health Insurance Program, the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor his compliance with this Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions.

o. Dr. Thomas shall co-operate with unannounced inspections of his office practice and patient charts by the College for the purpose of monitoring and enforcing his compliance with the terms of this Order.

p. Dr. Thomas shall notify any employer, or any hospital at which he may have privileges, about this Order.

q. Dr. Thomas shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Thomas pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2019

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Policy Consultation Update:

   I. Boundary Violations
   II. Disclosure of Harm
   III. Prescribing Drugs

2. Policy Status Table

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1. Policy Consultation Update

I. Boundary Violations

- The general consultation on the *Boundary Violations* draft policy and *Advice to the Profession* document closed on August 2, 2019. The consultation garnered a total of 117 responses: 24 through email or the online discussion page and 93 via the online consultation survey.[1]

- Overall, the feedback was positive. Respondents found the draft policy to be clearly written, well organized, and easy to understand. Most respondents also agreed with the expectations set out in the draft policy.

- Respondents did have some specific feedback on some of the provisions in the draft policy and advice to the profession document. A sample is set out below:

  - Some respondents felt that the draft policy should address the consequences for physicians if they violate boundaries.

[1] Organizational respondents include: the College of Nurses of Ontario, the Canadian Medical Protective Association, the Ontario Medical Association, the College of Physicians and Surgeons of Alberta, and the Ontario Trial Lawyers Association.

  - There were some comments about consent issues; for example, the draft policy should explicitly require that physicians obtain consent for intimate examinations and for third party attendance at an examination.
  - Some physician respondents felt that the draft policy required them to have third parties in all situations and felt that this was not possible. Public respondents felt that they should be able to refuse to have a third party present in an examination.
  - Some respondents felt that the draft policy should explain how some of the expectations will apply in rural scenarios or for physicians who work in the military, particularly the provisions with respect to non-sexual boundary violations.
  - Some respondents felt that the draft policy should allow physicians to comfort patients by giving them a hug. Others thought that the policy should be stronger in terms of expectations around non-clinical touching of patients for the purpose of comforting them.
  - There were some comments about clarity of language; in particular, there were suggestions that "minor or insubstantial" psychotherapy should be explained.
  - Respondents seemed satisfied with the Advice to the Profession document, but some respondents thought that there should be more specific examples of non-sexual boundary violations.

- All feedback is currently being reviewed in detail to help inform revisions to the draft policy and advice to the profession document.

II. Disclosure of Harm

- The general consultation on the *Disclosure of Harm* draft policy and *Advice to the Profession* document closed on August 2, 2019. The consultation garnered a total of 84 responses: 11 through email or the online discussion page and 73 via the online consultation survey.[2]

- Overall, respondents found the draft policy to be clearly written, well organized, and easy to understand. The majority of respondents also agreed with the general principles and expectations set out in the draft policy.

- Respondents provided specific feedback on certain provisions in the draft policy and advice document to promote clarity and comprehensiveness. This feedback includes requests for:

  - specific examples of key terms and concepts in the draft policy (particularly "no-harm" and "near miss" incidents);

[2] Organizational respondents include: the Canadian Medical Protective Association, Information and Privacy Commissioner of Ontario, Ontario Trial Lawyers Association, Ontario Medical Association, College of Physicians and Surgeons of Alberta, and Professional Association of Residents of Ontario.

  - further clarity around the role and obligations of Most Responsible Physicians, both inside and outside the hospital setting, and the role of postgraduate learners;
  - refinement of the disclosure obligation when a patient has died;
  - content geared toward specific areas of practice (in particular, surgery and laboratory work); and
  - content addressing the consequences for physicians if they violate their disclosure obligations.

- Feedback is being reviewed in detail and will help inform revisions to the draft policy and advice to the profession document.

