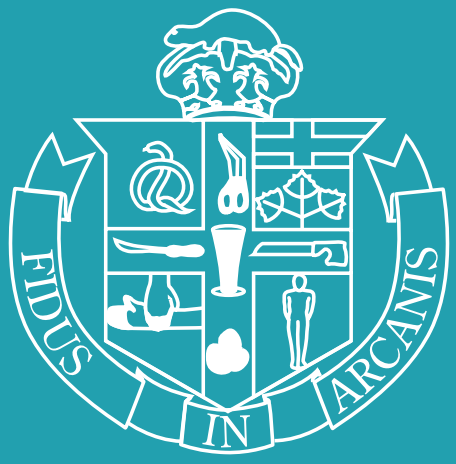
The College of Physicians and Surgeons of Ontario

Annual Financial Meeting of Council



May 30 and 31, 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 Thursday, May 30 and Friday, May 31, 2019 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m. on May 30, 2019.

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

May 14, 2019

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL

May 30 and 31, 2019

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

May 30, 2019

CALL TO ORDER

9:00 President's Announcements

Council Meeting Minutes of March 1, 2019 1

Executive Committee's Report to Council, March-April 2019 30

9:15 Registrar/CEO Report

10:00 MORNING BREAK

GUEST SPEAKER

10:15 Julie Drury: Inaugural Chair of the Minister's Patient and Family Advisory Council for the Ontario Ministry of Health and Long Term Care..... 32

11:15 MEMBER TOPICS

COUNCIL AWARD PRESENTATION

11:30 Council Award Winner: Dr. Marie Gear, Teeswater, Ontario 33

12:00 LUNCH BREAK

1:00 Strategic Plan 34

For Decision

A new strategic plan for 2020-2025 has been developed based on the February 28th strategic planning session, and refined by incorporating feedback from Council and the CPSO's leadership team. Council is asked to choose the vision and mission statements and approve the strategic plan.

2:00 Governance Committee Report..... 41

For Decision

- 2019-2020 Executive Committee Election

For Discussion

- Governance Modernization
  a) Review of Standing Committees
  b) Committee Term/Age Limits
  c) Strengthening Orientation and Education

For Information

- Appointments: Public Member Reappointment
- Appointments: Committee
- Completion of 2019 Committee Interest Forms

2:30 AFTERNOON BREAK

2:45 Harry Cayton Report: An Inquiry into the Performance of the College of Dental Surgeons of British Columbia (CDSBC) and the *Health Professions Act* 76

For Discussion

- This report, released in April 2019 is relevant to the CPSO given the potential for health professionals regulatory reform in Ontario and Mr. Cayton's influence as an international expert in health regulation.

3:00 Policy Redesign Implementation - Batch 1..... 85

For Decision

In December, Council approved the redesign of College policies in order to enhance their utility for physicians. All policies not currently under review will be redesigned by the end of 2019.

Council is presented with the first batch of redesigned policies, along with some proposed housekeeping amendments to two policies. Council is asked to approve the redesigned policies.

ADJOURNMENT DAY 1

May 31, 2019

CALL TO ORDER

9:00 Boundary Violations 202

For Decision

The College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy is currently under review. A new draft policy entitled *Boundary Violations* and a companion advice document have been developed. Council is being asked to approve the draft policy for external consultation.

9:20 Disclosure of Harm 219

For Decision

The College's *Disclosure of Harm* policy is under review. A new draft policy and a companion advice document have been developed. Council is being asked to approve the draft policy for external consultation.

9:40 Prescribing Drugs Policy..... 232

For Decision

The College's *Prescribing Drugs* policy is under review in accordance with the regular policy review cycle. An updated draft of the policy has been developed. Council is being asked to approve the draft policy for external consultation.

10:00 Transparency 247

For Decision

Currently, charges, bail conditions and findings of guilt are posted on the public register if they arise from Canadian proceedings. Council is asked to approve a by-law change that would make similar matters public if they arise from another jurisdiction.

10:15 MORNING BREAK

10:45 Finance and Audit Committee 251

For Decision

1. 2018 Audited Financial Statement and Appointment of the Auditor For 2019
2. Criminal Record Check Fee and Fairness Commissioner Fee
3. Pension Plan Resolution

At the Annual Financial Meeting of Council the College's auditor presents the audit report along with the audited financial statements for 2018. Council will also appoint the external auditors for the upcoming year.

The College is in the process of joining HOOPP but will continue to offer a defined contribution savings arrangement. A resolution must be signed by Council terminating the current defined contribution plan and establishing a new one.

The Finance and Audit Committee recommends to Council to Remove the Criminal Record Check and Fairness Commissioner Fees from the Fees By-laws.

INFORMATION ITEMS

1. **Policy Report..... 279**
2. **Government Relations Report 285**
3. **Discipline Committee Report of Completed Cases, May 2019 ..... 295**

11:30 IN CAMERA SESSION

ADJOURNMENT DAY 2

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Council Meeting Minutes of March 1, 2019**

Date of Meeting: **May 30, 2019**

It is moved by _____,

and seconded by_____, that:

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

or

The Council accepts the minutes of the meeting of the Council held on March 1, 2019 with the following corrections:

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
March 1, 2019

Attendees:

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

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

Regrets: Dr. Mary Bell, Dr. Brenda Copps, Dr. Michael Franklyn and Ms Judy Mintz

CALL TO ORDER

President's Announcements

Dr. Peeter Poldre opened the meeting with a traditional land acknowledgement statement as a demonstration of recognition and respect for indigenous peoples:

We acknowledge the land we are meeting on is the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunaee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples.

Council Meeting Minutes of December 6 and7, 2018

01-C-03-2019

It is moved by Dr. Deborah Hellyer and seconded by Dr. Jerry Rosenblum that:

The Council accepts the minutes of the meeting of the Council held on December 6 and 7, 2018.
CARRIED

Executive Committee's Report to Council, December – February 2019

Received with no comments.

REGISTRAR/CEO REPORT

Dr. Nancy Whitmore discussed the College's 2019 corporate plan, key goals and priorities, the Enterprise System (a large-scale application software package that supports business processes, information flows, reporting, and data analytics in organizations); and the Quality Management pilot program designed to integrate quality improvement and quality assurance, increase CPSO interaction with physicians, and use high cost assessments only for physicians in need.

GOVERNANCE EDUCATION

Guest Speaker: ***Linda Rothstein***

Linda Rothstein, a Partner at Paliare Roland Rosenberg Rothstein LLP is a recognized expert in Administrative and Public Law. She provided Council with an overview of the key functions of the board and board members, and spoke on governance modernization and best board practices. Her presentation is attached to these minutes as **Appendix " "**.

COUNCIL AWARD PRESENTATION

Dr. Patrick Safieh presented the Council Award to Dr. Rayfel Schneider of Toronto, Ontario.

Physician Council Member Prep Time

Committee Chairs were asked by the Finance Committee to consider committee efficiencies. As part of this, a summary of prep time claims submitted by physician Council members in 2018 was prepared, which shows some variation. Dr. Poldre proposed to Council that the Executive Committee review the prep time involved in reading the Executive Committee meeting materials leading up to each Council Meeting, and then provide physicians on Council a reasonable estimate to use as a guideline. Council supported the proposal.

MEMBER TOPICS

The issue of unproven and potentially risky stem cell therapies was raised. The matter will be reviewed by the Executive Committee and reported back to May Council.

Logo Simplification Proposal

The CPSO is launching a new modern user-friendly website in April 2019. The current logo does not meet Accessibility for Ontarians with Disabilities Act (AODA) standards and is not suitable for mobile-friendly website usage. Three options to replace the current logo (for website use only) were presented for Council's final decision and approval.

02-C-03-2019

It is moved by Ms. Ellen Mary Mills and seconded by Dr. Elizabeth Samson that:

Council approves the simplified logo, as set out below:

COLLEGE OF PHYSICIANS & SURGEONS OF ONTARIO

CARRIED

(Note: Ms. Catherine Kerr was absent for this motion)

Specific Direction to the Registrar Regarding Registration Requirements – Policies Requiring Revision

***Postgraduate Term for Clinical Fellows* Policy:**

00-C-03-2019

It is moved by Dr. Philip Berger, and seconded by Ms. Hilary Alexander, that:

The Council approves the revised policy "Postgraduate Term for Clinical Fellows" (a copy of which forms Appendix "…" to the minutes of this meeting) as a policy of the College.

CARRIED

00-C-03-2019

It is moved by Dr. Rob Gratton, and seconded by Ms. Joan Powell, that:

> **The Council approves the following amended Policies: "Alternatives to Degrees in Medicine from Schools Listed in the World Directory of Medical Schools Published by the World Health Organization", "One Year Canadian Practice Experience Exemption", Canadian Citizenship/Permanent Resident Status Exemption", and the "Pre-Entry Assessment Program Exemption" (copies of which forms Appendix "…" to the minutes of this meeting) as Policies of the College.**
>
> **CARRIED**

Governance Committee Report

- ***For Information***
  1. Governance Review/Modernization
  2. New Public Members of Council
  3. Committee Appointments

4. Election for Public Member to Fill Vacancy on 2019 Executive Committee

03-C-03-2019

It is moved by Mr. Mehdi Kanji and seconded by Dr. Panju Akbar that:

> **The Council appoints Ms Ellen Mary Mills (as public member) to the Executive Committee.**
>
> **CARRIED**

Finance and Audit Committee Recommendations

The Finance and Audit Committee met on January 24th and two items were discussed/reviewed that are being recommended to Council:

1. Removing Criminal Record Check and Fairness Commissioner Fees from the Fees By-Law

00-C-03-2019

It is moved by Mr. Peter Pielsticker 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. 127, after circulation to stakeholders:

By-law No. 127

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

CARRIED

2. Tariff Rate Increase for Discipline Hearings

00-C-03-2019

It is moved by Mr. Peter Pielsticker, and seconded by Dr. Deborah Hellyer, that:

The Council of the College of Physicians and Surgeons of Ontario amends the Discipline Committee's Tariff Rate for Costs and Expenses for the College to Conduct a Day of Hearing, increasing the Tariff Rate to $10,370, effective March 1, 2019.

CARRIED

INFORMATION ITEMS

1. **Policy Report**
2. **Government Relations Report**
3. **Discipline Committee - Report of Completed Cases, March 2019**

Motion to Go In Camera

00-C-03-2019

It is moved by Ms Joan Fisk, and seconded by Ms. Gerry Sparrow, 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.

CARRIED

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 3:00 pm.

_____
Dr. Peeter Poldre, President

_____
Ellen Spiegel, Recording Secretary

APPENDICES TO THE PROCEEDINGS OF THE

MEETING OF COUNCIL

OF

THE COLLEGE OF PHYSICIANS AND SURGEONS

OF ONTARIO

March 1, 2019

PALIARE ROLAND BARRISTERS

College of Physicians and Surgeons of Ontario

Good Governance: Council Members' and Committee Members' Roles and Responsibilities

Linda Rothstein, Partner
416.646.4327
linda.rothstein@paliareroland.com

1

Legal Framework

- Body corporate incorporated by Special Act
  - *Medicine Act, 1991*
  - *Regulated Health Professions Act, 1991*
- College is a legal entity with all the powers of an individual to hire/fire/commence and defend lawsuits, buy/sell property/borrow and lend money
- Doesn't issue shares/*Corporations Act* does not apply

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2

Legal Framework (cont'd)

- **s. 3(2) of the *RHPA***

"In carrying out its objects, the College has a duty to serve and protect the public interest."

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3

Governance Framework

- This is the overarching principle of the regulatory scheme: the College, Council & Committees have to govern in the *public* interest

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Governance Framework

- *Medicine Act* and *RHPA* (including Health Professions Procedural Code)
  - Key: dominant purpose of legislation is public protection
- By-laws
  - Passed by Council
- College Policies
  - Examples:
    - Conflict of Interest
    - Impartiality of Decision Making
    - Council Code of Conduct
    - Statement on Public Interest
    - Confidentiality Policy
    - Role Description of College Council Member

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5

Unique Aspects of College

- Mandated Board Composition
  - 16 elected by members and who **are** members
  - 13 – 15 appointed by LGIC and **not** members
  - 3 selected in accordance with by-law - members of Faculty of Medicine

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Unique Aspects of College (cont'd)

Does this structure require modernization?

- Is the board too big?
- Should there be greater public member representation?
- What's the appropriate selection process?

Unique Aspects of College (cont'd)

- Role of the Registrar
  - Implements policies & administers the affairs of the College

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Statutory Committees of Council

- Section 10 – *RHPA*
  - Executive Committee
  - Registrations Committee
  - Inquiries, Complaints and Reports Committee
  - Discipline Committee
  - Fitness to Practise Committee
  - Quality Assurance Committee
  - Patient Relations Committee

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Unique Aspects of College

- Members have limited role
  - Elect Council
  - Receive By-laws
  - Attend member meetings

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Duty of College

- **Duty to work in consultation with Minister to ensure, as a matter of public interest – people of Ontario have access to adequate numbers of qualified, skilled, competent regulated health professionals (section 2.1 *RHPA*)**

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Objects of College

- **Objects set out in Section 3 of Schedule 2 of RHPA**
  - Regulate practice of medicine and govern members in accordance with *Medicine Act*, RHPA, code, regulations and by-laws
  - Develop, establish and maintain:
    - Standards of qualification - registration
    - Programs and standards of practice to assure quality

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Objects of College - (cont'd)

- Standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement
- Standard of professional ethics
- Programs to assist individuals to exercise their rights under Code and *RHPA*
- Standards and programs to promote ability of members to respond to changes in practice environments, advances in technology and other emerging issues

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Objects of College - (cont'd)

- To administer *Medicine Act*, Code, *RHPA* as it relates to profession of medicine and to perform all other duties and exercise other powers that are imposed or conferred on the College
- Promote and enhance relations between College, its members and other colleges, key stakeholders and public
- Promote inter-professional collaboration with other colleges
- Any other objects related to human health care that Council consider desirable

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Governance vs Management

- Board "governs"
  - emphasis on *policy making* and *oversight*
- Management "manages"
  - emphasis on implementation of policy, and operations

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Governance vs Management (cont'd)

Board is responsible to see that the College is well managed – it is not the Board's role to manage the College

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Stewardship

- The responsibility of the board is to oversee the conduct of the business and to supervise management which is responsible for the day-to-day conduct of the business
- In addition, as stewards of the business, the Directors function as a "catch-all" to ensure no issue affecting the business and affairs of the company "falls between the cracks"

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Standard of Care

Directors must exercise the care, diligence and skill that may reasonably be expected of a person with their knowledge and skill

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Aspects of Fiduciary Duty

- Loyalty
- Honesty
- Good Faith
- Best Interests of College
- Confidentiality (*RHPA* – s.36)
- Avoidance of Conflicts of Interest

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Conflict of Interest and Reasonable Apprehension of Bias

- Fiduciary Duty – owed to College
  - Avoid conflict of interest

Conflict of Interest

- **Cannot be exhaustively defined:**
- **Includes:**
  - Interests (direct or indirect) in contracts or transactions
  - Misuse of confidential information
  - Appropriation of corporate opportunity

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Conflict of Interest (cont'd)

- Duty of Fairness – an administrative law principle – owed to persons who appear before a tribunal
  - Adjudicators should be free of an *appearance of bias*

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Reasonable Apprehension of Bias

- Also cannot be exhaustively defined
- Situations where committee member is found to have pre-judged matter, be predisposed to a particular outcome or to have a closed mind:
  - Not actual bias
  - Test is: Would a reasonable person, in possession of all the relevant facts and having thought the matter through carefully conclude that there is a reasonable apprehension of bias

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Reasonable Apprehension of Bias

- Examples
  - Personal relationships with party or witness
  - Prior knowledge through investigations
  - Prior knowledge through other committee work
  - Professional relationships
  - Expressing opinion on merits of case before public proceedings
  - Expression of views that indicate a pre-judgment of the issues
  - Improper behaviour during proceedings (flippant remarks)

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Managing Conflict of Interest / Apprehension of Bias

- *RHPA*
  - Person who sits on discipline panel should not have participated in investigation
- Policies and Procedures
  - Ask for guidance (committee support person)
  - Review and follow Impartiality in Decision Making Policy and Conflict of Interest Policy

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Avoidance of Liability

IMMUNITY

INSURANCE

INDEMNITY

DUE DILIGENCE

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Immunity

- Section 38 *RHPA* prohibits any action against a Director for:
  - Act done in good faith in performance or intended performance of any duty or exercise or intended exercise of any power, under *RHPA*, *Medicine Act*, *Drug and Pharmacies Regulation Act*, regulations, by-law; or
  - Any alleged neglect or default in the performance or exercise in good faith of any such duty or power, *RHPA*, *Medicine Act*, *Drug and Pharmacies Regulation Act*, regulation or by-law

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The Due Diligence Defence

- Ensure that all reasonable steps were taken to prevent occurrence of the offence
  - Proper governance procedures
  - Reasonable and prudent delegation
  - Supervision and monitoring

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Four Cornerstones of Director Due Diligence

Knowledge	**Behaviour and Participation**
Respect Roles, Structures and Processes	**Continuous Improvement**

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Director Due Diligence

- Knowledge
  - Legislative framework
  - By-laws
  - Committee structure
  - Governance policies
  - Business and affairs of the College
  - Duties and responsibilities of Directors
  - Standard of Care
  - Rely on professional advice

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Director Due Diligence

- Respect Board's Structures, Process and Roles
  - Governance vs Management
  - Committee mandates
  - Board policies
  - Delegation
  - Chair's Role
  - Consensus decision process

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30

Modernizing Governance: The Challenge

- All the professions are grappling with these issues:
  - How to improve efficiency?
  - How to increase effectiveness?
  - How to improve board competency?
  - How to strengthen public confidence?
  - What are the best practices in regulatory governance?

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BARRISTERS

THANK YOU

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Appendix B

POSTGRADUATE EDUCATION TERM FOR CLINICAL FELLOWS

This policy applies to all IMG clinical fellows holding a postgraduate education certificate issued under section 12 of the registration regulations. Under the regulation, the certificate terminates after two years. However, this policy enables the College to renew the certificate for three additional years, without the need for the College's Registration Committee to approve the third, fourth or fifth year, provided the applicant continues to meet non-exemptible registration standards.

Under this policy, applicants may apply for an extension for a third, fourth and/or fifth year, but will require approval by the College.

The proposed third, fourth and/or fifth years must be in the same clinical fellowship program and enrollment must be continuous; the certificate automatically terminates at the end of the fifth year of the clinical fellowship.

ALTERNATIVES TO DEGREES IN MEDICINE FROM SCHOOLS LISTED IN THE WORLD DIRECTORY OF MEDICAL SCHOOLS PUBLISHED BY THE WORLD HEALTH ORGANIZATION

A degree in medicine is defined in section 1 of the Registration Regulation to include the following:

a. an M.D. or equivalent basic degree in medicine, based upon successful completion of a conventional undergraduate program of education in allopathic medicine that,
    i. teaches medical principles, knowledge and skills similar to those taught in undergraduate programs of medical education at accredited medical schools,
    ii. includes at least 130 weeks of instruction over a minimum of thirty-six months, and
    iii. was, at the time of graduation, listed in the World Directory of Medical Schools published by the World Health Organization. The Registration Committee accepts an M.D. or equivalent basic degree in medicine from a medical school that was, at the time of graduation, listed in the World Directory of Medical Schools online registry as satisfying the requirement set out in s. 1 (b)(iii) of the Registration Regulation.

All applicants must satisfy all other criteria for registration.

ONE YEAR CANADIAN PRACTICE EXPERIENCE EXEMPTION

Requirements

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

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

In addition, Section 2.-(2)(b)(i) stipulates that the applicant must have Canadian citizenship or Permanent resident status before an independent practice certificate of registration can be issued.

This Policy provides an exemption from the requirement for one year Canadian Practice Experience for physicians otherwise fully qualified for an Independent Practice Certificate of Registration.

CANADIAN CITIZENSHIP / PERMANENT RESIDENT STATUS EXEMPTION

Requirements

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

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

In addition, Section 2.-(2)(b)(i) stipulates that the applicant must have Canadian citizenship or Permanent resident status before an independent practice certificate of registration can be issued.

This Policy provides an exemption from the requirement for Canadian Citizenship/Permanent Resident Status for physicians otherwise fully qualified for an Independent Practice Certificate of Registration.

PRE-ENTRY ASSESSMENT PROGRAM EXEMPTION

Provides exemption from the Pre-Entry Assessment Program requirement for IMGs applying for a postgraduate education certificate to take a residency in Ontario.

An applicant for a postgraduate certificate of registration, who has an appointment to a residency program at an Ontario medical school, may be exempted from the requirement to complete a Pre-entry Assessment Program, provided the applicant satisfies each of (a), (b) and (c) below at the time of applying to the College of Physicians and Surgeons of Ontario:

1. The applicant has already completed, within the last year, one or more years of residency training that is accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC), or one or more years of residency training in the USA, that is accredited by the Accreditation Council for Graduate Medical Education.
2. The applicant is entering an Ontario medical school to take either,
    1. A subsequent year of residency in the same discipline or a sub-discipline as the residency already completed; or
    2. A program to obtain recognition by the RCPSC or CFPC in a related discipline or field after having completed the educational requirements for certification by the RCPSC or CFPC.
3. The applicant has passed the Medical Council of Canada Evaluating Examination and completed all other requirements for a certificate of registration for postgraduate education.

Applicants are urged to submit their applications eight to twelve weeks in advance of their expected starting dates in Ontario. The application requires review by the College.

All registration regulations, policies and requirements are subject to change.

Council Briefing Note

May 2019

TOPIC: **Executive Committee's Report to Council**
January - March 2019
In Accordance with Section 12 HPPC

FOR INFORMATION

January 15, 2019 Executive Committee Meeting

4. Marijuana for Medical Purposes: Revised Policy Title

2-EX-Jan-2019 Upon a motion by Peter Pielsticker and seconded by Steven Bodley and CARRIED, the Executive Committee approved updating the name of the policy from **Marijuana for Medical Purposes** policy to the **Cannabis for Medical Purposes** policy.

6. Governance Committee Report

3-EX-Jan-2019 Upon a motion by Steven Bodley and seconded by Akbar Panju and CARRIED, the Executive Committee makes the following appointments:

- Hilary Alexander – ICR Committee
- Christine Tebbutt – Discipline and Fitness to Practise Committees
- Dr. Ken Lee – Quality Assurance Committee
- Dr. Ben Chen and Dr. David Finkelstein – ICR Committee

March 19, 2019 Executive Committee Meeting

7. Government Submission: Red Tape Reduction/Regulatory Modernization

The Executive Committee approved a submission to the Deputy Premier and Minister of Health and Long-Term Care that sets out recommendations to reduce red tape and achieve a more efficient and effective regulatory structure. The recommendations fall into two categories: regulatory process improvements, and governance modernization. Among the recommendations to improve processes is that the CPSO be provided with

greater discretion to triage complaints to allow us to focus regulatory activity on the complaints that most impact public safety.

6-EX-Mar-2019 Upon a motion by Peter Pielsticker and seconded by Brenda Copps, and CARRIED, the Executive Committee approves forwarding to Government the proposed red tape/regulatory modernization submission, with the inclusion of the Mental Health issue.

8. Governance Committee Report

7-EX-Mar-2019 Upon a motion by Peter Pielsticker and seconded by Brenda Copps, and CARRIED, the Executive Committee appoints Dr. Michael Franklyn to the Discipline and Quality Assurance Committees.

Contact: Peeter Poldre, President
Lisa Brownstone, x 472

Date: May 9, 2019

Julie Drury
Julie.drury@ontario.ca

JULIE DRURY is the inaugural Chair of the Minister's Patient and Family Advisory Council for the Ontario Ministry of Health and Long Term Care. Julie is passionate about the patient / family / professional partnership and experience in health. In her role, she facilitates and provides the patient and family perspective in health care policy and decision making. As the mother of a child who was diagnosed with SIFD, a rare form of mitochondrial disease, Julie has particular experience in system navigation, complex care, care coordination, palliative care and patient safety.

Julie is an experienced senior federal health policy advisor and is respected for her highly collaborative work style, stakeholder engagement, and leadership skills. Julie's personal and professional experience are focussed on advising government on key health priorities that have a real impact on patient care and experience in Ontario.

Julie is a patient advisor, chair, board member with several organizations including; MitoCanada Foundation, The Canadian Medical Association Patient Voice, the Rare Disease Foundation, Family Advisory Council for the Ontario Provincial Pediatric Palliative Care Steering Committee, Faculty and Coach for the Bridge to Home Quality Improvement Initiative with CFHI, Health Quality Ontario, Ontario Provincial PFAC Leadership Table, and Solutions for Kids In Pain. She is previously the chair of the Patient and Family Advisory Council for CHEO, and parent advisor for Complex Care Kids Ontario.

Julie's educational background is in the field of health sciences. As a patient and family advisor she consults and speaks to organizations, government and not for profits regularly on patient engagement strategies, patient partnership, and patient leadership.

Julie lives in Ottawa with her husband and son.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the May 30th meeting of Council, **Dr. Marie Gear** of Teeswater 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. Rob Gratton will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: May 9, 2019

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Strategic Plan

Date of Meeting: May 30, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Briefing Note

May 2019

TOPIC: Strategic Planning

FOR DECISION

ISSUE:

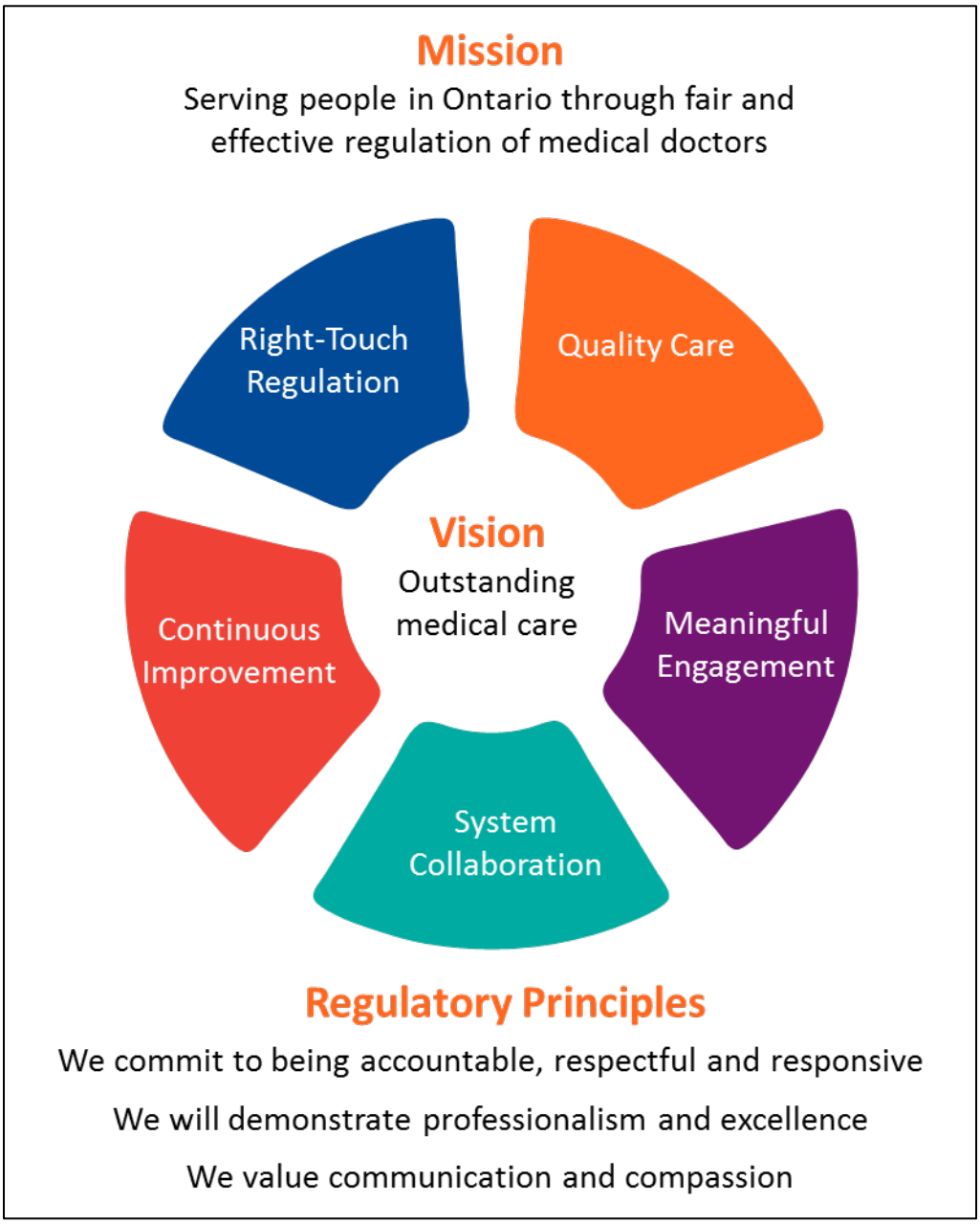
- A new strategic plan for 2020-2025 has been developed based on the February 28th strategic planning session, and refined by incorporating feedback from Council and the CPSO's leadership team. Council is asked to choose the vision and mission statements and approve the strategic plan.

BACKGROUND:

- The CPSO partnered with OPTIMUS | SBR from October 2018 through April 2019 to develop a clear, concise and implementable strategic plan.
- Through a robust engagement process, OPTIMUS | SBR and CPSO engaged a large number of stakeholders across Ontario. This process consisted of the following:
    - conducting 20 one-on-one interviews with thought leaders in the health system, other regulators, and CPSO senior leadership;
    - collecting and analyzing over 6,000 survey responses from physicians, members of the public, health system organizations, and CPSO staff to gain a broad understanding of what CPSO is currently doing well, where there are opportunities for improvement, and how stakeholders envisioned CPSO moving forward; and
    - engaging over 280 participants during 12 in-person and 6 telephone focus group sessions across the province; participants included physicians and members of the general public, as well as CPSO management, staff and select committee members.
- The inclusion of broad stakeholder perspectives was critical to ensuring the College's next strategic plan is focused on the right priorities, as well as reflects an understanding of the change and uncertainty currently happening in CPSO's operating environment.
- Working with CPSO's Council, OPTIMUS | SBR and CPSO facilitated a comprehensive strategic planning process focused on developing CPSO's next mission, vision, strategic priorities and regulatory principles through four working sessions:
    1. Session 1 with CPSO Council and senior leadership focused on reviewing initial stakeholder feedback and discussing what is and is not CPSO's role as a regulator.
    2. Session 2 with CPSO Council and senior leadership focused on reviewing and refining CPSO's role and identifying critical mission and vision elements and strategic priorities.
    3. Session 3 with CPSO senior leadership, and session 4 with CPSO full management team and medical advisors, focused on refining elements of CPSO's mission, vision, strategic

priorities and regulatory principles to ensure resonance and understanding, as well as beginning to identify specific initiatives to achieve CPSO's strategic priorities.

- In early April, a survey was circulated to Council to provide feedback on the components of the draft strategic plan that are included in the graphic below.



- The survey was completed by 24 of 36 Council members. Overall, the feedback was very supportive of the proposed elements of the strategic plan. Results are summarized below.

Component	Fully Endorse		Support		Opposed	
	#	%	#	%	#	%
Mission	13	54	9	37.5	2	8.5
Vision	13	54	10	42	1	4
Regulatory Principles	18	75	6	25	0	0
Priority: Right-Touch Regulation	19	79	5	21	0	0
Priority: Quality Care	18	75	6	25	0	0
Priority: Meaningful Engagement	16	67	8	33	0	0
Priority: System Collaboration	18	75	5	21	1	4
Priority: Continuous Improvement	21	87.5	3	12.5	0	0

- Additionally, 96% of Council respondents strongly agreed or agreed that the proposed elements of the strategic plan reflect the desired future direction for the CPSO, and the majority of Council respondents strongly agreed or agreed that the strategic plan elements communicate the right message to the profession, the public and our stakeholders about where we are going, our focus, and how we are going to do our work.

CURRENT STATUS:

- CPSO's next strategic plan includes a new mission, vision, strategic priorities and regulatory principles. This plan is intended to guide CPSO Council, management and staff moving forward and communicate the right message to the profession, the public and health system stakeholders.
- The planned life of the strategic plan will be five years, from 2020 to 2025. It will be re-confirmed by Council annually to guide corporate planning for the following year. After three years, an interim review will determine whether it remains relevant or needs to be refreshed.
- The proposed components of the new plan are presented below. For the mission and vision statements, Council is provided with options and is asked to select the preferred statements.

Mission

- A mission statement outlines the mandate of the organization and defines the boundaries of what the organization may do to contribute to achieving the vision. Our Mission is "what is ours to do."
- Council was asked to provide feedback on the proposed mission statement: "Serving people in Ontario through fair and effective regulation of medical doctors."
- Although the majority of Council respondents supported this proposed mission statement, it was suggested that "serving **the people of** Ontario" might be preferred to "serving **people in** Ontario" (which had been proposed to be inclusive of all people, not just those who have a

formal resident status). Also, some questioned whether it was necessary to include "fair", or if it was subsumed under "effective regulation".

- Given this, Council is being asked to select which option it prefers, of the following two:
    1. Serving people in Ontario through fair and effective regulation of medical doctors
    2. Serving the people of Ontario through effective regulation of medical doctors

Vision

- A vision statement defines what the desired future state will be, look like, feel like, and ultimately what the organization will achieve. Our vision statement is "what we want to be recognized for."
- Council was asked to provide feedback on the proposed vision statement: "Outstanding medical care."
- Although the vast majority of Council members who completed the survey supported this proposed vision statement, there were multiple comments that "outstanding" could be too high of a standard, and other comments that "outstanding medical care" may be too broad, as there are many elements required to deliver outstanding care which are outside of CPSO's mandate.
- Given this, another possible vision statement has been developed. Council is being asked to select which option it prefers, of the following two:
    1. Outstanding medical care
    2. Trusted doctors, great care

Regulatory Principles

- Regulatory Principles describe how CPSO will do its work.
- The regulatory principles remain unchanged from those that were shared in the survey.
- The proposed regulatory principles are:
    1. We commit to being accountable, respectful and responsive
    2. We will demonstrate professionalism and excellence
    3. We value communication and compassion

Strategic Priorities

- Strategic priorities are the elements that need to be in place for CPSO to achieve its mission. Strategic priorities help to guide initiatives and action planning at the organization level.
- There are five proposed strategic priorities in the new strategic plan. These remain unchanged from those that were shared in the survey.
- The proposed strategic priorities are provided in the table below.

Strategic Priority	Explanation
Right-Touch Regulation	To achieve Right-Touch Regulation, CPSO will: • Apply a proportionate, consistent, targeted, transparent, accountable, and agile approach to all aspects of medical regulation • Work to align legislation with right-touch regulation

	• Continually measure, monitor and report on our progress towards more effective regulation
Quality Care	To achieve Quality Care, CPSO will: • Use evidence to evaluate risk and address the greatest concerns for patient care • Guide and support doctors throughout their careers • Respond to emerging trends and new technologies
Meaningful Engagement	To achieve Meaningful Engagement, CPSO will: • Purposefully involve patients, the public and physicians to inform College decisions • Build awareness of our role, mandate, and processes through clear and accessible communication
System Collaboration	To achieve System Collaboration, CPSO will: • Develop open and collaborative relationships that support a connected health system • Promote inter-professional collaboration and share best practices
Continuous Improvement	To achieve Continuous Improvement, CPSO will: • Foster a culture of continuous improvement and openness to change • Modernize all aspects of our work to fulfill our mission

- Council is asked to approve the 2020-2025 strategic plan.

NEXT STEPS:

- Following Council's approval, the strategic plan will be launched externally.
- Management will use the plan to revise 2019's Corporate Plan and guide planning for 2020.

DECISIONS FOR COUNCIL:

1. Which mission statement does Council choose?
    a. Serving people in Ontario through fair and effective regulation of medical doctors
    b. Serving the people of Ontario through effective regulation of medical doctors
2. Which vision statement does Council choose?
    a. Outstanding medical care
    b. Trusted doctors, great care
3. Does Council approve the 2020-2025 strategic plan?

Contact: Maureen Boon, ext. 276
Lauren Nagler, ext. 338

Date: May 10, 2019

Appendices: Appendix A: 2020-2025 Strategic Plan

Appendix A: 2020-2025 Strategic Plan

Mission

1. Serving people in Ontario through fair and effective regulation of medical doctors, OR
2. Serving the people of Ontario through effective regulation of medical doctors

Vision

1. Outstanding medical care, OR
2. Trusted doctors, great care

Regulatory Principles

1. We commit to being accountable, respectful and responsive
2. We will demonstrate professionalism and excellence
3. We value communication and compassion

Strategic Priorities

Strategic Priority	Explanation
Right-Touch Regulation	To achieve Right-Touch Regulation, CPSO will: • Apply a proportionate, consistent, targeted, transparent, accountable, and agile approach to all aspects of medical regulation • Work to align legislation with right-touch regulation • Continually measure, monitor and report on our progress towards more effective regulation
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Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **2020 Executive Committee Election**

Date of Meeting: May 30, 2019

It is moved by_____,

and seconded by_____, that:

The Council appoints _____ (as President),

_____(as Vice President),

_____(as Executive Member Representative),

_____(as Executive Member Representative),

_____(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.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: **Governance Committee Report**

For Decision:

1. **2019-2020 Executive Committee Election**

For Discussion:

2. **Governance Modernization**
   a) **Review of Standing Committees**
   b) **Committee Term/Age Limits**
   c) **Strengthening Orientation and Education**

For Information:

3. **Public Member Reappointment/Appointment**
4. **Committee Appointments**
5. **Completion of 2020 Committee Interest Forms**
   (for submission at Council meeting)

For Decision:

1. 2019-2020 Executive Committee Election

ISSUE:

- At the December 2018 Council meeting, Council approved amendments to the General By-Law, subsections 28, 32 and 39 to support opening up the College president and vice-president positions to public Council members for the 2019-2020 Council year.
- Council members were provided with a memo from the Chair of the Governance Committee (Appendix A) describing the nomination and new election process for the 2019-2020 Executive Committee election.
- At the May Council meeting, Council will elect the members of the 2019-2020 Executive Committee for President, Vice President, and 3 Executive Member Representatives.
- As per the General By-law, subsection 39(1), Dr. Peeter Poldre will also serve on the 2019-2020 Executive Committee, as Past President.

- As per the General By-Law, subsection 39(1), the Executive Committee is required to have a minimum of 2 physician members and 2 public members of Council.
- Nomination Statements have been received from the following candidates for these positions: (see Appendix A).

For President:	Dr. Brenda Copps
For Vice President:	Dr. Akbar Panju
For Executive Member Representatives: *(3 positions)*	Ms. Ellen Mary Mills Mr. Peter Pielsticker Dr. Judith Plante

- *Nomination Forms* with signature of nominee, mover and seconder are due, prior to the commencement of the Council meeting on Thursday, May 30, 2019.
- Nominees will be given the opportunity to address Council, prior to the elections, if applicable.

DECISION FOR COUNCIL:

1. Election of 2019-2020 Executive Committee positions; President, Vice President, 3 Executive Member Representatives of Council.

For Discussion:

2. Governance Modernization

a) Review of Standing Committees

Background:

- The Governance Committee is reviewing the mandates and structure of all standing committees to ensure alignment with the draft strategic plan.
- The review is part of the Governance Committee's modernization work, which includes both legislative and non-legislative change proposals. A review of standing committees is part of the non-legislative changes which are intended to address a number of issues:
    - Overlap between the membership of standing and statutory committees, resulting in significant scheduling problems;
    - Review membership and quorum requirement requirements of standing committees;
    - Improve the efficiency of statutory committees; and
    - Potential overlap between mandates of committees.

Preliminary Considerations:

- ***Finance & Audit and Governance Committees:*** No changes are contemplated.

- ***Premises Inspection Committee (PIC):*** There was some discussion about incorporating PIC into the Quality Assurance Committee (QAC) given the focus of both committees on quality assurance. However, it has been decided that PIC will remain a standing committee for now. This decision is primarily due to the inherent conflicts between the confidentiality obligations on QAC regarding quality assurance information and public reporting of the PIC outcomes of out of hospital premises (OHP) inspections. In addition, there is discussion of merging independent health facility (IHF) panels into PIC, in which case, the confidentiality obligations on QAC would affect reporting required by the IHF program as well.
- The changes set out below are under consideration. Further analysis of committee membership, potential by-law revisions and implementation is ongoing:

Outreach Committee:

Proposal: Discontinue the Outreach Committee as a standing committee and incorporate key functions of the Outreach Committee into the Executive Committee mandate.

- Core functions of the Outreach Committee align with the Engagement priority in the draft strategic plan.
- The mandate of the Outreach Committee is to develop communications and outreach initiatives to the profession and public. This aligns with the mandate of the Executive Committee.

Education Committee:

Proposals: Options to be further discussed with various stakeholders:

(i) Discontinue the Education Committee as a standing committee, and incorporate the work of the Committee into QAC as an advisory group.

(ii) Consider renaming the committee to "Academic Liaison Committee" and review the work of the committee to determine clarity of mandate and connection to the strategic plan.

- Core functions of the Education Committee align with the System Collaboration priority in the draft strategic plan.
- The Education Committee provides important feedback and maintains a crucial relationship between the College and the medical schools and educational organizations.
- The Education Committee is committed to quality care, and its policy work, in particular, is closely connected to the work of the Quality Assurance Committee (QAC).

Council Award Selection Committee

Proposal: Restructure the Council Award Selection Committee to be a Council Award Working Group (rather than a standing committee) similar to the Policy Working Group.

Next Steps:

The Governance Committee will consider formal proposals at its June meeting and may bring revised by-laws where needed to effect these changes to the Council meeting in September.

b) Committee Term/Age Limits

Background:

- Council asked the Governance Committee to consider best practices relating to Committee term limits and Committee renewal and provide preliminary input in three areas: Age Limits, Active Practice/Retirement and Term Limits.
- The purpose of any changes to these areas would be to ensure appropriate Committee member succession and turnover, promote age diversity and to ensure that Committees have the right people to do their work.

Preliminary Considerations:

- ***Age Limits*** – The Committee is not recommending age limits because it believes the goals of committee turnover and succession, and age diversity, can be better achieved via other strategies, including term limits.
- ***Active Practice/Retirement*** – The Committee is considering changing the eligibility criteria for committee member appointments such that committee members will have to be in active practice or recently retired. It was the view of Governance that the majority of Committee work reasonably requires current or recent medical practice experience and knowledge.
    - Further work will be done to define 'active practice' and 'recent retirement' for purposes of the committee eligibility criteria.
- ***Term Limits*** – The Committee is supportive of establishing clear term limits in order to ensure appropriate turnover and succession on committees. The following proposals are under consideration. However, further work needs to be done to determine impact on individual committees and how implementation could be phased in to avoid destabilizing committees.

    - Current Practice: A Council member may serve for 9 consecutive years.
    - Proposal: Individual Committee terms are limited to a maximum of 9 years.
    - Proposal: In total, a member cannot serve more than 18 years on Council and/or Committee(s). *(Scenarios will be discussed at the Council meeting).*

Next Steps:

The governance team is assessing each of the committees to understand the specific factors unique to each Committee including learning curve, workloads and time commitments required (which affect availability of physicians in active practice). There will be a further assessment of preliminary findings of all committees, and timing of any changes will be positioned based on what fits best for committees.

The Governance Committee will consider formal proposals at its June meeting.

c) Strengthening Orientation and Education

Background:

- One of the recommendations of the ongoing College Governance Modernization activities is to enhance board (Council) orientation and education to reinforce and support the role and focus of Council.
- Options are being reviewed for a single point of access for all orientation and education materials.

Activities:

- The Governance Process manual will be revamped to consolidate and update critical information, in order to ensure clarity and ease of access.
- Injecting fresh content into the educational platform throughout the year by:
    - Tailoring educational speakers and activities to address important College-specific issues; and
    - Evaluating CLEAR webinars on regulatory excellence for future educational training modules specifically tailored for either new council members, chairs of committees and more experienced council members.

Next Steps:

Staff continues to build member-specific orientation and education modules throughout the year.

For Information:

3. Public Member Reappointment/Appointment

- Peter Pielsticker of Tehkummah, was reappointed to the CPSO Council by the Lieutenant Governor of Ontario for a three-year term, commencing July 1, 2019. (Appendix B)

- Shahid Chaudhry of Whitby, was appointed to the CPSO Council for a one-year term, commencing May 2, 2019. (Appendix C)

4. Committee Appointments

- The Executive Committee made the following committee appointments at the April 23, 2019 meeting:

o Ms. Judy Mintz (public member)	Council Award Selection Committee
o Dr. Jane Lougheed (non-council member)	Inquiries, Complaints and Reports Committee

5. Completion of 2019-2020 Committee Interest Forms

- All Council members are asked to complete the *Committee Interest Form* for 2019-2020 committees. (see Appendix D)
- Appended to the Form are descriptions of each committee, a chart that identifies the average time commitment for each committee and Council work, and a committee chair role description.
- The completed Form will inform the Governance Committee in its deliberations as it develops committee recommendations for the 2019-2020 Council year.
- **Council members are asked to complete the Committee Interest Form and submit their completed forms to Debbie McLaren by the end of the Council meeting on Friday, May 31.**
- Council will make committee appointments at the December meeting.

Contact: Dr. Steven Bodley, Chair, Governance Committee
Maureen Boon, ext. 276
Marcia Cooper ext. 546
Suzanne Mascarenhas, ext. 843
Debbie McLaren, ext. 371

Date: May 10, 2019

Attachments:
Appendix A: Memo to Council members re: Nomination/Election Process for the 2019-2020 Executive Committee Vote at the May Council Meeting and Nomination Statements for: Dr. Brenda Copps, Dr. Akbar Panju, Ms. Ellen Mary Mills, Mr. Peter Pielsticker and Dr. Judith Plante
Appendix B: *Order in Council* for Peter Pielsticker
Appendix C: *Order in Council* for Shahid Chaudhry
Appendix D: 2020 Committee Interest Form and attachments

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Appendix A

Memorandum

To	All Council Members
From	Dr. Steven Bodley, Chair, and Governance Committee
Date	April 11, 2019
Subject	Nomination/Election Process for the 2019-2020 Executive Committee Vote at the May Council Meeting

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At the December 2018 Council meeting, Council approved amendments to the General By-Law subsections 28, 32 and 39 to support opening up the College president and vice-president positions to public Council members for the 2019/2020 Council year.

At the May 2019 meeting of Council, an election will be held for elected positions on the 2019-2020 Executive Committee, as prescribed in the General By-Law, subsection 28, for a President, a Vice President and 3 Executive Member Representatives.

The past president will continue to automatically be on the Executive Committee, unless he or she is unwilling or unable to serve, in which case a physician or public member of Council will be elected to the Executive Committee in place of the past president.

Council also agreed to continue the established convention of having the vice-president position progress to the president position for the following Council year to ensure an incoming President has a minimum of 1 year experience on the Executive Committee, although it is still required that an election (even if an acclamation) be held for the president position.

As per the General By-Law, subsection 39, the Executive Committee is required to have a minimum of 2 physician members and 2 public members of Council. Therefore, the 6 member 2019-2020 Executive Committee can be comprised of:

- 2 physicians + 4 public members, **or**
- 3 physicians + 3 public members, **or**
- 4 physicians + 2 public members.

All members of Council are eligible for nomination for the elected positions on the 2019-2020 Executive Committee. Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.

There will be a multi-step ballot process to elect the 2019-2020 Executive Committee:

1. Elect President (if President and Past President are both physician members, the minimum requirement for 2 physician members will be met),
2. Elect Vice President (can be physician or public member of Council),
3. If Vice President is a physician member, election will be held for 2 public members of Council (to satisfy minimum requirement for 2 public members) **or,**

If Vice President is a public member, election will be held for 1 public member of Council (to satisfy minimum requirement for 2 public members),

4. If Vice President is a physician member, election will be held for 1 *additional* member on the Executive Committee (can be physician member or public member of Council) **or**
   If Vice President is a public member, election will be held for 2 *additional* members on the Executive Committee (can be physician members or public members of Council).

Council members who do not get elected in steps 2 or 3 may run for election in steps 3 or 4, if applicable.

A separate Council Contact List will be provided to nominees to facilitate communications between Council members. For your information, a list of current Executive Committee members is attached.

All Council members who wish to be nominated for an elected position on the Executive Committee are invited to submit a ***Nomination Statement*** **and indicate the elected position(s) they are running for.** The ***Nomination Statement*** is limited to 200 words. ***Nomination Statements*** will include brief biographical information and a candidate's photo. Completed ***Nomination Statements*** will be appended to the Governance Committee Report to Council, and sent by separate e-mail, to all Council members prior to the May Council meeting. ***Nomination Statements*** assist Council members to identify candidates who are running for election, and provide more information regarding a candidate's background, qualifications and reasons for running for an Executive Committee position.

In addition to your ***Nomination Statement***, a completed ***Nomination Form*** for each position a candidate is running in the election for, is due prior to the commencement of the Council meeting on Thursday, May 30, 2019. The ***Nomination Form(s)*** contains the signature of a nominee, as well as his or her nominator and seconder.

Timeframe and Process for Executive Committee Nominations:

1. If you wish to submit one or more ***Nomination Statements***, please forward your request for a *personalized template* to Debbie McLaren at dmclaren@cpso.on.ca

2. The deadline for submission of your completed ***Nomination Statement (s) is*** **Friday, May 3, 2019.**

3. The deadline for submission of your completed ***Nomination Form(s)*** is **Thursday, May 30, 2019,** prior to the commencement of the Council meeting.

4. Nominations from the floor will also be accepted during the Governance Committee Report on the day that the vote takes place.

5. Prior to the vote, each nominee will be given an opportunity to address Council about his/her candidacy for the office or position.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

6. The 2019-2020 Executive Committee positions determined at the May Council meeting will officially take office at the adjournment of the annual meeting of Council on December 6, 2019.

If you have any questions regarding the 2019-2020 Executive Committee nomination process, please contact Debbie McLaren at dmclaren@cpso.on.ca or, alternatively by phone at 416-967-2600, ext. 371, or toll free: 1-800-268-7096, ext. 371.

Thank you,

S.C. Bodley, MD, FRCPC
Chair, Governance Committee

att.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2018-2019 EXECUTIVE COMMITTEE MEMBERS

Executive Committee Members	Current position and Previous Committee Term(s)
Dr. Peeter Poldre – President/Chair	**President 18/19** Vice President 17/18 Physician Member 16/17
Dr. Brenda Copps	**Vice President 18/19** Physician Member 17/18
Ms. Ellen Mary Mills	**Public Member 2019** ***(appointed March 1, 2019)***
Dr. Akbar Panju	**Physician Member 18/19**
Mr. Peter Pielsticker	**Public Member 18/19**
Dr. Steven Bodley	**Past President 18/19 –** ***(non –council)*** President 17/18 Vice President 16/17 Physician Member 15/16

CANDIDATE FOR 2019-2020 EXECUTIVE COMMITTEE

Candidate for:

☒ **President** ☐ **Vice President** ☐ **Executive Member Representative**

DR. BRENDA COPPS

District 4 Representative
Hamilton, Ontario

Principal Area of Practice: Family Medicine

Elected Council Terms:
December 6, 2013 – December 2, 2016
December 2, 2016 – December 6, 2019

CPSO Committees and Other CPSO Work:

Vice President:	2018-2019
Education Committee:	2015-2018
Executive Committee:	2017-2019
Finance and Audit:	2018-2019
Governance Committee:	2018-2019, 2016-2017
Inquiries, Complaints and Reports Committee:	2018-2019
Outreach Committee:	2018-2019
Quality Assurance Committee: Quality Assurance Working Group Member:	Co-chair: 2015-2018 2013-2015 2016
Policy Working Groups: *-Accepting New Patients/Ending the Physician-Patient Relationship* *-Continuity of Care* *-Policy Redesign*	 2015-2017 Chair: 2016-Present Chair: 2019
FMRAC Annual Meeting Delegate:	2015

STATEMENT:

Thank you for your confidence in me by supporting my terms on Executive thus far.

It has truly been an honour to work with such a committed group of Council, Executive, and staff members and I hope you will see fit to continue to support my leadership by electing me as President.

As the above summary suggests, I have worked hard to accumulate the breadth of experience necessary for this role. On a personal level, my style and input has been described as principled, pragmatic, and progressive. I believe some of my leadership attributes are due to my family medicine background, which draws heavily on the CanMEDS competencies of communication and collaboration.

Here at the College, we are in the midst of an exciting transformation, one aspect of which is our new Strategic Plan. I have the utmost respect for our mandate to serve the public, and I firmly believe that our current direction and vision is well aligned with that mandate.

I welcome the opportunity to continue to play a key leadership role in stewarding our organization and look forward to your support today and going forward.