III. Prescribing Drugs

- The general consultation on the *Prescribing Drugs* draft policy closed on August 2, 2019. The consultation garnered a total of 130 responses: 33 through email or the online discussion page and 97 via the online consultation survey.[3]

- Feedback for the draft policy was largely positive. Respondents generally supported the expectations set out in the draft policy and described it as comprehensive, well-written, and useful. Feedback regarding the draft expectations and provisions included:

  - Respondents generally supported the inclusion of expectations for the tapering of narcotics and controlled substances. Some physician respondents requested guidance addressing instances where patients disagree with or are unwilling to discuss tapering.
  - Some respondents expressed support for “no narcotics” prescribing policies, though some physician respondents felt there may be instances where these blanket policies could be appropriate.
  - While respondents were generally supportive of the policy’s expectations for checking a patient’s digital prescription history, some were concerned about physicians’ inability to easily access these systems.
  - Advocates for patients experiencing chronic pain highlighted concerns regarding inadequate care and the lack of effective alternatives to prescription opioids for pain management treatment.
  - Some respondents called for increased inter-professional collaboration with pharmacists, especially when prescribing narcotics and controlled substances.
  - Several respondents suggested including the diagnosis or indication of medication on the written prescription, while others reported issues with physicians responding in a timely manner when contacted by pharmacists.

[3] Organizational respondents include: Information and Privacy Commissioner of Ontario, Canada Health Infoway, Ontario Medical Association, the College of Physicians and Surgeons of Alberta, the Ontario College of Pharmacists, and Professional Association of Residents of Ontario.

- All feedback is currently being reviewed in detail to help inform revisions to the draft policy.

2. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix A**. This table will be updated at each Council meeting.

- For further information about the status of any policy issue, please contact Craig Roxborough, Manager, Policy, at extension 339.

DECISIONS/DISCUSSION FOR COUNCIL:

For information only

Contact: Craig Roxborough, Ext. 339

Date: August 30, 2019

Appendices:

Appendix A: Policy Status Table

Appendix A

Policy Status Report – September 2019 Council

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle					Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Revising Draft Policy	Final Approval		
Advertising	May-19		✓				**2020**	A new policy is being developed to provide guidance and set parameters within the legislative framework.
Complementary/ Alternative Medicine	Mar-19		✓				**2020**	
Delegation of Controlled Acts	Mar-19		✓				**2020**	
Disclosure of Harm	Sept-18				✓		**2019**	
Prescribing Drugs	Dec-17				✓		**2019**	
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	Sept-17				✓		**2019**	The draft policy in development has a new title: *Boundary Violations*
Medical Records	Sept-17			✓			**2020**	
Confidentiality of Personal Health Information	May-17			✓			**2020**	
Continuity of Care and **Test Results Management**	May-16					✓	**2019**	
Practice Management Considerations for Physicians Who Cease to Practise…	May-16					✓	**2019**	The timeline for this policy was adjusted to align with the *Continuity of Care* given points of intersection.

Policy Status Report – September 2019 Council

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Female Genital Cutting (Mutilation)	2016/17	Professional Obligations and Human Rights	2020/21
Dispensing Drugs	2016/17	Consent to Treatment	2020/21
Professional Responsibilities in Postgraduate Medical Education	2016/17	Planning for and Providing Quality End-of-Life Care	2020/21
Third Party Reports	2017/18	Blood Borne Viruses	2021/22
Mandatory and Permissive Reporting	2017/18	Physician Treatment of Self, Family Members, or Others Close to Them	2021/22
Criminal Record Screening	2017/18	Physician Behaviour in the Professional Environment	2021/22
Professional Responsibilities in Undergraduate Medical Education	2017/18	Medical Assistance in Dying	2021/22
Medical Expert: Reports and Testimony	2017/18	Accepting New Patients	2022/23
Social Media – Appropriate Use by Physicians (Statement)	2018/19	Ending the Physician-Patient Relationship	2022/23
Providing Physician Services During Job Actions	2018/19	Uninsured Services: Billing and Block Fees	2022/23
Physicians' Relationships with Industry: Practice, Education and Research	2019/20	Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24
Telemedicine	2019/20	Public Health Emergencies	2023/24
Cannabis for Medical Purposes	2020/21		

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Motion

Motion Title: **In Camera Motion**

Date of Meeting: **September 20, 2019**

It is moved by____,

and seconded by____, that:

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