CANDIDATE FOR 2019-2020 EXECUTIVE COMMITTEE

Candidate for:

☐ **President** ☒ **Vice President** ☐ **Executive Member Representative**

DR. AKBAR PANJU

University Representative – McMaster University
Hamilton, Ontario

Principal Area of Practice: Internal Medicine

Appointed Council Terms:
December 5, 2014 – December 6, 2019

CPSO Committees and Other CPSO Work:

Education Committee:	Chair: 2017-2019 *(voting academic rep)* 2014-2017 *(non- voting academic rep)*
Executive Committee:	2018-2019
Inquiries, Complaints and Reports Committee:	Vice-Chair, Internal Medicine: 2016-2019 2014-2016 *(Dr. Panju has also served as non-council member of the Complaints Committee 2008-2009 and ICR Committee 2009-2011)*
Registration Committee:	Chair: 2017-2019 2014-2017
Policy Working Group: *Medical Records*	April 2018-present

STATEMENT:

I am a general internist involved in clinical work, teaching and administration. I was a family physician before I specialised in internal medicine.

My CPSO experience has included five years in Council, Chair of Registration and Education Committees, Vice Chair of ICRC and a member of the Executive Committee and Medical Record Policy Group.
I have experience in multiple areas of healthcare, having been the Chief of Medicine at Hamilton Health Sciences for 10 years, Division Director of Internal Medicine at McMaster for 20 years, past president of Canadian Society of Internal Medicine and a member of the Royal College Examination Board.

Our healthcare environment is changing. In order to serve the public interest, we have recently made many positive changes at CPSO: initiated ADR, implemented Right Touch Regulation, and developed the Quality Improvement Program. We are in the final stages of finalising the Strategic Plan. In doing all these exciting things, I believe that it is essential that we communicate effectively and regularly with our physician membership, the public and all stakeholders so that we continue to maintain their trust in CPSO.

I hope I can count on your support for my nomination as Vice Preside. I have the energy and time to do that job.

CANDIDATE FOR 2019-2020 EXECUTIVE COMMITTEE

Candidate for:

☐ **President** ☐ **Vice President** ☒ **Executive Member Representative**

MS. ELLEN MARY MILLS

Public Member of Council
Toronto, Ontario

Occupation: Volunteer, Member, Collingwood Heritage Committee and Information Host with Sunnybrook Health Sciences Centre

Appointed Council Terms:
September 6, 2017 – September 5, 2020

CPSO Committees and Other CPSO Work:

Executive Committee:	2019
Discipline Committee:	2017-2019
Premises Inspection Committee:	2017-2019

STATEMENT

Regarding my nomination, I believe I have had relevant experience and possess skills which would allow me to continue to make a contribution to the Executive Committee.

Membership on Council, and on the Discipline and Premises Inspection Committees, has provided me with a good understanding of many of the issues facing the College.

While I am somewhat new, I have demonstrated throughout my career that I am a fast learner as I have moved from one complex area to another, such as mastering pharmacy issues as VP Public and Government Affairs for the Canadian Association of Chain Drug Stores or representing the heavily regulated food manufacturers with the FCPC.

Membership on the Governance Committee of the North Simcoe Muskoka LHIN, provided me the opportunity to participate in the performance review of the Executive Director and the restructuring of the LHIN due to the merger of the CCACs with the LHIN, which I suggest would be helpful.

Further, I believe my skill base, including excellent analytical abilities, sound strategic planning skills, along with passion and creative thinking would be beneficial in the execution of the responsibilities of the Executive Committee.

CANDIDATE FOR 2019-2020 EXECUTIVE COMMITTEE

Candidate for:

☐ **President** ☐ **Vice President** ☒ **Executive Member Representative**

MR. PETER PIELSTICKER, CA, CPA

Public Member of Council
Tehkummah, Ontario

Occupation: Financial Consulting

Appointed Council Terms:
March 18, 2015 – March 17, 2018
March 18, 2018 – December 31, 2018
January 1, 2019 – June 30, 2019
July 1, 2019 – June 30, 2022

CPSO Committees and Other CPSO Work:

Discipline Committee:	2015-2019
Executive Committee	2018-2019
Finance and Audit Committee:	Chair: 2017-2019 2015-2017
Premises Inspection Committee:	2015-2019
Quality Assurance Committee:	2015-2019
Staff Pension Committee:	2017-2019

STATEMENT:

Since my appointment to CPSO in March 2015, I have been active on a number of committees as outlined above. This has afforded me a solid foundation in understanding and appreciating the effective role CPSO plays in the practice of medicine and the protection of the public.

Prior to retirement, my background was in finance as CFO of a public company. Accordingly, I am familiar with the C suite activities and I believe my financial background brings a unique perspective to the CPSO Executive Committee.

In mid-year 2018 CPSO appointed a new Registrar and CEO, Nancy Whitmore. Nancy has brought significant operational change to the organization but there is still a long distance to travel. I am committed to her new direction and would like to be part of the transitioning team. I have the time, motivation and enthusiasm. I ask for your support in seeking re-election to the Executive Committee for 2019-2020.

CANDIDATE FOR 2019-2020 EXECUTIVE COMMITTEE

Candidate for:

☐ **President** ☐ **Vice President** ☒ **Executive Member Representative**

DR. JUDITH PLANTE

District 7 Representative
Pembroke, Ontario

Principal Area of Practice: Family Medicine

Elected Council Terms:
December 4, 2015 – December 7, 2018
December 7, 2018 – December _, 2021

CPSO Committees and Other CPSO Work:

Inquiries, Complaints and Reports Committee:	2015-2019
Registration Committee:	2016-2019
Policy Working Groups: *Medical Records*	Chair: April 2018-present

STATEMENT:

Council is currently facing the challenge of modernizing our governance structure and developing increased flexibility in all areas of our mandate. We need to make these changes while respecting the core values of the institution.

I am putting my name forward for the Executive of Council because I have the skill set to contribute to this important work. I also have the time as, after 27 years, I have retired from full-time clinical practise. My background as a rural family physician is not only clinical, but includes experience as a Teaching unit Director, a hospital Department Chief and a MAC member. I am a team player and a good communicator. I am an active member of both ICRC and Registration Committee and, as my co-panelists can attest, I enjoy working through challenges and developing group solutions to problems.

I am excited about the changes that the College is currently undergoing and hope you will give me the opportunity to help lead these efforts as a member of the Executive Committee.

Appendix B

Ontario

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*, **Peter Pielsticker** of Tehkummah be reappointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding three years, effective July 1, 2019.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins*, **Peter Pielsticker** de Tehkummah est reconduit au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale de trois ans, à compter du 1er juillet 2019.

Recommended: Minister of Health and Long-Term Care
Recommandé par : La ministre de la Santé et des Soins de longue durée

Concurred: Chair of Cabinet
Appuyé par : Le président | la présidente du Conseil des ministres

Approved and Ordered: MAY 0 9 2019
Approuvé et décrété le :

Administrator of the Government
L'administrateur du gouvernement

O.C. | Décret : 758 / 2019

Ontario

Appendix C

Executive Council of Ontario
Order in Council

On the recommendation of the undersigned, the Lieutenant Governor of Ontario, by and with the advice and concurrence of the Executive Council of Ontario, orders that:

Conseil exécutif de l'Ontario
Décret

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur de l'Ontario, sur l'avis et avec le consentement du Conseil exécutif de l'Ontario, décrète ce qui suit :

PURSUANT TO clause 6(1)(b) of the *Medicine Act, 1991*, **Shahid Chaudhry** of Whitby, be appointed as a part-time member of the Council of the College of Physicians and Surgeons of Ontario to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding one year, effective the date this Order in Council is made.

EN VERTU DE l'alinéa 6 (1) b) de la *Loi de 1991 sur les médecins*, **Shahid Chaudhry** de Whitby, est nommé au poste de membre à temps partiel du Conseil de l'Ordre des médecins et chirurgiens de l'Ontario pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale d'un an à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par: la ministre de la Santé et des Soins de longue durée

Concurred: Chair of Cabinet
~~Appuyé par :~~ ~~Le président~~ | la présidente du Conseil des ministres

Approved and Ordered: MAY 02 2019
Approuvé et décrété le :

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 678/2019

Appendix D

2020 COMMITTEE INTEREST FORM
[2019-2020 COUNCIL TERM]

The Governance Committee follows Council's Nomination Guidelines in developing leadership and membership recommendations to Council. To assist the Governance Committee in its appointment of Councillors to committees for the 2019-2020 session of Council, please complete the form. A document entitled "College Committees" is attached to assist you in making your choices, as well as an Average Time Commitment Chart for Committee and Council Work.

In addition, please indicate whether you are interested in serving as Chair of that Committee in the column provided. The description of the role of a Committee Chair is attached for your information.

The Governance Committee reminds members of Council that it is often not possible to appoint members to every committee of their choice. In order to be considered for committee work, all Council members and committee members must sign the College's *Declaration of Adherence Form* that is contained in the Governance Process Manual. A *Criminal Record Check* must also be completed for all new Council members and all new non-Council committee members.

NAME: _____

Please mark your committee selections in the column that best describes your interest level and available time commitment. [Public members are asked to identify a preference for the Discipline Committee or the Inquiries, Complaints and Reports Committee].

Committee Name	Prefer Not to Serve on	Interested	Very Interested	Interested in Chairing this committee
Statutory Committees				
Discipline*	☐	☐	☐	☐
Fitness to Practise*	☐	☐	☐	☐
ICR*	☐	☐	☐	☐
Quality Assurance*	☐	☐	☐	☐
Registration	☐	☐	☐	☐
By-Law Standing Committees				
Council Awards**	☐	☐	☐	N/A
Education	☐	☐	☐	☐
Finance & Audit	☐	☐	☐	☐
Outreach	☐	☐	☐	☐
Premises Inspection	☐	☐	☐	☐

Potential Committee Conflicts:
ICR committee members will not be appointed to the Discipline Committee and/or Fitness to Practise Committee or the Quality Assurance Committee and vice versa.
It is recommended that whenever possible, Quality Assurance Committee members are not members of the Discipline and/or Fitness to Practise Committee and vice versa.
****Council Awards Selection Committee is available to public members only, physician composition/chair selection is prescribed in the General By-Law.***
*****Please complete the back of this form to outline your competencies to serve on the committees you have marked above, and if applicable, your competencies for chairing a committee.**

……continued on next page

Please note there is a nomination process and a council vote for the 2020 Executive Committee that will take place at the May 2019 Council meeting and a nomination process for the 2020 Governance Committee that will take place at the annual meeting of Council in December.

******COMMITTEE COMPETENCIES*:**

PLEASE STATE STRENGTHS, SKILLS, EXPERIENCE AND QUALITIES YOU WOULD BRING TO THE COMMITTEES YOU ARE INTERESTED IN SERVING ON.

******CHAIR COMPETENCIES*:**

PLEASE STATE THE STRENGTHS, SKILLS, EXPERIENCE AND LEADERSHIP QUALITIES YOU WOULD BRING TO THE POSITION OF CHAIR. IN WHAT DIRECTION WOULD YOU LEAD THE COMMITTEE?
PLEASE IDENTIFY ANY CURRENT PROBLEMS WITH THIS COMMITTEE AND YOUR IDEAS FOR SOLUTIONS.

GENERAL COMMENTS:

PRINT

COLLEGE COMMITTEES

Much of the work of the College is conducted through College committees. There are three types of committees. They include statutory committees, by-law committees and ad hoc committees and task forces.

Statutory committees are set out in the College's governing legislation, the Regulated Health Professions Act and the Medicine Act. They include:

- Discipline Committee
- Executive Committee
- Fitness to Practise Committee
- Inquiries, Complaints and Reports Committee
- Patient Relations Committee
- Quality Assurance Committee
- Registration Committee

Operating committees are set out in the College by-laws and are operational in nature. They include:

- Council Award Selection Committee
- Education Committee
- Finance & Audit Committee
- Governance Committee
- Outreach Committee
- Premises Inspection Committee

Working groups/task forces are established to address specific issues. These groups are established by Council and are generally time limited and deal with a particular problem or issue.

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Committee Mandates

Discipline Committee
The Discipline Committee hears matters of professional misconduct or incompetence.

The Inquiries, Complaints and Reports Committee, after conducting an investigation, refer allegations to the Discipline Committee. A discipline panel is comprised of at least three members – two must be public members and one must be a physician member of Council. Panels are usually made up of four or five members.

If the panel finds that the physician has committed an act of professional misconduct or is incompetent, it can make an Order directing the Registrar to:

- revoke the physician's certificate of registration
- suspend the physician's certificate, and/or
- impose specified terms, conditions or limitations on the physician's certificate.

If the panel finds the physician has committed an act of professional misconduct, it can also make an Order:

- requiring the physician to appear before the panel to be reprimanded
- requiring the physician to pay a fine of not more than $35,000 to the Minister of Finance, and
- if the act of professional misconduct was the sexual abuse of a patient, requiring the physician to reimburse the College for funding provided for the patient for counselling and therapy, and requiring the physician to post security to guarantee payment.

If the panel finds the physician has committed an act of professional misconduct by sexually abusing a patient, the panel must:

- reprimand the physician, and
- revoke the physician's certificate if the sexual abuse consisted of or included certain acts.

In an appropriate case, the panel may also require the physician to pay all or part of the legal, investigation and hearing costs and expenses. The Discipline Committee also hears applications for reinstatement and motions to vary prior orders of the Committee.

Education Committee
The Education Committee reviews and makes recommendations to Council on matters of medical education in the province.

The Education Committee is responsible for:

- reviewing the undergraduate studies at faculties of medicine in Ontario and encouraging curriculum enhancement
- monitoring and sustaining the level and quality of Ontario postgraduate programs of medical education, and
- reviewing the Ontario continuing medical education programs.

Executive Committee
The mandate of the Executive Committee, as defined in the legislation, is to serve as the decision-making body of the College in between regular meetings of Council, and to report on these actions to the Council at subsequent Council meetings.
In acting on Council's behalf in between Council meetings, the Executive monitors and reviews policy issues under development and operational issues of significance.

Finance & Audit Committee
The Finance & Audit Committee is responsible for reviewing the financial affairs of the College and reporting directly to Council. It reviews such matters as investment policy, control of assets, the auditor's report, and the College's overall financial position.
The Finance & Audit Committee is directly and indirectly involved in reviewing and/or making recommendations to Council concerning any financial matter affecting the functioning of the College, including: the banking of the College's funds, investments, borrowing of monies, levels of approval and disbursement procedures relating to purchased goods and services, major items concerning the building, the findings of the external annual audit, the annual budget preparation and the remuneration paid to members of the College whole on College business. It also reviews the College's annual financial position.

Fitness to Practise Committee
The Fitness to Practise Committee conducts hearings of allegations concerning a physician's capacity to practise medicine that are referred by an incapacity inquiry panel of the Inquiries, Complaints and Reports Committee.

A Fitness to Practise panel is comprised of at least three members, and one member must be a public member of Council.

If the panel finds that the physician is incapacitated it can make an Order directing the Registrar to:

- revoke the physician's certificate of registration
- suspend the physician's certificate, and/or
- impose specified terms, conditions or limitations on the physician's certificate.

The College makes every effort to carefully balance the physician's rights with the protection of the public. The Fitness to Practise Committee also hears applications for reinstatement and motions to vary prior orders of the Committee.

Inquiries, Complaints and Reports Committee
The ICR Committee oversees all investigations into members' care, conduct and capacity, including complaints investigations, Registrar's investigations, and inquiries into members' capacity to practise.

The ICR Committee may be called upon to provide investigative direction to staff, and is required to dispose of investigations with a decision. Examples of decisions the ICR Committee may make include:

- requiring members to attend before a panel of the ICR Committee to be cautioned in person
- referring allegations of professional misconduct and/or incompetence to the Discipline Committee
- referring matters of incapacity to the Fitness to Practise Committee
- requiring members to complete a specified education or remediation program
- taking any other action which is not inconsistent with the legislation. (including taking no action and accepting members' undertakings)

A quorum of the ICR Committee consists of 3 members, including at least 1 member of Council appointed by the Lieutenant-Governor in Council. Panels of the ICR Committee may vary in size from 3 – 6 members. Several committee meetings are held monthly. These meetings consist primarily of reviewing documentary information relating to investigations, and by law are not open to members or the public.

Governance Committee
The Governance Committee monitors the governance process adopted by Council and develops Governance policies and practises to ensure an effective system of governance. It also recommends to Council changes to governance processes and oversees the nominations process. This includes making recommendations to Council regarding the membership and leadership of College committees. In addition, the Governance Committee nominates other officers, officials or other people acting on behalf of the College.

Outreach Committee
The Outreach Committee works with the Policy and Communications Division to help develop major communications and outreach initiatives to the profession and public. It also assists in the development of major communication and government relations strategies. In addition, it develops plans to deliver on each of the communications and outreach related components of the strategic direction.

Patient Relations Committee

The Patient Relations Committee advises Council with respect to the patient relations program. *The Regulated Health Professions Act* (RHPA) established that all Colleges must have a patient relations program that includes measures for preventing or dealing with sexual abuse of patients by members. The measures must include:

- educational requirements for members
- guidelines for the conduct of members with their patients
- training for the college's staff
- and the provision of information to the public. (The Health Professions Procedural Code, Schedule 2 to *The Regulated Health Professions Act* (S.84))

The committee is also responsible for administering a program of funding for therapy and counselling for persons who, while patients, were sexually abused by members.

Premises Inspection Committee

The Premises Inspection Committee is responsible for administering and governing the College's premises inspection program. The duties of the Committee are set out in the College's General By-law, and include:

- ensuring appropriate individuals are appointed to perform inspections and re-inspections;
- ensuring adequate inspections and re-inspections are undertaken and completed;
- reviewing premises inspection reports and other material and determining whether premises pass, pass with conditions or fail an inspection.

Quality Assurance Committee

The Quality Assurance Committee develops, establishes and maintains:

- programs and standards of practice to assure the quality of practice of the profession; and
- standards of knowledge and skill, and programs to promote continuing competence among physicians.

Registration Committee

The Registration Committee reviews the applications of physicians who wish to become members of this College, but do not fulfil the requirements for the issuance of a certificate of registration. After considering an application, the committee is charged with taking appropriate action within the powers granted to it under the law. The Registration Committee is also responsible for the development of policies and regulatory changes pertaining to registration requirements for entry to practice, whether they are for training programs or for independent registration.

AVERAGE TIME COMMITMENT FOR COMMITTEE AND COUNCIL WORK

AVERAGE TIME COMMITMENT FOR COMMITTEE AND COUNCIL WORK						***Revised: May 6, 2019***
Committee Name	**Number of meeting days/hearings days per year?**	**Preparation Time (per meeting/hearing)**	**Attendance at CPSO per meeting/hearing**	**Additional Teleconferences per year?**	**Decision/Report Writing Required for Committee Members?**	**Average approximate time commitment per meeting/hearing** *(includes prep and attendance at meeting)*
Council Award Selection Committee	1 (may be done by teleconference)	8 hours	¼ day	Not usual and rarely required	No	15 hours
Council Meetings ***(all Council members attend Council meetings)***	Two 2-day meetings Two 1-day meetings + may include 1-day *Education Session for Council/ committee members*	6 hours per 2-day meeting 3 hours per 1-day meeting	Two 2-day meetings Two 1-day meetings One day orientation = 7 days	Not usual, but sometimes required	No	18 hours per 2-day meeting 9 hours per 1-day meeting
Executive Committee	7	3 hours (additional 1-hour spent on emails prior to each Exec meeting)	1 day per meeting (6 hours)	As required	No	9 hours
Discipline Committee	20 to 80 hearing days 150 days scheduled that are cancelled due to settlement Payment for late cancellation (<10 business days' notice) 2 days of business/education meetings 2 to 3 additional days of education	0 to 4 hours for meetings 0 to 4 hours for hearings 2 to 6 hours for motions 2 to 6 hours for closing submissions	1 day up to 5 to 10 days a month 70% of hearings proceed on an uncontested basis and complete in ½ day Contested hearings range from 2 days to several weeks Lengthy hearings are booked with 1 to 3 weeks in between in each hearing week There is an expectation that committee members commit to as many hearings panels as their schedules permit, including lengthy hearings. Active members commit to 70 to 80 days per year and, due to cancelled days, sit for 30 to 50 hearing days per year. Others commit to 8 to 18 days and sit for 5 to 15 days per year.	Case management conferences are conducted by teleconference. Sometimes required for motions or panel deliberation.	Yes One person on the 5-person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours *(could be more depending on hearing)*

Committee Name	Number of meeting days/hearings days per year?	Preparation Time (per meeting/hearing)	Attendance at CPSO per meeting/hearing	Additional Teleconferences per year?	Decision/Report Writing Required for Committee Members?	Average approximate time commitment per meeting/hearing *(includes prep and attendance at meeting)*
Education Committee	2	3 hours	1 full-day meeting X 2	No	No	9 hours
Finance and Audit Committee	3	2 hours	1 full-day	Not usual, but sometimes required	No	6 to 8 hours
Fitness to Practise Committee	Hearings rarely occur - 1 to 5 days for a hearing is possible -10 days scheduled that are cancelled due to late settlement -Payment for late cancellation (<10 business days' notice) ½ day business education meeting	0 to 4 hours for meetings 0 prep for most hearings 2 to 6 hours for motions	Hearings rarely proceed as cases tend to resolve with health and practice monitoring agreements. Uncontested hearings complete in ½ day. Contested hearing when they occur, range from 3 to 5 days.	Rare. Hearings are closed to the public, so may proceed by teleconference if uncontested.	Yes. One person on the 3-person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours
Governance Committee	4 half-day meetings 1 full-day meeting	1-3 hours	½ day 1 full-day meeting for committee nominations	2 x 2 hours (or, as required)	No	4 to 9 hours
Inquiries, Complaints and Reports Committee ***(Note: Individual members are not required to participate in all ICRC meetings.)***	36 General Panels (a member could participate on 3-6 panels per year on average) 88 Specialty Panels • 24 Surgical • 24 FP • 16 MHP • 12 OB • 12 Int. Med (a member could participate on 6-8 panels per year on average)	General Panels: Average prep 28 hours Specialty Panels: {Average prep} Surgical 20 hours FP 26 hours MHP 18-28 hours OB 14-20 hours Int. Med 24-34 hours Prep Time can vary depending on volume, complexity, case clarity, expertise/ experience etc.	General Panel meetings: In Person or Teleconference 2 – 6 hours Specialty Panels: In Person or Teleconference 2 – 3 hours	Teleconferences: 48 x 1 hour(weekly) Hybrid Panels: Teleconferences 48 x 2 hours (weekly) Settlement Panels: Teleconferences 24 x 2 hours twice a month Ad-Hocs: Teleconferences as required 20 x 1 hour (Rotation of member assignment to allow quorum for each)	Need to review cases in advance of meeting and submit "written notes and decision reasoning" Panel Chairs need to review and approve decisions from their assigned meetings.	General Panel Meeting: 30 - 34 hours Specialty Panels: Varies see preparation /attendance column Weekly Teleconferences: 6-8 hours Hybrid Panels: 18-20 hours Settlement Panel: 6-8 hours

Committee Name	Number of meeting days/hearings days per year?	Preparation Time (per meeting/hearing)	Attendance at CPSO per meeting/hearing	Additional Teleconferences per year?	Decision/Report Writing Required for Committee Members?	Average approximate time commitment per meeting/hearing *(includes prep and attendance at meeting)*
Inquiries, Complaints and Reports Committee (continued)	60 Verbal Caution Panels (with attendance for 4-6 half days per year) These are held on the same day as in person GPs/Specialty panels 24 Health Inquiry Panel meetings (16 are held on the same day as the MHP and the remainder 8 via teleconference) 2 days yearly to discuss Business and Policy matters relating to member specific issues (with attendance at 2 days per year)	Verbal Caution Panels: Approx. 1-2 hours Health Inquiry Panels: Approx. 2-3 hours Business meetings: Approx. 2 hours	Verbal Caution Panels: 2-3 hours (a member could participate on 3 - 6 panels per year) Health Inquiry Panels: 1 hours (rotation of member assignment to allow quorum for each) Business/Policy meetings: 1 day= 6 hours (all members invited)			Verbal caution panels: 3-5 hours Health inquiry panels: 3-4 hours Business/Policy meeting: 8 hours
Outreach Committee	3 half-day meetings per year	Between 1 and 2 hours	½ day	No *(Note: The first meeting of the year will be in-person and the other two by teleconference.*	No	4 hours
Patient Relations Committee	1 in person meeting + up to 11 teleconference meetings	2-3 hours 1-3 hours (for teleconference)	1 day (in-person meeting) 1 to 2 hours (for teleconference)	1 hour to 2 hour teleconferences, as required	No	7-9 hours 2-5 hours
Premises Inspection Committee	Estimate 3 full days for business/policy meetings - Estimate 6 + panel meetings per year (by teleconference)	Up to 10 hours to review premises reports and submissions	1 full day for policy /business meetings (x3) Up to ½ day for teleconference meetings	Possibly extra meetings held by teleconference for review of urgent cases	No (Completed by Program Decision Administrator)	Up to 12 hours

Committee Name	Number of meeting days/hearings days per year?	Preparation Time (per meeting/hearing)	Attendance at CPSO per meeting/hearing	Additional Teleconferences per year?	Decision/Report Writing Required for Committee Members?	Average approximate time commitment per meeting/hearing *(includes prep and attendance at meeting)*
Quality Assurance Committee (MSI meetings in panels; full committee for business meetings)	1-day orientation session for new members	None	Full Day in-person or by videoconference.	N/A	N/A	6 hours
	Three 1-day Policy/Business meetings	Up to 3 hours	Full day in-person	N/A	N/A	9 hours
	1-day Education meeting	None	Full day in-person	N/A	N/A	6 hours
	MSI panel meetings: Commitment to participate in a minimum of 3-4 additional member specific issue (MSI) meetings per year	Up to 12 hours	Up to 1 full day. May change to web/teleconference meetings (2-3 hours max) when no interview planned and/or depending on caseload volume.	Yes. Must commit to be available for ad-hoc Teleconference meetings (up to 1 hour) resulting from complex cases (# varies each year).	N/A	18 hours
	Working Group: (MSI & Policy/Business)	As above	As above	As above	N/A	As above
Registration Committee	10 days for MSI and 2 days for business meetings -12 panel meetings per year	12-16 hours	1 day	None	No	20 to 24 hours

Committee Chair

Reports to (Title): Council

Administratively to President

Updated: February 2010

Overview:

There are three types of committees that perform the work of the CPSO. These are comprised of statutory committees (i.e., Executive, Complaints, Discipline, Fitness to Practise, Registration, Patient Relations, and Quality Assurance), standing or operational committees (i.e., Education, Methadone, Governance, Outreach, Premises Inspection, and Finance) and ad hoc committees that are created by Council to undertake a particular project on behalf of the College on a time-specific basis. The role of the Committee Chair has some commonly held responsibilities that transcend specific committee mandates.

Chairs must be knowledgeable about the subject matter of the committee they lead and have the expertise necessary to fulfill its mandate. The Chair must understand the purpose of the committee, provide leadership to the committee to achieve its goals in a consistent, efficient, and balanced manner, and organize the committee's work so that action is taken in an orderly and timely manner. The Chair reports the work of the committee to Council and facilitates Council's understanding of this work. All Chairs are responsible for assessing whether their committee members have the resources and training to perform effectively in order to deliver on the mandate of the committee.

Major Responsibilities:

Leadership and Direction of the Committee

- Is knowledgeable and supportive of Council policy, and the work and responsibilities of the committee. Is knowledgeable about the regulatory and statutory obligations of the committee and CPSO.
- Read and become familiar with the College's By-laws and governance policies.
- Where applicable, works collaboratively with the other Chair to accomplish the work of the committee. If the other Chair is a non-Council committee member, they keep him or her informed of Council decisions and changes that occur.
- Adhere to, respect and model behaviour described in the Statement on Public Interest, Council Code of Conduct, Conflict of Interest Policy, Apprehension of Bias Policy and Confidentiality Policy.
- Works with the Committee and College staff to establish, monitor, and execute annual committee goals.
- Prepares for committee meetings by reviewing materials. Works with assigned staff in support of the successful fulfillment of the committee's mandate.

- Conducts meetings in a timely and cost effective manner, and facilitates the meeting process so that all members have the opportunity to participate and accept tasks that best meet their skills and interests.

- Facilitates dialogue at committee meetings in a manner that welcomes all members' perspectives on issues, encourages independent thinking, promotes alignment on decisions that are balanced and demonstrate good judgment for the successful fulfillment of the committee's purpose.

- Manages conflict effectively. When necessary, brings matters to the attention of the Registrar and President.

- Demonstrates cultural sensitivity in policy development, policy implementation, and communications, and personally models behaviours described in the Council's Code of Conduct.

- Obtains appropriate expertise pertinent to the committee's work to provide a synthesis of information that identifies important issues for discussion or requiring action to efficiently expedite the committee's work.

- Understands the relationship of the various activities of the College committees to facilitate decision-making and to provide clarity around responsibility.

- Ensures new committee members understand the purpose and functions of the committee. Helps to facilitate the succession process by working with the Governance Committee to recruit new committee members and subsequent committee Chairs.

- Evaluates the committee's performance of its duties and works to implement improvements to ensure its continued effectiveness. Provides feedback to the Governance Committee on the performance of committee members annually.

- Enforces attendance guidelines with committee members to ensure that if more than three consecutive meetings are missed or if one third of all meetings within the year are missed that a member's continued involvement with the committee is reviewed.

- Ensures that the committee provides feedback to the Governance Committee on the Chair's performance. Participates in self-evaluation with the President to obtain feedback on own and committee's performance.

Collaborative Linkage between the Committee and the College Management Staff

- Works in cooperation with College management and staff to ensure appropriate utilization of College resources in support of the committee's work.

- Works in cooperation with College management in the development of the committee's annual budget to allocate costs and expenses in a fiscally responsible manner.

Key Representative of the Committee

- Is the spokesperson for the committee to Council and within the College and ensures that Council is informed and understands the rationale for decisions made by the committee in the fulfillment of its mandate.

Role Outcomes:

- Uphold policies and standards of the College in the fulfillment of committee duties.
- Decisions comply with appropriate legislation and CPSO policies.
- Reports to the College Council are made, as required, representing committee activities.
- Risk as it relates to the committee's mandate is managed, and Council is alerted to pertinent issues in a timely manner.
- New policies are recommended to the Council, as required.
- Committee members are evaluated to support and promote the improvement of committee effectiveness.
- Interaction with College staff occurs by provision of information regarding the committee's work. Interaction with staff is managed in a respectful, collegial manner.

How far in advance must this position plan/execute its work? (i.e., daily, weekly, monthly, annually or longer)

- Preparation and attendance time is dependent on the nature and tasks of the committee (see Committee descriptions for more details).

Principle Interfaces:

Internal:	Council Committee Chair Committee members College staff Council
External:	Dependent on the mandate of the Committee

Desirable Behavioural Competencies

Key behavioural competencies that are essential for successfully performing this role:

Continuous Learning – Involves taking actions to improve personal capability, and includes the ability to quickly understand and apply information, concepts, and strategies. Demonstrates an interest in continuous personal learning.

Creativity – Is generating new solutions, developing creative approaches and implementing new approaches that lead to improved performance. It requires the ability to anticipate and lead change that contributes to organizational success.

Effective Communication – Is willing and able to see things from another person's perspective. Demonstrates the ability for accurate insight into other people's/group's behaviour and motivation, and responds appropriately. It is the ability to accurately listen, understand, and respond effectively with individuals and groups.

Leadership – Is the ability to take a role as leader of the Council or Committee. Creates strong morale and spirit in his/her team. Shares wins and successes. It includes demonstrating a positive attitude, energy, resilience, stamina and the courage to take risks. Integrity is recognized as a basic trait required.

Planning & Initiative - Recognizes and acts upon present opportunities or addresses problems. Displays effective use of time management skills. Is able to plan and organize workflow and meetings in an efficient manner to address the opportunity or problem.

Relationship Building – Is working to build or maintain ethical relationships or networks of contacts with people who are important in achieving Council-related goals and the College mission.

Results Oriented – Makes specific changes in own work methods or systems to improve performance beyond agreed standards (i.e., does something faster, at lower cost, more efficiently; improves quality, stakeholder satisfaction; revenues; etc.).

Stakeholder Focused – Desires to help or serve others, meets the organization's goals and objectives. It means focusing one's efforts on building relationships, and discovering and meeting the stakeholders' needs. Partnerships between internal colleagues within the College are essential to meet external stakeholders needs.

Strategic Thinking – Understands the implications of decisions and strives to improve organizational performance. It requires an awareness of organizational issues, processes, and outcomes as they impact key stakeholders and the organization's strategic direction.

Teamwork – Demonstrates cooperation within and beyond the Council or the College. Is actively involved and "rolls up sleeves". Supports group decisions, even when different from one's own stated point of view. Is a "good team player", does his/her share of work. Compromises and applies rules flexibly, and adapts tactics to situations or to others' response. Can accept set-backs and change own immediate behaviour or approach to suit the situation. Is candid about opinions and raises justified concerns.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: **Harry Cayton Report: An Inquiry into the Performance of the College of Dental Surgeons of British Columbia (CDSBC) and the Health Professions Act**

FOR DISCUSSION

ISSUE:

- Mr. Cayton's report was released in April 2019. The report has two parts, the first dealing with issues specific to the CDSBC and the second with the Health Professions Act and the statutory framework for health professional regulation in BC. A summary is provided below.
- The report is relevant to the CPSO given the potential for health professionals regulatory reform in Ontario and Mr. Cayton's influence as an international expert in health regulation.

BACKGROUND:

- The BC Minister of Health asked Mr. Cayton to conduct an inquiry into the CDSBC in March of 2018.
- The inquiry followed reports of the mishandling of allegations of sexually inappropriate comments made to a dentist by its then Registrar/CEO, although it was clear that the scope of the inquiry was broader than this particular incident.
- The BC Health Ministry also appointed five members to the CDSBC's board, including several ADMs from the Ministry.
- The complete report is available here: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/cayton-report-college-of-dental-surgeons-2018.pdf.

Part 1 – CDSBC

- The majority of the report focusses on Mr. Cayton's review of the CDSBC with respect to governance, performance, external relationships and protection of the public.
- The report identified significant problems:
    - Lack of trust between staff and the Board
    - Inappropriate conduct of the Board towards staff
    - Lack of transparency in decision making
    - Inappropriate operational involvement by the Board

- In terms of performance, the inquiry concluded that the CDSBC was meeting only 17 of the 28 international Standards of Good Regulation (which cover registration, standards/guidance, complaints & discipline, and governance).
- The inquiry concluded that the CDSBC was not focused on the safety of patients. While it acknowledged problems with the legislation, it listed the following as key reasons why the CDSBC was not able to meet its public protection mandate:
    - The election of members
    - Reluctance to publish clear standards
    - Complexity of the complaints process, which is open to protracted negotiations between health professionals and their lawyers, and
    - The College's commitment to voluntary consent and remediation.
- The report sets out 21 recommendations for the CDSBC, which are summarized, along with an assessment of how the CPSO's performance compares, in Appendix A. For the majority of recommendations, we either have something in place already or are working towards the same objective.
- Overall, the report supports the work that CPSO has been done on governance, policy redesign and physician engagement, and the work that will be done as part of the strategic plan and continuing governance modernization.

- Part 2 of the report addresses two issues: specific recommendations to reform the existing legislation and broader recommendations regarding an overhaul of regulation of all the professions, including the addition of an oversight body.

Part 2 – Reforming the Health Professions Act (HPA)

- The report indicates that a regulatory framework that will last needs to be effective to protect patients, flexible to adapt to change, efficient to provide value for money and reliable to promote public confidence. Recommendations to reform the current HPA are made in several categories:

Mandate

- Replace 'serving and protecting the public' with the duty 'to protect the safety of patients, to prevent harm and promote the health and well-being of the public'.

Governance

- Replace 'membership' with 'registrant'.
- Move to fully appointed boards. However, given that the current government appointments process is not independent, transparent or competency based, it is suggested that a competency based selection process be implemented at the CDSBC.
- Board members hold three year terms, renewable for a further three years.
- Reduce the number of statutory committees.
- Colleges should have freedom to change rules and by-laws.

- The Board should be removed from any involvement in complaints and discipline. Inquiry committees and disciplinary panels should be independent, separately appointed and should have regular training and appraisal.

Complaints and Discipline

- Streamline the complaints process into three clear stages: triage, investigation and adjudication. Ensure clear and consistent thresholds for each stage in the process.
- The Act has a mechanism for resolution, which Mr. Cayton has suggested be removed since 'matters not raising issues of competence or conduct, such as complaints about poor service or price, should be dealt with in an alternative way and not by a regulator'.
- Statutory time limit for complaints should be removed.

Increase Transparency

- Create consistency between Colleges by all adopting best practice.
- Reduce the secrecy of the complaints process, which protects registrants, not the public.
- All Colleges should publish annual reports with the same information and performance data specified by the Ministry, which should include, at minimum, information about standards and guidelines, registrants, complaints, security of data and diversity.

Health and Professions Review Board (similar to HPARB)

- Add two roles to existing functions:
    1) publish guidance for college on improving their complaints performance, and
    2) ability to review college decisions without a referral.

Part 2 - Replacing the Health Professions Act; professional regulation for the future

The report suggests replacing the existing health regulation model to achieve structural reform. Recommendations include:

- Colleges to be responsible for setting standards and licensing health professionals.
- Colleges to develop a single code of ethics for all professions.
- Colleges to investigate complaints but not adjudicate them.
- Establish a single register for all registrants of all health professions that includes name, recognized qualifications, place of work and all sanctions related to complaints.
- Establish a new professional registration and adjudication agency that would:
    - set up and manage the register,
    - manage the adjudication process for conditions of practice and removal from the register, and
    - establish inquiry committees and disciplinary panels to adjudicate matters.
- Establish a new oversight body that would:
    - approve shared standards for ethics and conduct,
    - establish a dataset to be reported on by all colleges,
    - encourage and support the voluntary amalgamation of colleges,

  - advise colleges and the Minister on improvements in regulatory practice,
  - assess risk of harm to patients and public, and
  - create and oversee an independent appointment process for both professional and public members, based on open competition, published competencies and relevant experience, and make recommendations to the Minister.
- A summary of the proposed regulatory model is set out in Appendix B.

Throughout the report and in the conclusions, Mr. Cayton makes a number of observations about health professional regulation. Selected quotes are included in Appendix C.

NEXT STEPS:

- The BC Minister of Health accepted the inquiry's 21 recommendations and has given the CDSBC 30 days to deliver a transparency and accountability plan.
- An all-party committee was also appointed to examine plans to modernize the regulatory framework for all of B.C.'s health professions.
- The previous Ontario government was highly influenced by Mr. Cayton's work. It is unclear whether this government has the same view. Generally speaking, the current government is not supportive of creating additional agencies like the oversight agency proposed in the report. However, they are likely to be supportive of initiatives intended to reduce regulation or regulatory bodies.

FOR INFORMATION ONLY

Contact: Maureen Boon, Ext.276

Date: May 13, 2019

Attachments:

- Appendix A: Summary of Recommendations for CDSBC
- Appendix B: Overview of Recommended Changes to Legislation and Proposal to Replace the Legislation
- Appendix C: Selected Quotes

Appendix A: Summary of Recommendations for CDSBC

	Recommendation	CPSO
	Governance, conduct and probity	
1	Reduce size of board, increase representation of public members, appoint officers from within its membership and require an induction program for those standing for election	Included in red tape submission
2	Three year cooling off period for representative organizations prior to joining CDSBC board	In place
3	Dentists ineligible for election/appointment while complaint outstanding	Not in place*
4	Dentists on board/committee should stand down until complaints resolved	Not in place*
5	Review committee structure with a view to reducing the number and making decision-making more streamlined	In progress
6	Improve tracking of Board decisions	In place
7	Create a risk register to be maintained by senior staff, monitored by Audit Committee and reported to Board	In progress
8	Increase transparency by reducing private Board meetings	In place
9	Implement proper procurement policies and contract protocols	In place
10	Improve relationship with senior staff	In place
	Performance of College	
11	Improve internal data collection and performance management	In progress
12	Clarify and consolidate Standards and Guidance; term 'policy' to be used for corporate policies only	In progress
13	Board should remove itself from involvement in the complaints process and not influence or interfere with complaints	n/a
	External relationships	
14	Develop a stakeholder mapping and communications strategy	In progress
15	Improve reach and response rate of its annual complaints survey	Not in place
16	Open Board meetings to questions and comments from public	Not in place
17	Build a different relationship with dentists: mutual respect and distance	In progress
18	Greater focus on CDAs and Dental Therapists	n/a
19	Improved engagement with other dental colleges	n/a
20	Inform dentists what portion of their fee is collected for the association	n/a
21	Stop collecting fees for the BC Dental Association	n/a

*There are eligibility and disqualification rules regarding *discipline* matters.

Appendix B: Overview of Recommended Changes to Legislation and Proposal to Replace the Legislation

Body	Retains	Loses	Gains
Colleges	Standards and Guidance	Adjudication of complaints	Publication of dataset
	Registration and Licencing	Holding register	
	Continuing professional development		
	Investigating complaints		
Health Professions Review Board		Reviewing timelines	Functions transferred to oversight body
		Review registration appeals	
		Reviewing determinations	
Registration and Adjudication			Holding a single register
			Adjudication of complaints
			Removal from register
Oversight body			Reviewing determinations
			Review registration appeals
			Publication of performance data
			Oversight of appointments process
			Approval of bylaw changes
			Risk assessment of occupations
			Investigations and reviews
Ministry of Health	Control of legislation	Appointments process	Independent advice
	Appointments to Boards		
	Decisions on regulation		Reviews and investigations

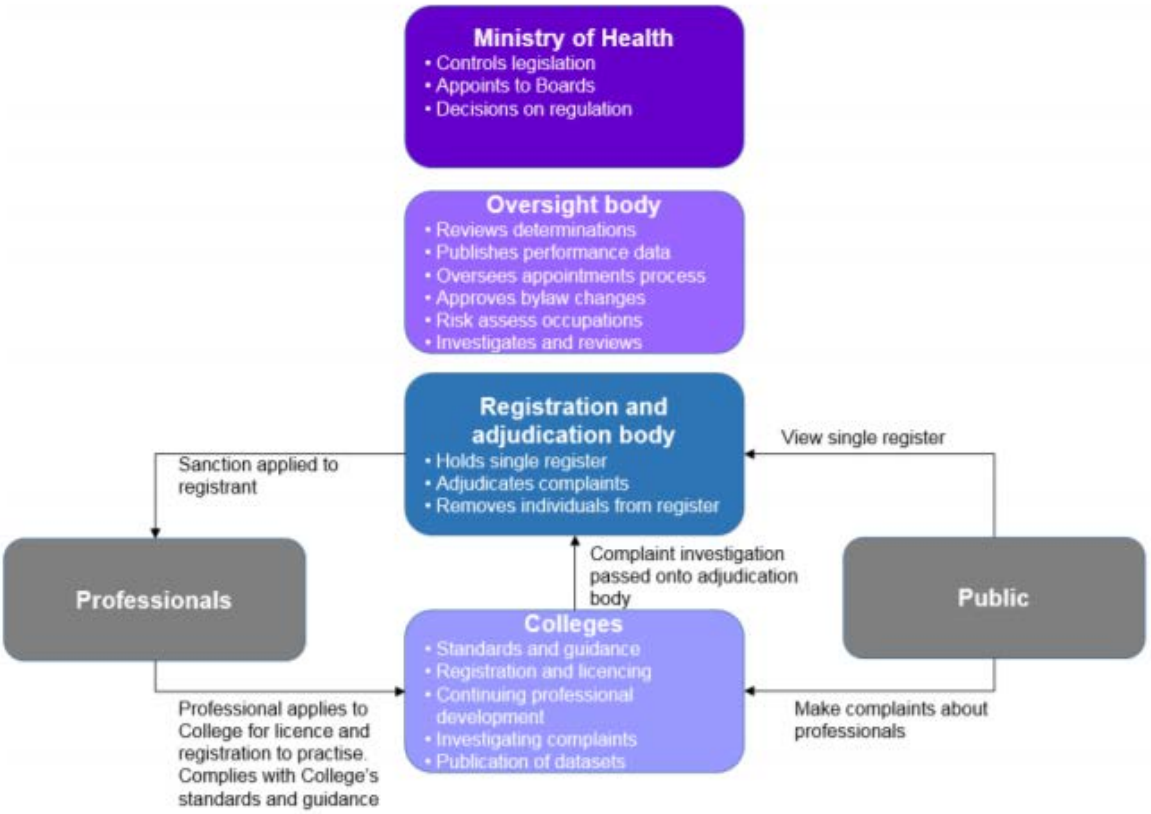

Table 8 and diagram 9: Both explain the different arrangements for professional regulation proposed in this Inquiry

Appendix C: Selected quotes

"….the roles of a Board are:

To ensure the College complies with its mandate and the law

To set strategy, to monitor performance

And to hold the registrar and chief executive to account for delivery …At every meeting the Board should be asking itself: how are we protecting the public, what will the decision of the meeting add to public protection? (p.20)

"Another concern is the lack of independence of the process and therefore potentially unfairness. The Inquiry Committee is not independent of the College Board. Members of the College Board sit on the Inquiry Committee. If Board members are involved there is a perceived or actual risk that the interests of the College (cost of legal action, time, inconvenience) may influence decision-making. Moreover, dentist members of the College Board are elected and therefore beholden to their colleagues." (p.35)

"Self-regulation needs the consent of the regulated. It does not need their enthusiastic support but it does need their acceptance...it also needs the confidence of the public." (p.48)

"The college needs to build a different relationship with its dentist registrants: one of both mutual respect and distance. It cannot do so when its Board is elected by registrants and partially subject to their control." (p.49)

"Regulators cannot work effectively alone or in isolation from the wider social structures of which they are a part. In the past, to some, self-regulation meant self-determination and isolation. A sentiment which lingers on in the claims 'We are different', 'We are special', 'We can be trusted to be left alone'. None of those claims are sustainable in the face of the many failures of professional regulation in many jurisdictions over many years nor in response to the needs of modern health services." (p.56)

"Stop assuming that remediation works in every case when the evidence shows it does not. Dentists who have a second complaint having previously signed an MAU should not be allowed to do so again. Stop hoping that dishonesty can be remediated by an ethics course." (p.64)

"Who owns the College? Well, the truth is that the citizens of British Columbia own the College; through their government they have given dentists self-regulatory powers but only as long as the College serves the public, the Board serves the public, the staff serve the public and dentists serve the public." (p.65)

"If Colleges do not have members, then there is no need for an Annual General Meeting nor indeed any of the other trappings of a club such as award ceremonies and gifts to volunteers. Some will protest that this removes the principle of professional self-regulation. It does.

Unlimited self-regulation has in general proved itself unable to keep patients safe or to adapt to changing healthcare provision and changing public expectations." (p.74)

"It is not possible for patients to give informed consent to care if they do not know that the health practitioner has had a complaint upheld against them. It should be recognized as a fundamental right of a patient to know about their healthcare provider's competence and conduct." (p.82)

"It is not that the time taken to progress complaints is not important but statutory time limits take no account of reality (complexity of cases, actions by the registrant, actions by lawyers, circumstances outside the College's control, resources available) and there are other better ways of improving timelines." (p.83)

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Policy Redesign Implementation – Batch 1

Date of Meeting: May 30, 2019

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policies:

(a) "Accepting New Patients" (a copy of which forms Appendix " " to the minutes of this meeting);
(b) "Blood Borne Viruses" (a copy of which forms Appendix " " to the minutes of this meeting);
(c) "Cannabis for Medical Purposes" (a copy of which forms Appendix " " to the minutes of this meeting);
(d) "Consent to Treatment" (a copy of which forms Appendix " "to the minutes of this meeting);
(e) "Ending the Physician-Patient Relationship" (a copy of which forms Appendix " " to the minutes of this meeting);
(f) "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" (a copy of which forms Appendix " " to the minutes of this meeting);

(g) “Female Genital Cutting (Mutilation)” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(h) “Planning for and Providing Quality End-of-Life Care” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(i) “Providing Physician Services During Job Actions” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(j) “Public Health Emergencies” (a copy of which forms Appendix “ ” to the minutes of this meeting);
(k) “Telemedicine” (a copy of which forms Appendix “ ” to the minutes of this meeting); and
(l) “Uninsured Services: Billing and Block Fees” (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: Policy Redesign Implementation – Batch 1

FOR DECISION

ISSUE:

- At its December 2018 meeting, Council approved a proposal to redesign College policies in order to enhance their utility for physicians. As part of this proposal, a commitment was made to redesign all policies not currently under review by the end of 2019.

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

BACKGROUND:

- In response to feedback that College policies can be difficult to read and understand, Council approved a proposal to redesign policies to be clearer and more concise and to better distinguish between mandatory and permissive expectations.

- Central to the approved approach 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, the proposal was clear that *all* existing mandatory and permissive expectations contained in these policies would be retained and would not be meaningfully altered through the redesign process. Instead, the focus would be on enhancing the utility of policies through changes in drafting conventions (e.g., using a numbered list format, using formatting to better identify and delineate mandatory and permissive expectations, etc.).

- An additional commitment was made to then re-evaluate, with an aim to eliminate, the use of permissive expectations as part of the College's normal policy review process on a go-forward basis. This commitment applies to any policy currently under review.

- The proposal also noted that companion 'advice' documents would be developed as-needed to capture important contextual information or rationale that was removed from the policies and to provide general advice regarding the policy expectations.

CURRENT STATUS:

- The redesign process is underway with support and oversight from the *Policy Redesign Working Group*. The Working Group is comprised of Council Members Brenda Copps (Chair), Ellen Mary Mills, Janet van Vlymen, and Medical Advisors Angela Carol and Keith Hay.

- Twelve policies have been redesigned as part of this process. Additionally, a number of *Advice to the Profession* companion documents have been created, where necessary.

    - The companion advice documents repurpose existing *Frequently Asked Questions* documents and capture important context or rationale that has been removed from the policies as part of the redesign. Because they are intended to be nimble communications tools that can address emerging issues between policy reviews, they do not require approval in the same way as policies. They are, however, included for informational purposes.

- The redesign implementation plan is outlined below, followed by an overview of the outcome of this work, as well as the proposed housekeeping amendments to two policies included in this first batch of redesigned policies.

- Importantly, the redesign process has not resulted in substantive changes to the existing policies. As such, with the exception of the housekeeping amendments outlined below, approval is being sought on the basis of the process that was undertaken and the oversight provided by the *Policy Redesign Working Group*, rather than a detailed review of each individual policy.

A. Redesign Implementation Plan

- In order to ensure that policies were redesigned without losing or altering any expectations, a robust redrafting and review process was implemented.

    - A line-by-line analysis of each policy was conducted to identify content that needed to be retained (i.e., expectations), repurposed into a companion document (e.g., context or rationale), or deleted altogether.

    - The policy was then re-drafted in line with the redesign approach, streamlining content if possible, and a companion advice document was developed if needed.

    - A comprehensive audit was then be conducted by another member of staff who would go line-by-line through the original policy, redesigned policy, and advice document to ensure the revisions were sound and that no expectations were lost or altered.

    - The Manager of Policy would then conduct an additional line-by-line audit, which was then followed by a final audit conducted by Legal Counsel.

- During this process, some interpretive issues arose. For example, some policies reflected older drafting conventions with respect to the language used (e.g., “should”, “expect”, etc.) that needed to be translated into current conventions (i.e., “must”, “advised”), and there were instances where implicit expectations needed to be made explicit.

- When these issues arose, proposed language was developed either: on the basis of consultation with the last author of the policy to ensure alignment with the original intention of the policy; or through a careful analysis of the language, spirit, and intention of the policy, and the *Practice Guide* if needed.

- The *Policy Redesign Working Group* was then provided with the rationale for each proposed revision and asked to consider whether the revision was reasonable and reflected the meaning of the original expectation. With their approval or direction to revise the proposed language, the policies were finalized.

B. Outcomes of the Implementation Plan: Batch 1

- To expedite the process and deliver redesigned policies to the profession quickly, the redesign process was divided into two batches.

- Following the implementation plan above, twelve policies have been redesigned and are included in the attached appendix, along with any respective advice documents. They are:

1. *Accepting New Patients*
2. *Blood Borne Viruses*
3. *Cannabis for Medical Purposes*
4. *Consent to Treatment*
5. *Ending the Physician-Patient Relationship*
6. *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*
7. *Female Genital Cutting (Mutilation)*
8. *Planning for and Providing Quality End-of-Life Care*
9. *Providing Physician Services During Job Actions*
10. *Public Health Emergencies*
11. *Telemedicine*
12. *Uninsured Services: Billing and Block Fees*

- Through the redesign process, significant reductions in policy content have been achieved.

    - The overall word count of these policies has been reduced by over 40%, with longer policies seeing reductions as high as 56%. This has resulted in a reduction of over 40 pages of policy content without losing or altering a single expectation.

    - While some of the content from the policies has been repurposed into companion advice documents, moving this peripheral information out of the policy and into a communications tool will improve the readability of the policies.

C. Additional Housekeeping Amendments

- Some housekeeping changes were made as part of the redesign process. These changes are outlined below.

Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice

- The current policy requires physicians to report any intentions to change their scope of practice or to re-enter practice on the Annual Renewal survey.

- However, the Annual Survey has since been updated and no longer asks physicians to report an intention to change their scope. The redesigned policy has been updated to reflect this change in process.

Planning for and Providing Quality End-of-Life Care

- In response to recent stakeholder activity and feedback, the Executive Committee directed that the policy language regarding no-CPR orders be revised in order to address areas of misinterpretation and misapplication, and to adjust the tone and nature of the language to be more reflective of physicians' clinical expertise in this area.

- The redesigned policy has been revised accordingly. Importantly, these revisions retain the intended meaning and spirit of the expectations found in the current policy, but may help to address some of the issues that are arising in practice. Revisions include:

    - Clarifying that physicians are only required to *inform* patients and/or substitute decision-makers that a no-CPR order will be written. The current language was being read as requiring that the no-CPR order be *proposed*, but the original intention was always to allow physicians to be directive in their discussion.

    - Revising the language and tone of the policy to help mitigate a feeling among some physicians that they should go above and beyond what the policy requires, for fear of reprisal. For example, by removing repeated references to acting in 'good faith' and relying instead on physicians' professional and clinical judgment in meeting the expectations of the policy.

    - Removing explicit mention of what the physiologic goals of CPR are, recognizing that this is a clinical matter best determined by physicians' clinical expertise. Importantly, this revision does not alter the nature of the exception to the general requirement that CPR be provided while conflict resolution about the no-CPR order is underway.

NEXT STEPS:

- Should Council approve each redesigned draft policy, they will replace the current version of each policy on the College's website. The companion advice documents will also be posted on the website, alongside their respective redesigned policy.

- Announcements regarding the approval of the redesigned policies will be made through the College's social media properties as well as in a feature *Dialogue* article. These communication efforts will emphasize that expectations have not changed, but that the policies have just been redesigned to be more user friendly.

DECISION FOR COUNCIL:

1. Does Council have any questions about the policy redesign implementation plan?

2. Does Council approve each redesigned draft policy as a policy of the College?

Contact: Craig Roxborough, ext. 339

Date: May 10, 2019

Attachments:
Appendix A: Policy Redesign Documents – Batch 1

Accepting New Patients Policy

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

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

Definitions

First-Come, First-Served Approach: An approach whereby new patients are accepted on a first-come, first-served basis, when the patient's needs are within:

- the physician's clinical competence and/or scope of practice;
- the physician's focused practice area[1]; and/or
- the terms and conditions of the physician's practice certificate and associated practice restrictions, if applicable.

Higher Need and Complex Patients: Patients who may be categorized as higher need and/or complex include, but are not limited to, those requiring urgent access to care, those with chronic conditions, particularly where the chronic condition is unmanaged, an activity-limiting disability and/or mental illness.

Policy

1. Physicians **must** employ the first-come, first-served approach when accepting new patients into their practices.[2]

2. Notwithstanding this requirement, physicians are permitted to make decisions about whether their practice is accepting new patients. Such decisions **must** be made in good faith.

3. Physicians **must not** refuse to accept patients based on any of the prohibited grounds of discrimination set out in the Ontario *Human Rights Code*[3].[4]

[1] Physicians with a 'focused practice area' may include those with a commitment to one or more specific clinical practice areas, such as geriatrics, psychotherapy or adolescent health, or who serve a defined target population.
[2] This policy applies to all physicians, and those acting on their behalf. For instance, physicians may rely upon clinical managers and/or office staff to accept new patients on their behalf. Organizations may also act as a physician's representative in this context.

4. 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;[5]
    c. requiring more time than another patient with fewer medical needs; or
    d. with an injury, medical condition, psychiatric condition or disability[6] that may require the physician to prepare and provide additional documentation or reports.

5. Where a physician refuses a patient based on clinical competence, scope of practice, and/or a focused practice area, the physician **must:**

    a. do so in good faith;
    b. consider the impact on the patient; and
    c. clearly communicate the reasons for the refusal to the patient (or referring practitioner, where appropriate).

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

7. Physicians **must not** use introductory meetings, such as 'meet and greet' appointments and/or medical questionnaires[7], to vet prospective patients and determine whether to accept them into their practice but are permitted to use them to share information about

[3] *Human Rights Code*, R.S.O. 1990, c. H.19.
[4] Prohibited grounds of discrimination include, but are not limited to, race, ancestry, place of origin, color, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. For more information see the College's Professional Obligations and Human Rights policy.
[5] Physicians are advised to consult the College's Prescribing Drugs policy for further information on the College's position on blanket 'no narcotics' prescribing policies.
[6] Physicians should be aware that under the *Code*, the term 'disability' is interpreted broadly and covers a range of conditions. 'Disability' encompasses physical, mental and learning disabilities, mental disorders, hearing or vision disabilities, epilepsy, drug and alcohol dependencies, environmental sensitivities, and other conditions. The *Code* protects individuals from discrimination because of past, present and perceived disabilities.
[7] Medical questionnaires include those administered in person, by phone, or electronically by physicians or those acting on their behalf.

the practice and obtain information about the patient after a patient has been accepted into a practice.[8]

Specialist Care

8. Physicians who provide specialist care **must** employ the first-come, first-served approach by accepting new patients in the order in which the referral was received. Physicians **must** only depart from this practice to accommodate patients requiring priority access to care, for example, due to urgent health-care needs.

9. Where a referral is outside of the specialist's clinical competence or scope of practice, the specialist **must** promptly communicate this information to the referring health-care practitioner, and/or patient where appropriate, to facilitate timely access to care.

10. Physicians are **advised**, where possible, to provide the referring health-care practitioner with suggestions for alternative care provider(s) who may be able to accept the referral.

Waiting Lists

11. Physicians who maintain a waiting list of prospective patients **must** accept patients in the same order in which they were added to the list.

12. Physicians are **advised** to use wait-lists cautiously, and to manage patient expectations by clearly communicating the expected waiting period.

Potential Exceptions to First-Come, First-Served Approach

13. Physicians are permitted to depart from the first-come, first-served approach to prioritize access to care for higher need and/or complex patients. Decisions to prioritize a patient's access to care **must** be made in good faith.

14. Physicians **must** use their professional judgment to determine whether prioritizing or triaging patients based on need is appropriate, taking into account the patient's health care needs, and any social factors, including education, housing, food security, employment, and income that may influence the patient's health outcomes.

[8] For instance, introductory meetings and/or medical questionnaires may be helpful to identify a new patient's needs and expectations, to disclose information about the physician's knowledge area, to advise of after-hours coverage, or to determine whether the terms of the physician-patient relationship are acceptable to the patient. Further, introductory meetings may involve establishing expectations regarding adherence to a prescribed therapy. This may include, for instance, establishing a treatment agreement (e.g., narcotics contract) between the physician and the patient.

15. The College acknowledges that caring for patients and their family members may assist in the provision of quality care. Accordingly, where a primary care physician's practice is otherwise closed, physicians are permitted to prioritize the family members of current patients. When doing so, physicians **must** consider whether accepting that family member would reasonably assist in the provision of quality care.

Advice to the Profession: Accepting New Patients

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

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

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

What's the rationale behind the first-come, first-served approach?

The first-come, first-served approach helps to ensure that physicians fulfil their legal obligations under the Ontario *Human Rights Code* (the *'Code'*).[1] The *Code* entitles every Ontario resident to equal treatment with respect to services, goods and facilities, without regard to race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

Under the Code, all those who provide services in Ontario, including physicians providing health services, must do so free from discrimination on any of the above-listed grounds. The first-come, first-served approach helps to ensure that all patients receive equal treatment with respect to health services.

Accepting new patients in a manner that is fair, transparent, and respectful of the rights, autonomy, dignity and diversity of all prospective patients reinforces public trust in the profession, and fosters confidence in the physician-patient relationship.

[1] *Human Rights Code*, R.S.O. 1990, c. H.19.

What does the College expect when patients want to change physicians within the same group practice?

In keeping with the principles of medical professionalism as set out in the *Practices Guide* and the spirit of the *Accepting New Patients* policy, it would be inappropriate for physicians to practice medicine in a manner that hindered patient autonomy and denied patients' freedom of choice of health care provider. Practice policies that prohibit patient movement between physicians in the same practice group/team, may compromise a patient's autonomy and ability to determine who provides their care.

If a patient requests a change, physicians are advised to discuss with the patient their reasons for seeking an alternative care provider and to make patients aware of circumstances where the structure of the practice (e.g. physician coverage arrangements) may necessitate care by and/or contact with their former physician.

The policy sets out specific instances whereby physicians must make decisions in "good faith". What does this mean?

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

For instance, physicians act in good faith by:

- closing their practice when it has reached capacity, not as a means of refusing patients who may be perceived as less desirable;
- assessing, in a fair and honest manner, whether their medical knowledge and clinical skills will meet a patient's health care needs, and not using a lack of medical knowledge or clinical skills to unfairly refuse patients with, for instance, complex or chronic health needs; and
- prioritizing access to care because a patient truly has higher and/or complex health care needs, and not because a patient is perceived as "easy" and/or requiring less time or resources.

What should a physician do if they feel that treating patients with a history of prescription opioid use is legitimately outside of their clinical competence and/or scope of practice?

As stated in the *Accepting New Patients* policy, physicians, or those acting on their behalf, must not refuse patients because they have a history of prescribed opioid use. Such refusals may cause the patient harm. This may result in patients experiencing discrimination in the provision of care, even where this is not the intention of the physician, and/or may lead to the abrupt

cessation of a patient's medication. If a dose is not reduced gradually, it may cause the patient increased pain, decreased function or opioid withdrawal, which can be dangerous.

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

1. Prescribing narcotics and controlled substances is part of good clinical care, and refusing to prescribe these drugs altogether (e.g., through 'no narcotics' policies) may lead to inadequate management of some clinical problems and leave some patients without appropriate treatment.[2]
2. There are relevant resources that can assist in managing the care of patients with a history of prescription opioid use, including the '*2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain'*, and the '*Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain'.*
3. Where elements of a current patient's care needs are legitimately outside of a physician's clinical competence and/or scope of practice, the College requires that the patient be provided with a referral for those elements of care that the physician is unable to manage directly.

Physicians are further reminded that given the broad scope of practice of primary care physicians, there are few occasions where scope of practice would be an appropriate ground to refuse a prospective patient and determinations about whether a patient's health care needs fall within their clinical competence and/or scope of practice must be made in good faith.

Where a practice is otherwise closed, the policy permits primary care physicians to prioritize the family members of current patients. How do I determine in what circumstances prioritizing patients' family members is appropriate?

When determining whether to prioritize access to care for a current patient's family member, physicians must take into account whether accepting that family member would reasonably assist in the provision of quality care. For instance, caring for the current patient's spouse or partner, parent, child, and/or sibling may allow physicians to gain a clearer picture of family history.

It may also be appropriate for physicians to prioritize access to care for extended family members when doing so would reasonably assist in the provision of quality care. For instance,

[2] Please refer to the College's *Prescribing Drugs* policy for expectations regarding the use of "no narcotics" prescribing policies.

caring for family members who share a household and/or have the same hereditary health condition may contribute to better health outcomes.

How do wait-time targets for specialist consultations and surgeries that are set by the province fit with the first-come, first-served approach?

Physicians are permitted to depart from the first-come, first-served approach to accommodate patients requiring priority access to care. The College acknowledges that there are a number of factors, some of which are outside of a physician's sole discretion, that determine when a patient is provided priority access to care. These factors include, for instance, wait-time targets set by the province for cancer consultations and surgeries.

Blood Borne Viruses

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

Blood Borne Viruses: Blood borne viruses (BBVs) refer to hepatitis B virus (HBV), hepatitis C virus (HCV), and/or human immunodeficiency virus (HIV).

Exposure Prone Procedures: The Centers for Disease Control and Prevention (CDC) defines an exposure prone procedure as one which involves one or more of the following:

1. digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health-care worker's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site (e.g., during major abdominal, cardiothoracic, pelvic, vaginal and/or orthopaedic operations); or
2. repair of major traumatic injuries; or
3. manipulation, cutting or removal of any oral or perioral tissue, including tooth structures during which blood from a health-care worker has the potential to expose the patient's open tissue to a blood borne pathogen.[1]

The College has adapted the list of procedures that have been identified in the SHEA Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus as those for which there is a definite risk of blood borne virus transmission (Category III Procedures).

Examples of procedures that are classified as 'exposure-prone' are set out in Appendix A.

Routine Practices: Routine Practices refers to a set of practices designed to protect health-care workers and patients from infection caused by a broad range of pathogens including

[1] Centers for Disease Control and Prevention, 1998.

blood borne viruses. These practices must be followed when caring for all patients at all times regardless of the patient's diagnosis. Key elements of Routine Practices include: point of care risk assessment; hand hygiene; use of barriers (e.g., personal protective equipment, such as gloves, mask, eye protection, face shield and/or gowns) as per the risk assessment; safe handling of sharps; and cleaning and disinfection of equipment and environmental surfaces between uses for each patient.

Routine practices are set out in Appendix B.

Treating Physician: For the purposes of this policy, treating physician refers to the physician who is managing the care of the seropositive physician with respect to their infection with a blood borne virus.

Policy

1. Physicians **must** take steps to safeguard their own health and that of their patients, and report their own seropositive status to the College in accordance with the requirements of this policy.

Safeguarding Health

2. Physicians **must** comply with the expectations set out in this section, as well as other precautionary measures, as required and as recommended by their treating physician and relevant public health authorities.[2]

Routine Practices

3. Physicians **must** adhere to Routine Practices in accordance with Appendix B. This expectation applies equally to physicians who are seropositive for blood borne viruses, and physicians who are seronegative.

HBV Vaccination

4. Physicians who are not currently and have not previously been infected with HBV are **strongly advised** to be immunized for HBV and tested to confirm the presence of an

[2] This includes precautionary measures required by hospitals and other health-care institutions where physicians work.

effective antibody response[3], unless a contraindication exists, or there is evidence of prior immunity.

5. Physicians who do not respond to the vaccine (do not seroconvert as evidence of immunity) are **advised** to seek expert advice on alternative vaccination protocols in order to confirm the presence of an effective antibody response.

Testing for BBVs

Beginning Exposure Prone Procedures in Ontario

6. Physicians[4] who want to perform or assist in performing exposure prone procedures in Ontario[5] **must** be tested for HCV, HIV and HBV, if they have not been confirmed immune to HBV, before they commence performing or assisting in performing exposure prone procedures in Ontario.

Periodic Testing

7. Physicians who perform or assist in performing exposure prone procedures **must** be tested for HCV and HIV every three years.

8. Physicians who perform or assist in performing exposure prone procedures **must** be tested annually for HBV unless the physician has been confirmed immune to HBV.

Testing Post-Exposure

9. Physicians who have been exposed to bodily fluids of unknown status through a specific incident, such as a needle prick, or splash onto a mucous membrane or non-intact skin **must** seek expert advice regarding the frequency of testing that is required to determine if they have been infected with one or more blood borne viruses and whether any post-exposure prophylaxis is necessary.

[3] If a physician has received the hepatitis B vaccine and is immune, the physician will have antibody to hepatitis B surface antigen (anti-HBsAg).

[4] This includes physicians who perform or assist in performing procedures that may become exposure-prone (for example, a laparoscopic procedure that may convert to an open procedure) and also includes physicians who have the potential to perform or assist in performing exposure prone procedures in the course of providing day-to-day care (e.g., emergency medicine physicians) even though they may not be currently performing them.

[5] This applies to new registrants (including physicians who perform or assist in performing exposure prone procedures in other jurisdictions), physicians who will begin performing or assisting in performing exposure prone procedures as part of their educational training, and physicians who are changing their scope of practice or re-entering practice. Physicians may wish to consult *the Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy for more general guidance on these topics.

10. Physicians are advised to consult the Blood Borne Diseases Surveillance Protocol for Ontario Hospitals[6] and their own hospital's protocols and/or policies for detailed information about post-exposure protocols, including post-exposure prophylaxis.

Reporting Serological Status

11. Physicians who perform or assist in performing exposure prone procedures **must** report if they are seropositive with respect to HBV, HCV (including either HCV antibody or HCV RNA), and/or HIV through the completion of the Annual Renewal Survey.

12. When physicians learn they are seropositive for HBV, HCV (including either HCV antibody or HCV RNA) and/or HIV they **must** report, outside the context of the Annual Renewal Survey. Physicians **must** make a report to the College as soon as is reasonably practical after learning of their status and not wait to report their status on the next Annual Renewal Survey.[7]

Seropositive Physicians

13. Physicians[8] who have tested positive for HBV, HCV (including either HCV antibody or HCV RNA), and/or HIV and who wish to begin performing or assisting in performing exposure prone procedures in Ontario or to continue performing or assisting in performing exposure prone procedures **must** be under the care of a treating physician who has expertise in the management of their infection (e.g., infectious diseases expert, hepatologist).

14. Physicians who have tested positive for HBV, HCV (including either HCV antibody or HCV RNA), and/or HIV **must** undergo such regular testing as is recommended by their treating physician, and approved by the College for the purposes of monitoring their health, including their viral loads.

[6] This document is available at: https://www.oha.com/Documents/Blood%20Borne%20Diseases%20Protocol%20(November%202018).pdf

[7] Physicians **are advised** to contact the College's Physicians Advisory Service at 416-967-2606; Toll Free: 1-800-268-7096 Ext.606

[8] This includes physicians who wish to perform or assist in performing procedures that may become exposure-prone (for example, a laparoscopic procedure that may convert to an open procedure) and also includes physicians who will have the potential to perform or assist in performing exposure prone procedures in the course of providing day-to-day care even though they may not be currently performing them.

Appendix A

SHEA Guideline for Management of Healthcare Workers who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus

Examples of Procedures Classified as Exposure Prone

The College has adapted the list of procedures that have been identified in the SHEA Guideline as those for which there is a definite risk of blood borne virus transmission (Category III Procedures). The list that follows sets out examples of procedures that are classified as 'exposure prone' for the purposes of the Annual Renewal Survey, and the Blood Borne Viruses policy:

- general surgery, including nephrectomy, small bowel resection, cholecystectomy, subtotal thyroidectomy, other elective open abdominal surgery;
- general oral surgery, including surgical extractions, hard and soft tissue biopsy (if more extensive and/or having difficult access for suturing), apicoectomy, root amputation, gingivectomy, periodontal curettage, mucogingival and osseous surgery, alveoplasty or alveoectomy, and endosseous implant surgery;
- cardiothoracic surgery, including valve replacement, coronary artery bypass grafting, other bypass surgery, heart transplantation, repair of congenital heart defects, thymectomy, and open-lung biopsy;
- open extensive head and neck surgery involving bones, including oncological procedures;
- neurosurgery, including craniotomy, other intracranial procedures, and open-spine surgery;
- nonelective procedures performed in the emergency department, including open resuscitation efforts, deep suturing to arrest hemorrhage, and internal cardiac massage;
- obstetrical/gynecological surgery, including cesarean delivery, hysterectomy, forceps delivery, episiotomy, cone biopsy, and ovarian cyst removal, and other transvaginal obstetrical and gynecological procedures involving hand-guided sharps;
- orthopedic procedures, including total knee arthroplasty, total hip arthroplasty, major joint replacement surgery, open spine surgery, and open pelvic surgery;
- extensive plastic surgery, including extensive cosmetic procedures (e.g., abdominoplasty and thoracoplasty);
- transplantation surgery (except skin and corneal transplantation);
- trauma surgery, including open head injuries, facial and jaw fracture reductions, extensive soft-tissue trauma, and ophthalmic trauma; and

- any open surgical procedure with a duration of more than three hours, probably necessitating glove change.

Appendix B

Routine Practices

The information set out in this appendix consists of information found in Public Health Ontario's documents set out in the references below.

Preamble

The term "Routine Practices" (RP) refers to a set of practices designed to protect health-care workers (HCW) and patients from infection caused by a broad range of pathogens including blood borne viruses. These practices must be followed when caring for all patients at all times regardless of the patient's diagnosis. Although RP are targeted to prevent transmission of microbes from patient to patient and HCW to HCW as well as between HCW and patient, the focus of this discussion is the transmission of microbes from HCW to patient and/or patient to HCW, in particular as related to the blood borne viruses hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV).

RP begin with a point of care risk assessment to consider the potential for microbial transmission during the upcoming process of care. This risk assessment is routinely followed by hand hygiene and donning of the appropriate barrier equipment (Personal Protective Equipment) prior to examining the patient. RP also include care in the use and disposal of needles and other sharp instruments, documented immunity/immunization against HBV as appropriate, and proper reprocessing of medical equipment. HCWs performing exposure prone procedures* are at an increased risk of infection with blood borne pathogens and must be knowledgeable about and diligently adhere to RP. The key elements of RP are discussed briefly below, and a glossary of terms appropriate to this document follows. For more information please check the appropriate reference(s).

Point of Care Risk Assessment

- The risk of exposure to blood, body fluids* and non-intact skin* must be considered by assessing the nature of the upcoming process of care, the patient, the HCW and the health-care environment.
- Strategies (e.g., choice of barrier precautions) must be identified and implemented to decrease exposure risk and prevent the transmission of microorganisms.

Hand Hygiene

- Hand hygiene is the single most important measure to prevent the spread of infection.
- Hand hygiene refers to both washing with soap and water or the use of alcohol-based hand rubs (ABHR).
- Use of ABHR (70-90% alcohol) is the preferred method of cleaning hands when hands are not visibly soiled. Hand washing with soap and water must be performed when hands are visibly soiled.
- Hand hygiene must be performed:
    - before initial patient/patient environment contact,
    - before performing an aseptic procedure,
    - after body fluid exposure risk and after gloves have been removed, and
    - after patient/patient environment contact.

To prevent cross-contamination of different body sites, it may be necessary to perform hand hygiene between procedures on the same person.

Gloves

- Medical grade gloves (clean, non-sterile gloves are adequate for routine care) must be worn when contact with blood/body fluids, secretions, excretions, mucous membranes*, non-intact skin and/or potentially contaminated items is anticipated.
- Gloves must be changed or removed after touching a patient's contaminated body site and prior to touching the patient's clean body site or the environment.
- Gloves must be removed promptly after use, followed by immediate hand hygiene.

Personal Protective Equipment: Mask, Eye Protection, Face Shield and Gowns

- Masks, eye protection (safety glasses, goggles or face shield) and/or gowns as appropriate to the type of contact anticipated must be worn in order to protect mucous membranes and/or clothing during clinical procedures, care activities or handling used medical equipment if splashes or sprays of blood, body fluids, secretions, or excretions might be generated.

Handling Sharps

- Sharps must be handled as minimally as possible.
- Needles must not be re-capped.

- Used needles and other sharps must be discarded in a specially designed sharps container.
- For specific requirements under Ontario's needle safety legislation see the *Occupational Health and Safety Act*, O. Regulation 474/07, Needle Safety, available at: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_070474_e.htm.

Cleaning and Disinfection of Equipment and Environmental Surfaces

- All used medical equipment must be cleaned and then disinfected or sterilized as appropriate prior to use on another patient.
- Equipment that enters sterile tissues, including the vascular system is referred to as a critical device and must be sterilized after cleaning.
- Equipment that comes in contact with non-intact skin or mucous membranes but does not penetrate them is referred to as a semi-critical device and requires high level disinfection after cleaning.
- Equipment that touches only intact skin and not mucous membranes, or does not directly touch the patient is referred to as a non-critical device and requires low level disinfection after cleaning.
- Single-use items must be discarded after use and never be reprocessed.

Glossary

***Body fluids:** blood, vomit, stool, semen, vaginal fluid, urine, CSF, peritoneal fluids, pleural fluids, droplets from coughing or sneezing, except sweat, regardless of whether or not they contain visible blood.

***Mucous membranes:** lining of the eyes, nose and mouth.

***Non-intact skin:** open lesions, and dermatitis.

References

Public Health Ontario. Ministry of Health and Long-Term Care of Ontario. Routine practices and additional precautions in all health care settings. November 2012 http://www.publichealthontario.ca/en/eRepository/RPAP_All_HealthCare_Settings_Eng2012.pdf

Public Health Ontario. Ministry of Health and Long-Term Care of Ontario. Best practices for hand hygiene in all health care settings. April 2014

http://www.publichealthontario.ca/en/eRepository/2010-12%20BP%20Hand%20Hygiene.pdf

Public Health Ontario. Ministry of Health and Long-Term Care of Ontario. Best practices for cleaning, disinfection and sterilization of medical equipment/devices. May 2013. http://www.publichealthontario.ca/en/eRepository/PIDAC_Cleaning_Disinfection_and_Sterilization_2013.pdf

Advice to the Profession: Blood Borne Viruses

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.

Hepatitis B virus, hepatitis C virus and human immunodeficiency virus can be transmitted between a physician and a patient during the course of treatment. The risk of transmitting infectious diseases is a concern shared by both physicians and patients.

The risk of transmitting blood borne viruses (BBV) to a patient is greater when a physician's blood borne infection is unrecognized and untreated. This is why it is important for a physician to know his or her status in regard to whether they are infected with a blood borne virus. This information is essential not only to safeguard physicians' health and that of their patients, but also to ensure that patient and public trust in the profession is maintained.

The College's *Blood Borne Viruses* policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.

This advice document is intended to help physicians interpret their obligations as set out in the *Blood Borne Viruses* policy and provide guidance around how these obligations may be effectively discharged.

Does the Blood Borne Viruses policy apply to all physicians?

No. The policy only applies to physicians including postgraduate trainees who perform exposure prone procedures (EPPs) or who assist in performing these procedures as these are procedures where there is a higher risk of blood borne virus transmission. This includes physicians who perform or assist in performing procedures that may become exposure-prone (for example, a laparoscopic procedure that may convert to an open procedure) and also includes physicians who have the potential to perform or assist in performing exposure prone procedures in the course of providing day-to-day care even though they may not be currently performing them, for example, emergency physicians.

Why does the policy apply to physicians who assist in performing exposure prone procedures?

The policy applies to physicians who assist in performing exposure prone procedures because we recognize that physicians assisting with these procedures may be subject to similar risks as physicians who actually perform the procedures.

Why does the policy apply to physicians who have the potential to perform or assist in performing exposure prone procedures?

The policy applies to physicians who have the potential to perform or assist in performing exposure prone procedures, for example, emergency physicians, because we want to ensure that both patients and physicians are protected. Performing or assisting in performing exposure prone procedures is within an emergency physician's scope of practice. A patient who requires an exposure prone procedure could come to the emergency department. Although this may not happen every day or even often, if it does the emergency physician would need to perform the exposure prone procedure.

How do I know if I am performing exposure prone procedures?

The College has adopted the following definition of "exposure prone" procedures from the Laboratory Centre for Disease Control (1998):

1. digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health-care worker's fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site (e.g., during major abdominal, cardiothoracic, vaginal and/or orthopaedic operations[1]);
2. repair of major traumatic injuries; or
3. manipulation, cutting or removal of any oral or perioral tissue, including tooth structures, during which blood from a health-care worker has the potential to expose the patient's open tissue to a blood borne pathogen.

The College has adapted the list of procedures for which there is definite risk of blood borne virus transmission according to the SHEA Guideline for Management of Healthcare Workers who are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus. Examples of procedures that are classified as 'exposure-prone' are set out in Appendix B of the *Blood Borne Viruses* policy. Examples of procedures that are not EPPs can be found in the SHEA Guidelines.

[1] Pelvic operations, as per the SHEA Guideline, are another example.

What are the blood borne viruses?

Hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) are blood borne viruses.

How often must I be tested for blood borne viruses?

The frequency with which physicians must be tested for BBVs will vary, depending on the applicable circumstances.

a. Physicians who perform or who assist in performing EPPs or who have the potential to perform or assist in performing EPPs to be tested for HCV and HIV every three years.
b. Physicians who are not immunized and confirmed immune to HBV must be tested for HBV annually.
c. Physicians who want to perform or assist in performing EPPs or who have the potential to perform or assist in performing EPPs (including procedures that may become exposure-prone) must be tested for HCV, HIV and HBV, if they haven't been confirmed immune to HBV, before they commence performing or assisting in performing EPPs in Ontario. This includes new registrants, physicians who will begin performing or assisting in performing exposure prone procedures as part of their educational training, and physicians who are changing their scope of practice or re-entering practice.
d. Physicians who have been exposed to bodily fluids of unknown status through a specific incident, such as a needle prick, or splash onto a mucous membrane or non-intact skin, must seek appropriate expert advice regarding the frequency of testing that is required to determine if they have been infected with one or more blood borne viruses.

Why do you require periodic testing for BBVs?

In the absence of a firm testing requirement, we found that physicians were not routinely testing despite their ethical obligation to know their serologic status. Testing allows physicians to monitor and safeguard their own health. As well, periodic testing will reassure the public that the profession is doing everything possible to ensure public and physician safety.

I have never been immunized for HBV. I understand that the policy recommends that I do.

Yes. HBV immunization is widely regarded as an important safety precaution, and the policy strongly recommends that physicians be immunized and tested to confirm the presence of an effective antibody response unless a contraindication exists or they already have immunity.

Physicians who do not respond to the vaccine (do not seroconvert as evidence of immunity) are advised to seek expert advice on alternative vaccination protocols in order to confirm the presence of an effective antibody response.

Why have you chosen the interval of three years for HCV and HIV testing?

Although any interval for testing is arbitrary as the literature does not provide any direction with respect to a testing interval, a three-year testing interval is a reasonable compromise amongst possible options.

What should I do in addition to testing, following an exposure?

The College encourages physicians to consult the Blood Borne Diseases Surveillance Protocol for Ontario Hospitals[2] and their own hospital's protocols and/or policies for detailed information about post-exposure protocols, including post-exposure prophylaxis.

What happens if I test positive for a blood borne virus?

Physicians must report to the College if they are seropositive with respect to HBV, HCV, and/or HIV through the completion of the Annual Renewal Survey. Physicians are expected to make a report to the College as soon as is reasonably practical after learning of their status. It is not acceptable for physicians in these circumstances to wait to report their status on the next Annual Renewal Survey. To make a report to the College, physicians are advised to contact the College's Physicians Advisory Service at 416-967-2606 or toll-free at 1-800-268-7096 ext. 606.

In order to comply with the policy and the annual renewal requirements, physicians may have to share with the College very confidential and private information. How does the College protect physician privacy?

We understand and respect that physicians are asked to share with us very personal, sensitive information and may be nervous about doing so. The College respects the confidentiality and privacy of all the information that we receive; this includes physician information about BBVs and their health. To help reassure physicians, we have outlined our practices regarding confidentiality and the management of seropositive physicians below.

What will happen if I do not answer the questions?

Successful renewal of your certificate of registration is dependent on:

1. completion of the annual renewal form, and

[2] This document is available at: https://www.oha.com/Documents/Blood%20Borne%20Diseases%20Protocol%20(November%202018).pdf

2. full payment of all fee amounts due.

If you do not understand the questions on the renewal form or have any other questions, please contact the College's Physician Advisory Service at 416-967-2606 or 1-800-268-7096 ext. 606 for clarification.

College Practices: Blood Borne Viruses

What if I have tested positive for a blood borne virus and do exposure prone procedures?

Physicians who have tested positive for HBV, HCV, and/or HIV must undergo such regular testing as is recommended by their treating physician, and approved by the College for the purposes of monitoring their health, including their viral loads.

In determining whether seropositive physicians will be able to continue performing or assisting in performing EPPs, the College's priority is to ensure that patient safety is protected. The College will evaluate each situation based on the specific facts, including the physician's practice and viral loads, and will consider the best available evidence and where applicable, the recommendations of the Expert Panel. An Expert Panel is a panel struck to evaluate the health information and practices of seropositive physicians for the purpose of recommending to the College what restrictions, if any, will be required on the seropositive physician's practice. It is comprised of experts, external to the College, in surgery, public health, infectious diseases, occupational medicine, along with a chief of staff, and other experts, including those from the member's own specialty, as appropriate.

If the College has determined that a seropositive physician can safely perform or assist in performing EPPs, the physician must take such precautions (in addition to Routine Practices defined in Appendix B of the policy) that are required or recommended by the College. The College's recommendations regarding additional precautions will be consistent with the SHEA Guideline, and the recommendations of the Expert Panel, where applicable.

The following contains further detail on College practices with respect to the Evaluation of Practice and Practice Restrictions.

It does not create any new or unique obligations but, rather, articulates how existing obligations and practices apply to blood borne viruses.

Confidentiality and Privacy

As set out in the Privacy Code, the College respects the confidentiality and privacy of all information it receives or creates in the course of fulfilling its regulatory functions. This includes information about blood borne viruses and physician health.

To do so, the College ensures that information about physicians' serological status and physicians' practices is only made available to College Committees or the Expert Panel, if it is struck, for the purpose of evaluating seropositive physicians' practices and making decisions regarding any practice restrictions if necessary. All those who have access to this information know and understand their obligations regarding confidentiality and privacy. The Expert Panel is not advised of a physician's name.

Seropositive Physicians: Evaluation of Practice and Practice Restrictions

When a physician is seropositive, and wishes to continue performing and assisting in performing exposure prone procedures, the College will evaluate the physician's practice and health information to determine what restrictions, if any, are required to safeguard patient health.

The College will take steps to gather relevant information about the physician's health and practice. The College will evaluate each situation based on the specific facts, including the physician's practice and viral loads.

Based on the information the College receives, there are two potential outcomes for a physician. If a physician poses no increased risk of causing harm to a patient based on his or her serologic status, the physician will be monitored to ensure that the physician continues to pose no increased risk of harm. If a physician poses a higher risk of harm to a patient then practice restrictions may be imposed. Where the College requires assistance in coming to a decision, the College will convene an Expert Panel. A physician will have an opportunity to make representations and to provide his or her own expert's opinion if he or she wishes to do so.

Restricting physicians from doing exposure prone procedures is resorted to when other options are not sufficient to safeguard patient health. If the College does impose restrictions on a physician's practice, it will ensure that the institution(s) at which the physician works are aware of the restrictions. The College generally does not make institutions aware of the details when a physician poses no increased risk, and is subject only to health monitoring to ensure the risk level stays the same. Whether broader notification of the practice restrictions is required will depend on the circumstances of each case. When evaluating whether broader notification is required, the College will strive to protect physician privacy to the greatest extent possible, while not compromising patient safety.

Any advice provided by the College to the physician or where necessary, restrictions imposed on a physician's practice, will be informed by evidence and the recommendations of the Expert Panel if one is struck.

I know the policy is directed at physicians, but is there any way for physicians to know if a patient they are treating has a BBV?

Yes, physicians may be able to find out a patient's status under the Mandatory Blood Testing Act, 2006. This is an Ontario law, and it allows physicians and other care providers to get confirmation of a patient's serological status in some circumstances. Physicians should inquire with their institution, or seek independent legal advice from legal counsel or the Canadian Medical Protective Association, as to whether this statute is applicable in the circumstances.[3]

[3] The Ministry of Community Safety and Correctional Services and local public health units may also have information regarding the *Mandatory Blood Testing Act, 2006.*

Cannabis for Medical Purposes

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

Cannabis (marijuana): Throughout this policy, the terms "cannabis" and "cannabis for medical purposes" should be understood to mean not only dried cannabis, but also any other form of cannabis that is legally permitted for medical use.[1]

Medical document: The *Cannabis Regulations*[2] require that patients obtain a "medical document" completed by an authorized healthcare practitioner in order to access a legal supply of cannabis for medical purposes. The medical document contains information that would normally be found on a prescription, including the patient's name, the physician's name and CPSO number, and the daily quantity of cannabis to be used by the patient, among other information.[3]

Prescription: It is the College's position that the medical document is equivalent to a prescription. Throughout this policy, the term "prescription" should be understood to include the completion of a medical document in accordance with the *Cannabis Regulations*.

Policy

1. When prescribing cannabis for medical purposes, physicians **must** comply with:

    a. the requirements for prescribing cannabis that are set out in this policy,
    b. the general expectations for prescribing that are set out in the College's Prescribing Drugs policy,

[1] The College has no formal position or guidance with respect to the consumption of cannabis for recreational purposes.
[2] *Cannabis Regulations*, SOR/2018-144.
[3] Section 273 of the *Cannabis Regulations.*

c. any other relevant College policies,[4] and
d. relevant legislation.[5]

Before Prescribing

As with any treatment, physicians are not obligated to prescribe cannabis if they do not believe it is clinically appropriate for the patient.[6]

2. Physicians **must** always practise within the limits of their knowledge, skills, and judgment, and not provide care that is beyond the scope of their clinical competence.[7,8]

Assessing the appropriateness of cannabis for the patient

3. Physicians **must** carefully consider whether cannabis is the most appropriate treatment for the patient.[9]

4. In making this determination, physicians **must:**

   a. consider the risks associated with the use of cannabis;[10] and
   b. weigh the available evidence in support of cannabis against other available treatment options, including the oral and buccal[11] pharmaceutical form of cannabinoids.

[4] Including, but not limited to, the Dispensing Drugs, Complementary/Alternative Medicine, and Telemedicine policies.
[5] The Government of Canada's *Cannabis Regulations* establish the legal framework that enables patients to obtain authorization to possess cannabis for medical purposes. The recreational consumption of cannabis, which is not addressed in this policy, is governed by separate legislation.
[6] Physicians may sometimes have difficulty addressing patient disagreement with a decision not to prescribe cannabis. Recommendations for communicating with patients about this decision can be found in Kahan, Meldon, et al. (2014). Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations. *Canadian Family Physician*, 60, 1083-1090.
[7] Sections 2(1)(c), 2(5), O. Reg. 865/93, *Registration*, enacted under the Medicine Act, 1991, S.O. 1991, c.30; Changing Scope of Practice policy; The Practice Guide.
[8] This expectation applies to all non-emergent situations. In emergency situations, physicians may be permitted to act outside their scope of expertise in some circumstances. See the Public Health Emergencies policy for more detail.
[9] While conclusive evidence regarding the safety and effectiveness of cannabis is currently limited, there are a number of resources physicians can consult for more information. These include, among others: Health Canada's *Information for Health Professionals* webpage; the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance;* and Kahan, Meldon, et al. (2014). Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations. *Canadian Family Physician*, 60: 1083-1090. Physicians are reminded that resources may become outdated as further research is undertaken in this field.
[10] Evidence shows that risks may include, among others: a risk of addiction; the onset or exacerbation of mental illness, including schizophrenia; and – when smoked – symptoms of chronic bronchitis. For a more complete overview of the adverse health effects associated with the consumption of cannabis, please see: Volkow, N.D, et al. (2014). Adverse Health Effects of Marijuana Use. *The New England Journal of Medicine*. 370(23): 2219-2227.

5. Physicians **must** comply with the applicable standard of practice when assessing the risk of cannabis to their patients, and take such steps as are clinically indicated in the specific circumstances of each case to mitigate those risks.[12]

Prescribing to patients under the age of 25

6. As evidence strongly suggests that the risks of cannabis are greater for youth and young adults, physicians **must** not prescribe cannabis to patients under the age of 25 unless all other conventional therapeutic options have been attempted and have failed to alleviate the patient's symptoms.[13]

7. Even after all other conventional therapeutic options have been exhausted, physicians **must** still be satisfied that the anticipated benefit of cannabis outweighs its risk of harm.

Obtaining consent

8. Physicians **must** always obtain valid and informed consent in accordance with their legal obligations[14] and the College's Consent to Medical Treatment policy.

    a. In keeping with this obligation, physicians **must** advise patients about the material risks[15] and benefits of cannabis, including its effects and interactions, material side effects, contraindications, precautions, and any other information pertinent to its use.
    b. Physicians **must** also caution all patients who engage in activities that require mental alertness that they may become impaired while using cannabis.[16]

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[11] Buccal pharmaceutical cannabinoids include oromucosal sprays.

[12] The published literature with respect to cannabis provides some general guidance as to some of the recommended components in such a risk assessment. These include, among others: an assessment of each patient for their risk of addiction and substance diversion; and an assessment of risk factors for psychotic disorders, mood disorders, and other mental health issues that may be affected by the use of cannabis.

[13] Current evidence strongly suggests that children, adolescents, and young adults who consume cannabis are at a greater risk than older adults for cannabis-associated harms, including suicidal ideation, illicit drug use, cannabis use disorder, and long-term cognitive impairment. For more information, please see Volkow, N.D, et al. (2014). Adverse Health Effects of Marijuana Use. *The New England Journal of Medicine*. 370(23): 2219-2227, Health Canada's *Information for Health Professionals* webpage, the Centre for Addiction and Mental Health's *Cannabis Policy Framework*, and the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance*.

[14] *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A.

[15] The material risks that must be disclosed are risks that are common and significant, even though not necessarily grave, and those that are rare, but particularly significant. In determining which risks are material, physicians must consider the specific circumstances of the patient and use their clinical judgment to determine the material risks.

[16] The consumption of cannabis has been correlated with an increased risk of traffic accidents based on epidemiological studies. For more information on the impact of cannabis on driving, please see: Neavyn, M, Blohm, E, & Babu, K. (2014). Medical Marijuana and Driving: A Review. *American College of Medical Toxicology*. DOI l0.1007/s13181-014-0393-4.

When Prescribing

9. Absent established clinical guidelines, physicians **must** proceed cautiously when determining what dosage to prescribe:

    a. Physicians are **advised** to initiate prescribing with a low quantity of cannabis[17] and using strains and/or formulations that are low in the psychoactive compound tetrahydrocannabinol (THC)[18].

10. Physicians **must** specify on every prescription the quantity of cannabis to be dispensed to the patient as well as the percentage of THC it must contain.

11. Physicians **must** monitor patients for any emerging risks or complications.

12. Physicians **must** discontinue prescribing where cannabis fails to meet the physician's therapeutic goals or the risks outweigh the benefits.

13. Physicians are **advised** to follow the guidelines for managing the risk of abuse, misuse, and diversion of narcotics and controlled substances set out in the College's *Prescribing Drugs* policy.

14. Physicians are further **advised** to require patients to sign a written treatment agreement.[19]

    a. This agreement **must** contain, at minimum, a statement from the patient that they: will not seek cannabis from another physician or any other source, will only use cannabis as prescribed, will store their cannabis in a safe and secure manner, and will not sell or give away their cannabis.
    b. It is **advised** that the treatment agreement contain a statement that if the agreement is breached, the physician may decide not to continue prescribing cannabis to the patient.

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[17] While there are currently no established clinical guidelines setting out appropriate dosages for cannabis in any formulation, more information on dosing can be found on Health Canada's *Information for Health Professionals* webpage and the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance* document.

[18] Tetrahydrocannabinol (THC) is the primary psychoactive compound found in cannabis. At high levels, THC has been correlated with cannabis-related harm and is more likely to produce undesirable psychoactive effects in patients.

[19] Treatment agreements are formal and explicit agreements between physicians and patients that delineate key aspects regarding adherence to the treatment. A sample treatment agreement can be found in the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance* document.

Charging Fees

15. Physicians **must** not charge patients or licensed producers of cannabis for completing a medical document, or for any activities associated with completing the medical document, including, but not limited to: assessing the patient, reviewing his/her chart, educating or informing the patient about the risks or benefits of cannabis, or confirming the validity of a prescription in accordance with the *Cannabis Regulations*.[20]

[20] The College considers the medical document authorizing patient access to cannabis to be equivalent to a prescription. Prescriptions, together with activities related to prescriptions, are insured services. Physicians who are unsure about what services they may charge for are advised to refer to the College's Block Fees and Uninsured Services policy and the OHIP Schedule of Benefits for further guidance.

Consent to Treatment

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

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

Definitions

Treatment: Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic, or other health-related purpose, and includes a course of treatment, plan of treatment, or community treatment plan.[1]

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

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

Emergency: A situation where the patient is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

Policy

General Expectations

1. Physicians **must** be aware of, and comply with, all of the requirements in the *Health Care Consent Act, 1996* (*HCCA*).[2]

[1] Under the *HCCA*, "treatment" does not include: a capacity assessment, health history-taking, assessment or examination of a patient to determine the general nature of his or her condition, communication of an assessment or diagnosis, admission to a hospital or other facility, personal assistance service, a treatment that in the circumstances poses little or no risk of harm to the person, or anything prescribed by the regulation as not constituting treatment. See section 2(1) of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A. and sections 1(1) and 33.7 of the *Mental Health Act*, R.S.O. 1990, c. M.7 for further information.

[2] This policy sets the expectations for physicians regarding consent to treatment and, as such, incorporates key elements of this portion of the *HCCA*. The policy does not speak to other portions of the *HCCA*; the ability to make

2. Physicians **must** obtain valid consent before a treatment is provided.

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

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

    a. Physicians **must** use their professional judgment to determine whether it is appropriate to use family members as interpreters, and are **advised** to take the potential limitations of doing so into account in the specific circumstances (e.g., the family dynamics, the seriousness of the condition and/or treatment, etc.).

5. Physicians are **advised** to obtain independent legal advice if they are unsure of their legal obligations in specific circumstances. The obligation to ensure that valid consent is obtained always rests with the physician proposing the treatment.

Obtaining Consent

6. For consent to be valid, physicians **must** ensure that it:

    a. Is obtained from the patient, if they are capable with respect to treatment, or from the patient's SDM, if the patient is incapable with respect to treatment.
    b. Relates to the specific treatment being proposed.[3]
    c. Is informed.
    d. Is given voluntarily and not under duress.
        i. If physicians believe that consent is not being freely given, they **must** ensure that there has been no coercion.
    e. Is not obtained through misrepresentation or fraud.

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decisions about personal finances or personal health information; or consent to the collection, use, or disclosure of personal health information. In addition, the *HCCA* does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to that person or others, nor does it affect the law relating to consent on another person's behalf with respect to procedures whose primary purpose is research, sterilization that is not medically necessary for the protection of the person's health, and removal of tissue for transplantation.

[3] Unless it is not reasonable to do so in the circumstances, physicians are entitled to presume that consent to treatment includes:

- consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different; and
- consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

i. Physicians **must** be frank and honest when interacting with patients, including when conveying information about the proposed treatment.

7. To ensure that consent is informed, physicians **must**:

   a. provide information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action and the likely consequences of not having the treatment prior to obtaining consent, which includes:
      i. providing information that a reasonable person in the same circumstances would require in order to make a decision about the treatment;
      ii. considering the specific circumstances of the patient, on a case-by-case basis, and using their clinical judgment in determining what information to provide; and
      iii. providing information relating to material risks that are relevant for a broad range of patients and those that are particularly relevant for the specific patient;
   b. engage in a dialogue with the patient or the SDM (as the case may be) about the information specified in 7.a., regardless of whether physicians use supporting documents (such as consent forms, patient education materials or pamphlets) to facilitate the provision of this information;
   c. provide a response to requests for additional information about the treatment; and
   d. be satisfied that the information provided is understood and, as such, take reasonable steps to facilitate the comprehension of the information provided.

8. While consent can be either express or implied, physicians are **strongly advised** to obtain express consent, particularly when the treatment is likely to be more than mildly painful, carries appreciable risk, will result in ablation of a bodily function, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness.

9. While a physician proposing treatment may delegate the act of obtaining consent to another health-care provider, they **must** be assured that the health-care provider has the knowledge, skill, and judgment required to obtain consent.[4]

10. If unsure about whether the consent obtained is valid, physicians **must not** provide the treatment until assured that valid consent has been obtained.

[4] In this context, "delegation" is used in the colloquial sense; it does not refer to the delegation of controlled acts, as defined in the College's *Delegation of Controlled Acts* policy.

Capacity

11. Physicians **must** ensure that the patient or SDM providing consent (as the case may be) is capable with respect to the treatment. In doing so, physicians are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g., something in a patient's history or behaviour raises questions about their capacity to consent to the treatment).

12. Physicians **must** consider the patient's capacity at various points in time and in relation to the specific treatment being proposed.

Incapable Patients and Substitute Decision-Making

The *HCCA* sets out a hierarchy of people who may give or refuse consent on behalf of an incapable person, as well as additional requirements that must be met in order for a person to be eligible to act as SDM.[5]

13. Where a patient is incapable with respect to treatment, physicians **must** obtain consent from the highest ranking person in the hierarchy set out in the HCCA.

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

15. In identifying an SDM, physicians **must** take reasonable steps to ensure that the individual is the highest-ranking person that satisfies the requirements of the HCCA. In doing so, physicians are entitled to rely on the representations made by an individual about their relationship to the patient, unless there is reason to believe the representations are false.

16. Physicians **must** ensure that SDMs understand the requirements for giving or refusing consent to a treatment:

    a. The SDM must give or refuse consent in accordance with the most recent and known wish expressed by the patient, while capable and at least 16 years old.
    b. If no wish is known, or the wish is impossible to convey or inapplicable to the circumstances, the SDM must act in the patient's best interests.

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

[5] See *Advice to the Profession: Consent to Treatment* [hyperlink] for further information from the *HCCA* about identifying an SDM.

a. Where a patient disagrees with the finding of incapacity, physicians **must** advise them that they can apply to the Consent and Capacity Board (CCB) for a review of the finding.
b. Where a patient disagrees with the involvement of the present SDM, physicians **must** advise them that they can apply to the CCB to appoint an SDM of their choice.[6]
c. Physicians are **advised** to take reasonable steps to assist the patient if they express a desire to exercise either option in provision 17 a. or b. (e.g., by providing the contact information for the Law Society of Ontario's Lawyer Referral Service).
d. When appropriate, physicians **must** involve the incapable patient, to the extent possible, in discussions with the SDM.

Minors

18. The test for capacity to consent to a treatment is not age-dependent and, as such, physicians **must** make a determination of capacity for a minor just as they would for an adult.

19. If a minor is capable with respect to a treatment, the physician **must** obtain consent from the minor directly, even if the minor is accompanied by their parent or guardian.

Documenting Consent

20. Physicians **must** document in the patient's record information regarding consent to treatment where the treatment is likely to be more than mildly painful, carries appreciable risk, will result in ablation of a bodily function, is a surgical procedure or an invasive investigative procedure, or will lead to significant changes in consciousness.

21. Physicians are **advised** to document consent in the patient's record information in all other circumstances.

[6] If the patient intends to file, or has filed, an application to the CCB, you are required to ensure that treatment is not given:
a. until 48 hours after the physician was first informed of the intent to apply to the CCB without an application being made,
b. until the application to the CCB has been withdrawn,
c. until the CCB makes its decision, if none of the parties informs the physician that they intend to appeal the CCB's decision, or
d. if a party to the application before the CCB informs the physician that he or she intends to appeal the CCB's decision, until the period for commencing an appeal has elapsed with no appeal having been started, or until the appeal of the CCB's decision has been resolved.

22. Physicians **must** use their professional judgment to determine what information to document in the patient's record, taking into consideration the specific circumstances of the case. Physicians are **advised** to record:

    a. the date of the dialogue(s) regarding consent;
    b. who was involved in the dialogue;
    c. the specific material risks that were communicated;
    d. any unique material risks related to the specific circumstances of the patient that were communicated;
    e. the risks of not treating the condition that were communicated;
    f. whether consent was given or refused and by whom;
    g. the date that consent was given or refused; and
    h. any findings of incapacity and the identity of the SDM, as necessary.

Emergency Treatment

23. In emergencies, physicians **must** obtain consent from a patient who is apparently capable with respect to the treatment unless, in the opinion of the physician:

    a. the communication required in order for consent to be given or refused cannot take place because of a language barrier or because the patient has a disability that prevents the communication from taking place;
    b. steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means have been found;
    c. the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the patient is apparently experiencing or will put the patient at risk of sustaining serious bodily harm; and
    d. there is no reason to believe that the patient does not want the treatment.

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

25. In emergencies, when a patient is incapable with respect to the treatment, physicians **must** obtain consent from the incapable patient's SDM unless, in the opinion of the physician, the delay required to obtain consent or refusal on the patient's behalf will prolong the suffering that the patient is apparently experiencing or will put the patient at risk of sustaining serious bodily harm.

a. If during the course of treatment the patient becomes capable with respect to the treatment, the physician **must** seek the patient's consent to the continuation of the treatment.

26. Where an SDM refuses to consent to a treatment in an emergency, the physician **must** respect this decision unless, in the physician's opinion, the SDM has not complied with the requirements for substitute decision-making outlined in the *HCCA*. In this case, the treatment may be administered despite the refusal.

27. After administering treatment in an emergency without consent, the physician **must** promptly note in the patient's record the opinions the physician held at the time and upon which they relied in administering the treatment in an emergency.

28. Treatment in an emergency may continue only for as long as is reasonably necessary to find a practical means of enabling communication to take place or to find the incapable patient's SDM, and physicians **must** ensure that reasonable efforts are made in this regard, as the case may be.

Advice to the Profession: Consent to Treatment

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

Patient autonomy and respect for personal dignity are central to the provision of ethically sound care. In order to exercise their autonomy, patients have the moral and legal right to make decisions regarding their treatment when they are capable of doing so or having a substitute decision-maker make these decisions on their behalf, when they are not capable to do so. In support of these rights, physicians have a legal and professional obligation to obtain consent prior to providing treatment.

The College's *Consent to Treatment* policy sets out physicians' professional and legal obligations with respect to obtaining consent to treatment. This advice document is intended to help physicians interpret their obligations as set out in the *Consent to Treatment* policy and provide guidance around how these obligations may be effectively discharged.

Source of Obligations

What is the source of my consent obligations?

Physicians have both legal and professional obligations to obtain consent prior to providing treatment. Although the policy does not contain an exhaustive catalogue, it does highlight many of the legal obligations set out in the *Health Care Consent Act, 1996* (*HCCA*). It also sets out certain obligations that are not codified in the *HCCA*, but are professional expectations of physicians set by the College.

Obtaining Consent

I am required to consider and address language and communication barriers when obtaining consent. Why is this necessary, and what resources or techniques can I use to help overcome these issues?

A range of language or communication issues may impede a patient's ability to give valid consent, including situations where the physician and patient do not speak a common language, the patient is deaf or has difficulty speaking/communicating, or the patient has a cognitive impairment.

To help overcome language and/or communication issues, you may want to consider using family members or third party interpreters, speech language pathologists, occupational

therapists, and communication techniques such as writing, typing, and non-verbal communication (e.g., hand squeezing, blinking, etc.).

What should I consider when using my professional judgment to determine whether it is appropriate to use family members to facilitate communication with the patient?

Depending on the specific circumstances of each case, there are potential limitations of using family members instead of third-party interpreters, such as language limitations, difficulty understanding medical terms, conflicts within families, and important information being deliberately or accidentally omitted.

Remember that you must also have consent to share the patient's personal health information with any interpreter, regardless of whether the interpreter is a family member or a third party. For more information see the College's *Confidentiality of Personal Health Information* policy.

I am required to take reasonable steps to facilitate the comprehension of the information provided. What steps can I take to meet this requirement?

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

- Considering patients' level of numerical literacy (e.g. ability to understand probabilities) and medical literacy (e.g. ability to understand medical terms), and using plain language to help them understand probability data and other concepts.
- Discussing with the patient how they prefer to receive information (e.g., format, level of detail, etc.) and accommodating preferences for different learning modalities (e.g. visual, auditory, etc.).
- Considering the presence of pain, mood disorders, and biases (e.g., heightened emotion, focusing on short-term concerns, being influenced by unrelated past events, etc.) when communicating information.

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

Remember that the information you provide to patients or substitute decision-makers (SDMs) with will only facilitate decision-making if it is provided, reviewed, and understood prior to giving or refusing consent to a treatment.

How can I encourage patients and SDMs to ask questions?

You can create a positive environment for patients and SDMs by scheduling enough time for the appointment to allow for questions and inviting questions throughout the dialogue, using

open ended language such as, “What questions do you have for me?” It may also be helpful to arrange a time to answer any questions that arise after the appointment.

What is the difference between express and implied consent?

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

Implied consent is inferred from the words or behaviour of the patient, or the surrounding circumstances, such that a reasonable person would believe that consent has been given, although no direct, explicit, and unequivocal words of agreement have been given.

What do I do if a patient or SDM wants to waive their right to be informed and provide consent without hearing about the risks?

Patients or SDMs may feel anxious about the proposed treatment and may not want to hear about the risks. However, it is a key legal requirement that consent must be informed in order to be valid, which means that you are required to provide information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action, and the likely consequences of not having the treatment. If a patient or SDM refuses to hear this information, their decision will not be informed and their consent will not be valid.

You may want to sensitively explain this requirement to the patient or SDM, and emphasize the importance of understanding the risks. You may also want to give patients or SDMs time to process the information, and try to arrange for an opportunity to continue the dialogue at a later date. If the patient or SDM continues to refuse to hear about the risks, you may want to seek legal advice regarding how to proceed.

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

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

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

The particular circumstances of the patient are also crucial to determining whether a risk is material to a reasonable person in the position of that patient. Therefore, the risks that must be discussed with each patient may well vary and must be determined on a case-by-case basis. Patient-specific considerations could include, but are not limited to, the patient's values, lifestyle, profession, and hobbies.

Why does the College require that I document information about the material risks associated with the treatment?

You must use your professional judgment to determine what information to document in the patient's record, taking into consideration the specific circumstances of the case. However, the College recommends noting the specific material risks that were communicated and any unique material risks related to the specific circumstances of the patient that were communicated. This may include, but is not limited to, documenting the risks that may lead the patient to refuse or withhold consent to the treatment.

Remember that a legible, understandable and contemporaneous note in the patient's record regarding consent to treatment is the best evidence a physician has to demonstrate that the requirements of the *HCCA* have been satisfied.

Determining Capacity

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

No. Capacity is fluid: it can change over time and depends on the nature and complexity of the specific treatment decision. In addition, a patient may be incapable with respect to a treatment at one time and capable at another, and be incapable with respect to some treatments and capable with respect to others.

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

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

Not necessarily. Patients and SDMs have the legal right to refuse or withhold consent. Consent can also be withdrawn at any time, by the patient if they are capable with respect to the treatment at the time of the withdrawal, or by the patient's SDM if the patient is incapable.

Patients or SDMs may sometimes make decisions that are contrary to the physician's treatment advice. You cannot automatically assume that because the patient is making a decision you do not agree with, that they are incapable of making that decision.

It is possible, however, that a patient's decision may cause you to question whether the patient has the capacity to make the decision (e.g., that the patient may not truly understand the consequences of not proceeding with the treatment). Where this is the case, you may want to consider doing a more thorough investigation of the patient's capacity to ensure the patient's decision is informed and valid.

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

Incapable Patients and Substitute Decision-Makers

How do I identify the SDM?

In identifying the SDM, you should consult the following hierarchy of individuals/agencies set out in the *HCCA* who may give or refuse consent on behalf of an incapable patient:

1. guardian, if authorized to give or refuse consent to the treatment;
2. attorney for personal care, if authorized by a written power of attorney document to make decisions about personal care on behalf of the patient, in the event that the patient is incapable;
3. representative appointed by the Consent and Capacity Board (CCB), if authorized;
4. spouse or partner, as defined by sections 20(7) to (9) of the *HCCA;*
5. child or parent or individual/agency entitled to give or refuse consent instead of a parent (this does not include a parent who has only a right of access);
6. parent with right of access only;
7. brother or sister;
8. any other relative (related by blood, marriage or adoption);
9. Public Guardian and Trustee.

The SDM is the highest-ranking person set out in the above list who is also:

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

Can only one person act as the SDM?

No, the SDM may be more than one person within the same rank, provided that they meet the above requirements.

If two or more SDMs within the same rank disagree about whether to give or refuse consent, and they are higher on the hierarchy than all others and satisfy all the requirements for SDMs, the Public Guardian and Trustee will make the decision.

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

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

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

Where the patient's wishes are unknown, do not apply, or cannot be complied with, the SDM is required to act in the patient's "best interests". What does this mean?

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

- any values and beliefs the incapable patient held while capable;
- any wishes the incapable patient expressed that are not required to be followed (i.e., the patient was not capable or under the age of 16 when the wishes were expressed);
- the impact of providing and not providing the treatment on the patient's condition or well-being;

- whether the expected benefit of the treatment outweighs the risk of harm; and
- whether a less restrictive or less intrusive treatment would be as beneficial.

The impact of providing or not providing the treatment on the patient's condition or well-being will include assessing whether:

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

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

You will first need to determine how familiar the SDM is with the *HCCA* requirements. Some SDMs may not know what the *HCCA* requirements are, so you may need to tell them. You may want to consider referring SDMs to existing substitute decision-making resources that outline the requirements, such as the Hamilton Health Sciences' Making Decisions for Others: Your Role as a Substitute Decision Maker education document.

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

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

If you are of the view that the SDM is not acting in accordance with the *HCCA*, you can apply to the Consent and Capacity Board for determination as to how to proceed. For more information visit: http://www.ccboard.on.ca/scripts/english/index.asp

Further Resources

Are there resources to help me navigate consent and capacity issues?

Physicians may wish to refer to the *HCCA* directly. Additionally, physicians may find the Ontario Hospital Associations' Decision Tree for Obtaining Consent Under the Health Care Consent Act[1] to be a helpful resource for navigating the consent process.

[1] See Appendix A of the Ontario Hospital Associations' A Practical Guide to Mental Health and the Law in Ontario.

Ending the Physician-Patient Relationship

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

1. Physicians **must** comply with the expectations set out in this policy when ending the physician-patient relationship, except when discontinuation is due to the physician's retirement, relocation, leave of absence, or as a result of disciplinary action by the College of Physicians and Surgeons of Ontario.[1]

2. Physicians who provide specialist care **must** comply with the expectations set out in this policy when ending the physician-patient relationship prior to reaching the normal or expected conclusion of the patient's care. When, in the normal course of providing care, involvement with a patient reaches its natural or expected conclusion (for example, because treatment has concluded), this policy does not apply.

3. Physicians **must** comply with the expectations set out in this policy except where, in the physician's judgment, the patient poses a genuine risk of harm to the physician, the physician's staff, or to other patients. In these circumstances, physicians are under no obligation to engage with the patient prior to ending the relationship.

General expectations

4. Prior to ending the physician-patient relationship, physicians **must:**

    a. apply good clinical judgment and compassion to determine the most appropriate course of action;
    b. bear in mind that ending the relationship may have significant consequences for the patient (for example, by limiting their access to care); and

[1] Expectations for physicians in instances of retirement, relocation, leave of absence, or disciplinary action are included in the CPSO policy Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close their Practice Due to Relocation.

c. undertake reasonable efforts to resolve the situation in the best interest of the patient.

Situations which may lead a physician to end the physician-patient relationship

5. While the following examples include situations in which it may be appropriate to end the physician-patient relationship, physicians **must** consider each case independently, and in keeping with the expectations of this policy.

Where there has been a significant breakdown in the physician-patient relationship

Examples of situations that may lead to a significant breakdown include:

- prescription-related fraud;
- where a patient frequently misses appointments without appropriate cause or notice;
- as a result of behaviour which significantly disrupts the practice; and
- other forms of inappropriate behaviour, including abusive or threatening language.

6. In these circumstances, physicians **must** only end the physician-patient relationship after reasonable efforts have been made to resolve the situation in the best interest of the patient, including**:**

a. proactively communicating expectations for patient conduct to all patients,[2]
b. considering whether a problematic incident or behaviour is an isolated example or part of a larger pattern, and
c. discussing with the patient the reasons affecting the physician's ability to provide care.

Where the physicians wishes to decrease their practice size

7. When reducing a practice size, physicians **must**:

a. exercise professional judgment, consistent with this policy, to select which patients to remove from the practice;
b. employ a method of selecting patients that is fair, transparent, and compassionate;
c. take into account the medical needs of each patient; and
d. consider any other relevant factors, including the patient's vulnerability, and the patient's ability to find alternative care in an appropriate timeframe.

[2] For example, physicians can fulfil this expectation by establishing office policies and posting them in a prominent location.

8. Physicians **must** not selectively or disproportionately discharge difficult or complex patients.

Where a patient has been absent from the practice for an extended period of time

9. In these circumstances, physicians **must:**

    a. Make a good-faith effort to determine whether the patient would prefer to maintain the relationship. In doing so, physicians **must**, at minimum, send a letter of inquiry to the patient's last known address. Where no response is received, or the patient indicates that care has been sought elsewhere, physicians may formally remove the patient from the practice.

When a patient has refused to pay an outstanding fee[3]

10. In circumstances where a patient has refused to pay an outstanding fee, or has accumulated a number of unpaid fees and provided no reasonable justification for nonpayment (such as evidence of financial hardship), physicians **must**:

    a. consider the financial burden that paying the fee will place on the patient;
    b. if appropriate, consider waiving or allowing for flexibility with respect to fees based on compassionate grounds;[4,5] and
    c. undertake discontinuation in accordance with the general expectations of this policy, including that reasonable efforts be undertaken to resolve the situation in the best interest of the patient.

Where the patient has sought care outside of a rostered practice[6]

11. Where a patient has sought care outside of a rostered practice, physicians are **advised** to consider the factors that may have led the patient to do so (including the physician's own availability).

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[3] In the course of providing care, physicians may sometimes charge patients for services that are not covered by the Ontario Health Insurance Plan (OHIP). Physicians are entitled to pursue and receive payment for uninsured services.

[4] 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".

[5] For further expectations related to fees for uninsured services please see the College's policies on Uninsured Services: Billing and Block Fees, Medical Records, and Third Party Reports. Physicians are further reminded that, in accordance with the College's Third Party Reports policy, they are encouraged to refrain from requiring prepayment for uninsured services on compassionate grounds, when the patient or examinee is responsible for payment directly, and the report relates to basic income and health benefits.

[6] Rostered practices impose specific commitments on both family physicians and their patients: physicians commit to provide comprehensive and timely care, and patients commit to seek treatment only from their enrolling physician or group except in specified circumstances. When patients seek care outside of a rostered practice, except in these specific circumstances, there is a risk that the physician's trust and the patient's continuity of care may be undermined.

12. When considering ending the physician-patient relationship, physicians **must** first:

    a. provide the patient with clear information about their obligations within the rostered practice,
    b. provide the patient with an appropriate warning, and
    c. undertake reasonable efforts to resolve the situation in the best interest of the patient.

13. Physicians **must** only end the physician-patient relationship after these efforts have been undertaken, and after the patient has continued to wilfully seek care outside of the practice without appropriate justification.

Circumstances where physicians must not end the physician-patient relationship

14. Physicians **must** not end the physician patient relationship where doing so is prohibited by legislation.[7]

15. Physicians **must** respect patient autonomy with respect to lifestyle, healthcare goals, and treatment decisions,[8] and not end the physician-patient relationship solely because the patient:

    a. does not follow advice (for example, with respect to smoking cessation, drug or alcohol use, or the patient's decision to refrain from being vaccinated or vaccinating his/her children);
    b. suffers from an addiction or dependence, or is on a high dose of a prescribed controlled drug and/or substance[9]; or
    c. seeks treatment to which the physician objects on the basis of conscience or religious beliefs.[10]

Expectations when ending the physician-patient relationship

Notifying the patient

16. Physicians **must** notify the patient of the decision to end the physician-patient relationship.

[7] Physicians must ensure that any decision to end the physician-patient relationship is compliant with relevant legislation. This legislation includes *The Commitment to the Future of Medicare Act, 2004*, which prohibits physicians from ending the physician-patient relationship because the patient chooses not to pay a block or annual fee; the Ontario *Human Rights Code*, which prohibits ending the physician-patient relationship due to one of the protected grounds set out in the Code; & the professional misconduct regulations under the *Medicine Act, 1991.*
[8] *Health Care Consent Act*, *1996.*
[9] Controlled Drugs and Substances are defined in the *Controlled Drugs and Substances Act,* 1996.
[10] The College's expectations for physicians who limit care due to conscience or religious beliefs can be found in the Professional Obligations and Human Rights policy.

a. Physicians are **advised** to notify each patient in person, whenever it is safe and possible to do so.[11]
b. In all cases, physicians **must** provide every patient with written notification that the relationship has been discontinued (see the accompanying Advice Document for a sample letter). Physicians **must** retain a copy of the notification and any confirmation of receipt in the patient's medical record. Physicians **must** use a secure method to transmit the written notification, and ensure patient confidentiality.[12]

17. Physicians are **advised** to inform patients of the reasons why the relationship is being discontinued, unless there is a genuine risk of harm associated with communicating those reasons to the patient.

Providing interim care

18. Physicians **must** ensure the provision of necessary medical services while the patient seeks a new physician.[13] This may include, for example, renewing prescriptions, where medically appropriate and for a reasonable length of time, and ensuring appropriate follow-up on all laboratory and test results ordered.[14]

19. Physicians **must** be as helpful[15] as possible to the patient in finding a new physician or other primary care provider, and provide them with a reasonable[16] amount of time for doing so.[17] The College does not require physicians to continue to provide care indefinitely, but physicians **must** provide care in an emergency, where it is necessary to prevent imminent harm.

[11] In most cases, it is appropriate and useful for the patient to be advised of the reasons why the relationship is being discontinued; however, physicians may use their discretion in situations where there is a genuine risk of harm associated with communicating those reasons to the patient.
[12] Acceptable methods of transmission include, among others: hand delivery to the patient during an appointment, registered mail, and courier.
[13] Discontinuing professional services that are needed may constitute professional misconduct unless alternative services are arranged, or the patient is given a reasonable opportunity to arrange alternative services (O. Reg. 856/93 s.1(1)7).
[14] For further information on appropriate follow-up, refer to the CPSO policy on Test Results Management.
[15] The help that a physician is able to provide will ultimately be case-specific; however, examples include referring the patient to an organization that may be able to assist him/her in finding another healthcare provider, such as a Community Health Centre, local hospital or emergency room, or other organization. Alternatively, physicians may wish to refer the patient to a colleague who may be accepting new patients.
[16] 'A reasonable amount of time' may vary from community to community, depending on the availability of alternative healthcare providers.
[17] What is 'reasonable' will depend on a variety of factors. These will include the circumstances of each case, including the patient's specific health-care needs.

20. Physicians **must** seek to accommodate patients with special needs or disabilities that may make seeking new care challenging.

Additional requirements

21. When ending the physician-patient relationship, physicians **must**:

a. document in the patient's medical record the reasons for the discontinuation and all steps undertaken to resolve the issue(s);
b. clearly convey to the patient that they should seek ongoing care;
c. inform the patient that they are entitled to a copy of their medical records, and provide an estimate of any fees associated with providing copies of, and/or transferring, medical records;[18]
d. ensure the timely transfer of a copy or summary of the patient's medical records upon the patient's request;[19]
e. notify appropriate staff (e.g., office receptionist) that care is no longer being provided to the patient;[20] and
f. notify the patient's other health care providers that care is no longer being provided if such notification is necessary for the purposes of the patient's care, and if the patient has not expressly restricted the physician from providing information to other health care providers.[21]

[18] In accordance with the College's Medical Records policy, physicians are able to charge a reasonable fee for copying and transferring medical records.
[19] For further information, refer to the CPSO's Medical Records policy.
[20] Such notification must only be provided when the patient has not withheld or withdrawn consent to the collection, use or disclosure of their personal health information by the member of the physician's staff to whom the notification would otherwise be provided.
[21] Under the *Personal Health Information Protection Act*, *2004*, a health care provider may provide personal health information about a patient to another health care provider for the purposes of providing health care or assisting in the provision of health care to the patient. Despite this provision, the Act also gives patients the right to expressly restrict his/her physician from providing another health care provider with his/her personal health information, including whether the physician is providing the patient with services. In cases where a physician is asked by another health care provider for information about a patient that is reasonably necessary for the provision of health care or assisting in the provision of health care to the patient, the physician must notify the other health care provider if they have been restricted from disclosing information about the patient and they may wish to advise the other health care provider to direct any inquiry to the patient him/herself for a response.

Advice to the Profession: Ending the Physician-Patient Relationship

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

An effective physician-patient relationship is essential for the provision of quality medical care, and it forms the foundation of the practice of medicine. It is also a partnership which benefits from the mutual trust and respect of both the physician and the patient. While this relationship is of central importance to the practice of medicine, circumstances may sometimes arise which lead either the physician or the patient to end the physician-patient relationship.

This advice document is intended to help physicians interpret their obligations as set out in the *Ending the Physician-Patient Relationship* policy, and provide guidance for how these obligations can be effectively discharged.

This policy applies to all physicians, regardless of speciality or area of practice

The expectations of this policy apply to specialist physicians and physicians practising outside of primary care, however, only when ending the physician-patient relationship prior to reaching the "normal" or "expected" conclusion of the patient's treatment or assessment (for example, as the result of a conflict with the patient that makes the continued provision of care impossible).

When, in the normal course of providing care, a specialist's involvement with a patient reaches its natural or expected conclusion (for example, because the treatment or assessment have concluded, and/or the patient's care has been transferred back to their referring physician), this policy does not apply.

The patient's best interests are paramount, even when there is conflict or disagreement

Physicians have a professional responsibility to act first and foremost in the best interest of their patient, and the policy establishes expectations which reflect this responsibility.

This responsibility is not altered simply because a conflict or disagreement has arisen with the patient.[1]

[1] It is important to note that in situations where the patient poses a genuine risk of harm to the physician, the physician's staff, or to other patients, physician may end the physician-patient relationship immediately, and are not obligated to engage directly with the patient.

Patient complaints

In circumstances where a patient has filed a complaint against their physician, the primary consideration is whether the mutual trust and respect that are essential to an effective physician-patient relationship are undermined, and if so, whether the relationship can be repaired.

The policy expects that ending the physician-patient relationship will not be an automatic response to a complaint, but that physicians will make a determination with consideration for the specific circumstances of each situation, exercising their professional judgment, and in keeping with the principles and expectations of the policy (for example, by considering the factors that may have led to the complaint with an open mind, and by undertaking reasonable efforts to resolve the situation whenever possible).

Sample notification letter

The policy requires physicians to notify each patient in writing when the physician-patient relationship has been discontinued.

The following is a sample letter for situations where there has been a significant and irremediable breakdown in the physician-patient relationship.

Physicians can customize this letter to fit the specific circumstances of each case, and to help ensure that the letter is written in a way that the patient can understand.

Dear [patient's name]:

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

It has become clear that because of [if appropriate, indicate reason], our physician-patient relationship has broken down, and this has made it difficult for me to continue providing quality care to you.

Despite taking the following steps to resolve the situation [if appropriate, list the steps undertaken to resolve the situation in advance of ending the relationship], I therefore regret to inform you that I will not be in a position to provide you with further medical services after [enter the date -- this time will vary from community to community, but you should give sufficient notice].

I urge you to obtain another physician or primary health-care provider as soon as possible. With your consent, I will be pleased to provide them with a copy or summary of your medical records. I will also ensure appropriate follow-up on all laboratory and test results still outstanding.

For assistance in locating another physician, you may wish to contact your local Community Health Centre, which is an organization that provides primary health care and prevention programs through physicians and a variety of other health professionals. A list of community health centres in Ontario is available on the Ontario Ministry of Health and Long-Term Care website. You may also wish to contact your local hospital to see whether any physicians on staff are accepting new patients. Lastly, some physicians, including those who are new to an area or who are beginning to establish a practice, will advertise that they are accepting new patients

Yours truly,

[Signature of physician]

Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice

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

Scope of practice: Scope of practice is a term that describes a physician's practice at a particular point in time. A physician's scope of practice is determined by a number of factors including:

- education, training, and certification;
- the patients the physician cares for;[1]
- the procedures performed;
- the treatments provided;
- the practice environment.[2]

Change in scope of practice: A change in scope of practice occurs when there has been a *significant* change to any of the factors set out in the description of scope of practice. A change in scope of practice also occurs when physicians wish to return to a scope of practice in which they have not practised for two consecutive years or more.[3] Additional information regarding whether a change is significant and must be reported to the College is set out in the companion advice document.

Policy

1. Physicians **must** only practise in the areas of medicine in which they are educated and experienced.[4]

Reporting to the College

The following expectations do not apply to physicians who intend to change their scope of practice or re-enter practice in positions focused on teaching, research, or administration, where there is no assessment or treatment of patients.[5]

[1] This would include populations (e.g. where a physician is practising as a Medical Officer of Health).
[2] Practice environment may include colleague supports, access to resources, payment systems, geographic or health system demands.
[3] For example, a family physician focusing in emergency medicine who wishes to return to family medicine after an absence from this clinical area for two or more years.
[4] The requirement that physicians practise in the areas of medicine in which they are educated and experienced is a term, condition and limitation on a physician's certificate of registration. The *Professional Misconduct* regulation 856/93 under the *Medicine Act*, *1991*, S.O. 1991, sets out that it is professional misconduct for a physician to contravene a term, condition or limitation on their certificate of registration (Section 1(1)1).

2. Physicians **must** report to the College when they:

   a. wish to re-enter practice and have not been engaged in practice for a period of two consecutive years or more[6]; and/or
   b. wish to change their scope of practice. This includes physicians who are making a significant change in scope of practice or who wish to return to a scope of practice in which they have not practised for two consecutive years or more[7].[8]

3. As part of the process of reporting, physicians **must:**

   a. complete the applicable application form;[9] and
   b. where reporting an intention to re-enter practice, indicate in the Annual Renewal Survey that they have made this report.[10]

4. Physicians who are uncertain about whether they are required to report an intention to change their scope of practice or an intention to re-enter practice, are **advised** to contact the Inquiries Section in the Applications and Credentials Department of the College for further guidance at 416-967-2617 or by email at inquiries@cpso.on.ca.

College Review Process

5. All physicians who wish to change their scope of practice and/or re-enter practice **must** participate in an individualized College review process to demonstrate their competence in the area in which they intend to practise.[11]

6. Physicians **must not** practise in a new scope of practice or re-enter practice unless the College has approved their request.[12]

[5] The College requires all physicians to maintain competence regardless of type of practice and for those physicians changing their scope of practice or re-entering practice in positions that involve teaching, research or administration there are separate processes at universities and hospitals for ensuring competence.
[6] This includes physicians who have continuously maintained their certificate of registration during their absence.
[7] This expectation applies even if the physician has previously trained and had experience in the scope of practice to which they are returning.
[8] This includes physicians who are intending to change their scope of practice to an area which involves reviewing medical records for individuals with whom the physician does not have a treating relationship for the purpose of providing third party reports (i.e. Independent Medical Examiners).
[9] The application to request a change in scope of practice can be found here. The application to request re-entry to practice can be found here.
[10] In accordance with section 51(3) of the College's *General By-Law*.
[11] The process generally includes a needs assessment, training, supervision, and a final assessment. For greater detail on the requirements for changing scope of practice and/ or re-entering practice, please refer to Appendix 1.
[12] Physicians are reminded that when they work in areas of medicine that are different from their area of primary certification they must comply with the *Use of Specialist Title* regulation. For more information on the requirements under the regulation please refer directly to Section 9 of O. Reg. 114/94 under the *Medicine Act, 1991* S.O. 1991, C.30 and the College's article, *Describing your* credentials *in advertising and promotional materials*.

Appendix: Process for Changing Scope of Practice and/or Re-Entering Practice

The changing scope of practice[13] and/or re-entering practice process is composed of four stages: a needs assessment, training, supervision, and a final assessment. Decisions about the specific stages that must be undertaken will be determined on an individual basis. Physicians must not practise in a new scope of practice or re-enter practice unless the College has approved their change in scope of practice and/or re-entry request.

A description of the four stages of the process is set out below.

Needs Assessment

After physicians report their intention to change their scope of practice or to re-enter practice, they are required to submit an application.[14] The College will review the application and consider which stages of the College's process require participation by the physician; in particular whether the physician requires supervision and/or training. Decisions regarding training and/or supervision will be informed by a number of factors, including the physician's prior experience, any training the physician has undertaken, the continuing professional development the physician has engaged in, the potential risk of harm to patients, the length of time the physician has been away from practice, and the degree to which the discipline has advanced during the physician's absence.

Training

Completing relevant training is an important part of ensuring competence. The College will review the physician's application and determine whether the physician requires training.

If the College determines that the physician requires training, the physician must provide the College with a proposed Individualized Education Plan (IEP), to be approved by the College. The IEP must include a description of the training the physician will undertake. If the physician has undergone training prior to reporting to the College, they must provide the College with evidence of the training.

Physicians should note that the College has developed frameworks which set out the training that is required for areas of clinical practice where there are no recognized Canadian specialty training programs. These frameworks inform the College's decisions about the training a physician will be

[13] This process only applies to changes in scope that are significant.
[14] The application to request a change in scope of practice can be found here. The application to request re-entry to practice can be found here.

required to undertake. More information about the frameworks that have been developed can be accessed here.[15]

Supervision

Where the College determines that supervision is required, physicians must find one or more physicians who will act as their Clinical Supervisor. The Clinical Supervisor must be approved by the College and the supervision must take place in accordance with the Guidelines for College-Directed Supervision.

As competency is gained and demonstrated, the level of supervision will decrease and the physician will be afforded a greater level of autonomy. There are three levels of supervision. Physicians typically start out under high level supervision, and then will move on to moderate and then low level supervision. The level and duration of supervision will be at the discretion of the College with input from the Clinical Supervisor, and will be dependent on the content and duration of the training completed, if training was required.

A description of the different levels of supervision is set out below.

High Level Supervision

A physician must arrange to work in another physician's practice. This physician will act as Clinical Supervisor and must be practising in the same discipline in which the physician wishes to practise. During high level supervision the Clinical Supervisor is the Most Responsible Physician (MRP) for all patients.

The physician will continue to practise under a high level of supervision until the Clinical Supervisor is satisfied that the physician can work as the MRP under a moderate or low level of supervision.

The Clinical Supervisor will notify the College when they are of the view that the physician has the required knowledge and skills to practise in a less supervised environment (moderate and low level supervision). The College will review the recommendation from the Clinical Supervisor and determine whether the physician may move on to a lower level of supervision.

[15] Frameworks that are currently developed include expectations for: cardiologists intending to interpret nuclear cardiology studies in independent facilities, physicians intending to practise sleep medicine, physicians intending to practise as Medical Officers of Health, physicians who intend to change their scope of practice to include endo-colonoscopy, physicians who intend to change their scope of practice to include interventional pain management, physicians who intend to change their scope of practice to include surgical cosmetic procedures, radiologists intending to interpret and supervise nuclear medicine studies in Independent Health Facilities, and physicians who intend to change their scope of practice to include caesarean section for non-obstetricians.

The length of high level supervision will vary depending on the circumstances of each individual physician. It may be brief if the physician is capable of practising independently or it may be longer if the physician is not yet capable of practising independently.

Moderate and Low Level Supervision

In moderate and low level supervision the physician works in his or her own practice, makes decisions independently and is considered the MRP. The Clinical Supervisor will periodically visit with the physician to review charts and cases, and discuss patient management to ensure appropriate care is provided. The Clinical Supervisor will submit written reports to the College on a periodic basis. The frequency of visits from the Clinical Supervisor is initially weekly, but will become less frequent when the College determines that physician competency has been demonstrated. Once the Clinical Supervisor is satisfied that the physician is able to practise independently, the Clinical Supervisor will notify the College. The College will then determine whether the physician is ready for their final assessment.

The length of the periods of moderate and low level supervised practice will vary, but generally they will be longer than the time spent under high level supervision.

Final Assessment

Once physicians have completed the required training and/or supervision, they generally will be required to undergo a College-directed assessment of their practice. There may be an observational component to the assessment. For example, where the care involves performing new procedures the assessor may observe the physician performing the new procedures. Assessments may also involve interviews with colleagues and co-workers to provide feedback on care provided.

The College will review the final assessment report and will make a determination as to whether the physician is competent to practise independently.

Costs

Physicians who wish to change their scope of practice and/or re-enter practice must pay for all costs associated with training, supervision and assessment. The cost of the training and supervision will be quite variable depending on the training taken, the length of the training necessary and the cost of supervision.

Advice to the Profession: Changing Scope of Practice and/or Re-entering 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 may wish to change their scope of practice if they become interested in a different area of medicine or if their personal circumstances change. Physicians may also be absent from practice for a period of time for a variety of reasons. They may go on an extended parental leave, take a sabbatical, or take on a teaching role, for example. When they wish to return to practice, they may wish to practise in a different area of medicine.

This advice document is intended to help physicians interpret their obligations as set out in the *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy and provide further guidance around what constitutes a *significant* change of scope of practice. It also serves to address some frequently asked questions about the application of the policy to changes in practice environment.

Description of *Significant* Change in Scope of Practice

Significant changes in scope of practice are all determined on a case-by-case basis. A change in scope of practice has been considered by the College to be "significant" in the following circumstances:

a. physicians completely change their type of practice (e.g. a surgeon wants to practise in family medicine); or
b. physicians are adding something to their practice that:
    i. they have not done before, and
    ii. is not something that is considered a usual part of the discipline (e.g. a pediatrician who wants to start working in an emergency department caring for adult patients); or
c. physicians begin to practise in a location where the health-care system is significantly different from where they had been practising previously (e.g. an urban setting versus a rural setting).

Physicians who have undergone the Changing Scope of Practice process do not practise in the same capacity as specialists. Changes in scope of practice are only permitted once the physician

has demonstrated their competence to the College with respect to the specific changes they intend to incorporate into their practice.

Examples of changes in scope of practice that have been considered significant by the College include **but are not limited to:**

- a family physician who wishes to perform cosmetic surgical procedures;
- a family physician who wishes to primarily practise and receive referrals for psychotherapy, disorders of the skin, or palliative care;
- a family physician who wishes to practise components of fertility medicine;
- a physician who practises in chronic pain management but who wishes to practise in interventional pain management;
- a psychiatrist who wishes to practise in sleep medicine;
- a neurosurgeon who wishes to practise in palliative care;
- an orthopedic surgeon who wishes to practise in family medicine;
- an emergency medicine physician who wishes to practise in sports medicine.
- a physician who has been working in primary care in a developing country wishes to return to Ontario;
- a physician who wishes to relocate from an urban, academic practice to a rural, underserviced area.

A transition from residency to independent practice does not constitute a change in scope of practice as long as you are practicing in the area in which you were trained.

Description of Evolution in Practice

When there is a change to one of the factors set out in the definition of scope of practice but the change is not significant, the College considers this to be an evolution in practice. An **evolution in practice** is characterized by the gradual development or progression of a physician's practice within a certain area in keeping with the direction of the specialty. An evolution in practice may include narrowing or limiting a practice, performance of innovative techniques or procedures or prescribing new medications within the context of a specialty.

Examples include:

- a family physician who, within their general area of training, decides to narrow the focus of their practice to women's health issues;
- an emergency medicine physician who is incorporating bedside ultrasound into their practice; or
- the transition from a solo practice to a Family Health Team.

If physicians are uncertain about whether a change of scope is considered significant or is an evolution in practice, they should contact the Inquiries Section in the Applications and Credentials Department of the College for further guidance at 416-967-2617 or by email at inquiries@cpso.on.ca.

Application of policy to changes in practice environment

The College receives many questions about how the policy applies in specific scenarios. Answers to some frequently asked questions are set out below.

Is a change in practice environment (a move from an urban-based practice setting to a rural practice setting, for example) considered a significant change in scope of practice?

Not always. Not all changes in practice environment will be considered a significant change in scope of practice.

Whether a change in practice environment constitutes a significant change in scope of practice will depend on a number of factors including whether there are significant differences in access to resources, in the availability of support from colleagues, or in the health system demands between the urban and rural practice settings. Differences in these factors may present unforeseen changes in the way that physicians practise. For instance in a rural setting, physicians may not have the same access to specialists, facilities, diagnostic or social services that are available in an urban setting. If physicians are moving to a rural community from an urban practice and there are no differences in the way they would be practising, the change would not be considered significant.

When the College considers a change in practice environment to be significant, what is the process required to facilitate this change?

There are four general stages of the College's Changing Scope of Practice process: needs assessment, training, graduated supervision and a final assessment. However, not every stage of the process is required for all change of scope cases. The specific stages of the process that a physician is required to undertake are tailored to each physician's specific situation.

For example, if the treatments and procedures you are intending to perform are generally consistent with your current scope of practice, and the College feels there are appropriate supports to assist you in your transition to a rural setting, the College may decide after the needs assessment, that no further stages of the process are required. The College may instead suggest you find an informal supervisor to act as a mentor or resource person with whom you can meet or chat on a regular basis, to help you settle into your new environment.

The College has developed frameworks which set out the training that is required for certain

areas of clinical practice. For physicians who are not certified in Emergency Medicine and are intending to include Emergency Medicine as part of their rural practice, please refer to the College's framework that sets out the specific requirements for this change and the FAQ that accompanies this framework.

Female Genital Cutting (Mutilation)

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

Female genital cutting/mutilation: Involves the cutting and removal of the female genitalia, and permanent mutilation of the sexual organs of young females for non-medical reasons.[1]

Policy

Patient Care

1. Physicians **must not** perform or refer patients to any person for the performance of any female genital cutting/mutilation (FGC/M) procedures.[2]

2. During the course of a vaginal delivery of a woman who has been previously subjected to an FGC/M procedure, it may be necessary to surgically disrupt the scar tissue resulting from the earlier procedure. In this circumstance, at the conclusion of the delivery, the physician **must** confine activities to repairing the surgical incision or laceration required during the delivery, and **must not**, for example, endeavor to reconstruct an infibulation.

3. Wherever possible physicians **must** inform the patient of this limitation prior to delivery, although are **advised** to do so prior to pregnancy or during the course of prenatal care.

[1] Ontario Human Rights Commission. Policy on Female Genital Mutilation. See also Section 268.3(a-b) of the *Criminal Code,* R.S.C., 1985, c. C-46 (hereinafter, *Criminal Code)*, which defines the act as involving the infibulation, excision or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person, except where performed for the purpose of the person having normal reproductive function, sexual appearance or function or the person is at least 18 years of age and there is no resulting bodily harm.

[2] The *Criminal Code* prohibits the performance of or referral for FGC/M (see Sections 268(3), 21-22 and 273.3(1)). Physicians are reminded that it is an act of professional misconduct to contravene a federal law, where the purpose of the law is to protect the public's health or the contravention is relevant to the member's suitability to practise (See Section 1(1) par. 28 of the *Professional Misconduct*, O. Reg. 856/93 enacted under the *Medicine Act*, 1991, S.O. 1991, C.30).

4. Where there is doubt about whether a procedure is considered to be FGC/M, physicians are **advised** to seek independent legal advice.

5. Physicians are **advised** to:

    a. provide culturally sensitive counseling regarding the dangers related to performing FGC/M, and
    b. educate themselves on the appropriate management of possible complications in order to provide appropriate counsel and care when they encounter patients subjected to FGC/M.

Reporting

6. Physicians who have reasonable grounds to believe that another physician is performing FGC/M procedures **must** immediately bring the issue to the attention of the College.

7. Physicians who have reasonable grounds to believe that an FGC/M procedure has been performed on, or is being contemplated for, any female under the age of 18, **must** notify the appropriate child protection authorities, regardless of where the procedure has been or will be undertaken.[3]

[3] Pursuant to *Child and Family Services Act,* R.S.O. 1990, c. C.11, s.72(1) and Section 273.3(1) of the *Criminal Code*, as well as the College's *Mandatory and Permissive Reporting* policy.

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]

[1] Adapted from Ontario Medical Association, *End of Life Terminology*. https://www.oma.org/Resources/Documents/EOLC_Definitions.pdf
[2] Adapted from Canadian Medical Association, *Statement on Life-Saving and -Sustaining Interventions*. http://policybase.cma.ca/dbtw-wpd/Policypdf/PD14-01.pdf
[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/

Palliative sedation refers to the practice of relieving intolerable suffering through the proportional and monitored use of opioids and/or sedative medications to intentionally lower a patient's level of consciousness at the end of life.[6]

Substitute decision-maker (SDM): A person who may give or refuse consent to a treatment on behalf of an incapable person.[7]

Policy

Quality Care and Communication

1. When helping patients plan for or when providing end-of-life care, physicians **must** endeavour to understand what is important to the patient in order to ensure that the patient's goals of care are understood and that quality care is provided.

    a. In doing so, physicians are **advised** to provide assistance to patients or substitute decision-makers (SDM) in order to help them articulate the patient's goals of care.

2. Physicians **must** communicate effectively and compassionately with patients and/or SDMs, in a manner and tone that is suitable to the decisions they may be facing. This includes initiating communication as early as possible and as regularly as is necessary to share information, helping patients and/or SDMs understand the information shared, and answering questions.

3. Where patients and/or SDMs wish to involve family and/or others close to them in the patient's care, physicians **must** obtain consent to disclose personal health information about the patient and document this decision.

Advance Care Planning

4. As it is never too early for physicians to discuss advance care planning with their patients, as part of routine care physicians are **advised** to:

    a. discuss the importance and benefits of advance care planning, choosing an SDM, documenting and disseminating advance care plans to their loved ones, SDM, and health-care providers, and reviewing advance care plans throughout life; and
    b. help patients engage in such planning by providing necessary medical information 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.

5. When significant life events or changes in the patient's medical status occur, physicians are **advised** to:

    a. encourage patients who have already engaged in advance care planning to review existing advance care plans; or
    b. where the patient has not already done so, remind patients of the importance of this process, create opportunities for discussion, and encourage them to engage in this process.

Consent to Treatment[8]

6. Physicians **must** obtain valid consent before a treatment is provided.

7. In order for consent to be valid, physicians **must** ensure it is obtained from the patient if the patient is capable with respect to the treatment or from the incapable patient's SDM, and it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.

8. Physicians are entitled to presume the patient is capable unless there are reasonable grounds to believe otherwise (e.g., something in a patient's history or behaviour raises questions about their capacity to consent to the treatment). However, physicians are **advised** to exercise caution regarding this presumption in the end-of-life context and to reassess capacity as appropriate, because in this context the capacity to consent to treatment may be affected by a number of health conditions.

Palliative Care

9. When proposing or providing palliative care, physicians **must** clearly explain what palliative care entails. This includes being clear that palliative care involves providing active care focused on relieving pain and other symptoms and addressing psychological, social, and spiritual distress related to the patient's condition, which can be provided in conjunction with other treatments intended to prolong life, or when these treatments have been stopped.

10. While palliative care does not have to be provided by specialists, physicians are **advised** to seek the support or involvement of specialists in palliative care and/or referral to hospice 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

Potentially Life-Saving and Life-Sustaining Treatments

11. Physicians are **strongly advised** to discuss potentially life-saving and life-sustaining treatment options as early as possible and where appropriate (e.g., a change in the patient's medical status, where no further treatment options are available, or when a patient is admitted to an intensive or critical care unit).

12. Physicians **must** involve the patient and/or SDM in the assessment of the treatment options that fall within the standard of care and **must** obtain consent to provide potentially life-saving and life-sustaining treatment, unless certain conditions are met during an emergency[10].

13. In instances where the outcomes of potentially life-saving and/or life-sustaining treatments are uncertain and physicians propose these treatments on a trial basis, physicians **must** be clear about the outcomes that would warrant the continuation of treatment and the outcomes that would warrant the discontinuation of treatment.

14. Physicians **must not** unilaterally make a decision to withdraw life-sustaining treatment and **must** obtain consent in order to withdraw life-sustaining treatment.[11]

    a. As part of the consent process physicians **must** explain why they are proposing to withdraw life-sustaining treatment and provide details regarding any treatment(s) they propose to provide (e.g., palliative care).
    b. When consent is not provided, physicians **must** engage in the conflict resolution process as outlined in this policy, which may include an application to the Consent and Capacity Board.[12]

15. Physicians **must not** unilaterally make a decision regarding a no-CPR order.

    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.[13]

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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.*

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.[14]
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 CPR unless the physiologic goals of CPR cannot be achieved.
d. In providing CPR physicians **must** use their professional judgement to determine the nature and duration of the resuscitative efforts provided.

16. Decisions concerning potentially life-saving and life-sustaining treatment may change over time and as such, physicians **must** review these decisions with patients or SDMs whenever it is appropriate to do so (e.g., when the patient's condition changes).

Aggressive Pain Management and Palliative Sedation

17. When providing aggressive pain management[15] or palliative sedation in order to address pain and symptoms and not to hasten death, physicians **must** provide treatment in proportion to the pain and/or symptoms the patient is experiencing and closely follow any changes in the patient's pain and/or symptoms to ensure that appropriate treatment is provided.

Dying at Home

18. When patients express a preference for staying at home as long as possible and/or dying at home, physicians **must**:

    a. help patients and caregivers assess whether home care and/or dying at home are manageable options, including assessing:

        - patient safety considerations;
        - the caregiver's ability to cope with the situation; and
        - whether the patient can be provided with necessary care (e.g., whether round the clock on-call coverage is needed and available, whether home palliative care physicians or community based programs are available to assist, etc.);

[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] Physicians are advised that the Consent and Capacity Board has heard and ruled on conflicts pertaining to no-CPR or do not resuscitate orders. 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.
[15] For example, significantly high dosages of opioids.

b. ensure that patients and caregivers are educated and prepared for what to expect and what to do when the patient is about to die or has just died; and
c. ensure that caregivers are instructed regarding whom to contact when a patient is about to die or has just died.

19. If the patient has also expressed a wish not to be resuscitated, physicians are **advised** to order and complete the Ministry of Health and Long-Term Care "Do Not Resuscitate Confirmation Form"[16] and, if completed, **must** ensure that caregivers are instructed on the importance of keeping the form accessible and the necessity of showing it to emergency services personnel if they are called.[17]

Certification of Death

20. A physician[18] who has been in attendance during the last illness of a deceased person, or who has sufficient knowledge of the last illness **must** complete and sign a medical certificate of death immediately following death,[19, 20] unless there is reason to notify the coroner.[21]

a. Physicians **must not** rely on the coroner to certify the death when their involvement is not required.

21. Physicians are **advised** to plan in advance by designating the physician(s) or nurse practitioner(s) who will be available to attend to the deceased in order to complete and sign the death certificate and to take into consideration any local or community strategies that are in place to facilitate the certification of death.[22]

[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.
[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,

Wishes and Requests to Hasten Death

22. Physicians **must** respond to a patient's wish or request to hasten death in a sensitive manner and be prepared to engage patients in a discussion to seek to understand the motivation for their expression and to resolve any underlying issues that can be treated or otherwise addressed (e.g., adjusting pain management strategies, referral for psychological counselling, getting other professionals (e.g., chaplain, social worker, grief counsellor, etc.) involved in the patient's care, etc.).

23. With respect to medical assistance in dying, physicians **must** comply with the expectations set out in the College's *Medical Assistance in Dying* policy.

24. Patients have a right of access to their personal health information and physicians **must** release patient medical records or personal health information to the patient if they choose to explore medical assistance in dying, unless it is determined that an exception to this right is applicable.[23]

Managing Conflicts

25. In order to minimize and/or resolve conflict that can arise regarding treatment decisions, physicians **must**:

    a. communicate clearly, patiently, and in a timely manner information regarding the patient's diagnosis and/or prognosis, treatment options and assessments of those options, and the availability of supportive services (e.g., social work, spiritual care, etc.) and palliative care resources;
    b. identify misinformation and/or misunderstandings that might be causing the conflict and take reasonable steps to ensure that these are corrected and that questions are answered;
    c. offer referral to another professional with expertise in the relevant area and facilitate obtaining a second opinion, as appropriate;
    d. offer consultation with an ethicist or ethics committee, as appropriate and available;
    e. where appropriate, seek legal advice regarding mediation, adjudication or arbitration processes that are available; and

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.

f. take reasonable steps to transfer the care of the patient to another facility or health care provider as a last resort and only when all appropriate and available methods of resolving conflict have been exhausted. [24]

26. Physicians are **advised** to apply to the Consent and Capacity Board when:

a. conflicts arise between a physician and SDM over an interpretation of a wish or assessment of the applicability of a wish to a treatment decision, or
b. a physician is of the view that the SDM is not acting in accordance with their legislative requirements.

27. Physicians who limit their practice[25] on the basis of moral and/or religious grounds **must** comply with the College's *Professional Obligations and Human Rights* policy.

Documentation

28. In accordance with the College's *Medical Records* policy, physicians **must** document every patient and/or SDM encounter and all patient related information. In addition to these general expectations, in the end-of-life care this means physicians **must**:

a. document references to discussions and decisions regarding treatment, goals of care, and advance care planning; and
b. explicitly and clearly reference when a no-CPR order is in effect.

Organ and Tissue Donation

The *Trillium Gift of Life Network Act*[26] sets out requirements relating to organ and tissue transplantation measures for health facilities designated by the Minister of Health and Long-Term Care. In particular, designated facilities have specific reporting obligations to the Trillium Gift of Life Network (TGLN) to ensure the patient's family is able to be approached and affirm the patient's donation decision or make a decision about organ and tissue donation on the patient's behalf.

29. Physicians working in designated facilities **must** comply with any policies and procedures established in accordance with the *Trillium Gift of Life Network Act*.

30. Physicians not working in designated facilities are **advised** to:

[24] In following such a course, the physicians must comply with the College's Ending the Physician-Patient Relationship policy.
[25] This may include, but is not limited to, refusals to provide care, withdraw care, and/or discuss care options.
[26] *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20 (hereinafter *TGLNA*).

a. provide their patients with the opportunity to make choices with respect to organ and tissue donation, ideally in the context of an ongoing relationship with the patient and before any medical crisis arises;
b. contact TGLN for more information and/or for materials or resources; and
c. direct patients to TGLN for more information.[27]

[27] 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.

When planning for and providing end-of-life care, physicians have an important role to play in helping patients or their substitute decision-maker identify meaningful and realistic goals of care that are compassionate, respectful, and that seek to incorporate patient wishes, values, and beliefs. This may take a bit of time and patients or their caregivers may need some assistance articulating these goals.

What role does communication play in providing quality end-of-life care?

Good communication is a fundamental component of a good physician-patient relationship and is even more important when providing end-of-life care.

End-of-life care situations can be highly stressful and difficult for those involved. Frequent and effective communication can help manage these highly emotional situations by building trust and confidence in the physician-patient relationship and it can help to relieve patient or substitute decision-maker anxiety and doubt in what is an otherwise challenging time. For these reasons, the policy sets out expectations for physicians with respect to communication.

What role can family members or others close to the patient play in end-of-life care?

Involving family and/or others close to the patient in the ongoing care of a patient may be beneficial. For example, it can help patients understand their diagnoses, prognoses, medications, the tests that are required, and the decisions they have to make about treatment options. It can also help family caregivers to provide more effective care and support at home and mitigate their own distress.

What are the benefits of advance care planning? What resources can I use or direct my patients to?

Advance care planning can lead to improved outcomes and quality of life, help to ensure that the care provided aligns with the patient's wishes, values, and beliefs, and may even help encourage realistic treatment goals. While advance care planning does not constitute consent, it can be helpful in terms of informing treatment discussions and decisions.

The policy encourages physicians to take an active role in supporting their patients in advance care planning. This could include: asking general questions about their patient's wishes, values, and beliefs; discussing specific issues such as preferences for the location of their death or attitudes towards certain interventions (e.g., resuscitation, mechanical ventilation, etc.); and, as appropriate, their wishes with respect to organ and tissue donation. These conversations may be difficult to initiate and patients may need multiple opportunities to discuss in order to engage effectively.

Speak Up (www.advancecareplanning.ca) has information intended for both physicians and patients and includes a workbook tailored to Ontario patients (http://www.makingmywishesknown.ca/get-started/).

What are rules for substitute decision-makers when it comes to giving or refusing consent?

The *Health Care Consent Act, 1996* requires that substitute decision-makers give or refuse consent in accordance with the most recent and known wish expressed by the patient, while the patient was capable and was at least 16 years of age. If no wish is known or the wish is impossible to comply with or not applicable to the circumstances, the substitute decision-maker must make decisions in the incapable patient's best interests.

Wishes can be general or specific in nature and can be expressed in writing (including advance care planning document or an "advance directive"), orally or in any other manner. Later wishes expressed while capable, whether written, oral or in any other manner, prevail over earlier wishes. This is the case even if, for example, the earlier wishes are expressed in an advance care planning document.

Who can provide palliative care other than specialists in palliative care?

Palliative care focuses on relieving pain and other symptoms, as well as addressing psychological, social, and spiritual distress and can be provided at any stage of a patient's life-threatening illness or life-limiting chronic condition. Many physicians, including most family physicians, may have the knowledge, skill, and judgment necessary to provide basic palliative care that aims to alleviate pain and keep patients comfortable.

How can physicians support good decision-making regarding potentially life-saving and life-sustaining treatments? How can a trial of treatment be beneficial?

Decisions regarding potentially life-saving and life-sustaining treatment can be particularly challenging, both for physicians and for patients or their substitute decision-maker. It is beneficial for these discussions to happen before events requiring a decision occur and so the policy strongly advises physicians to engage in these discussions as early as possible. It's also beneficial for these discussions to be informed by advance care planning, reinforcing the points raised above.

There are also times where the outcomes of a potentially life-saving or life-sustaining treatment are uncertain. In these instances, proposing a trial of treatment allows for the exploration of a possibly positive outcome while building consensus about the circumstances where the care should then be withheld or withdrawn.

Does the policy require that CPR be provided in all instances?

No. The policy only requires that CPR be provided in a very narrow set of circumstances: when a physician has indicated that a no-CPR order will be written, the patient or substitute decision-maker has disagreed with this decision and conflict resolution is underway, the patient experiences an event requiring CPR, and the patient's condition does not prevent the physiologic goals of CPR from being provided.

What are the legal requirements regarding no-CPR orders?

The law is currently unclear regarding whether consent is required for a no-CPR order. The College is aware of decisions from the Consent and Capacity Board, the Health Professions Appeal and Review Board, and of various Ontario courts that relate to this issue, but is of the view that there is not yet clarity regarding this issue. Given this legal uncertainty, the College has set out professional expectations that seek to achieve a balance on this difficult and challenging issue.

Does the College require that consent be obtained before writing a no-CPR order?

No. In the absence of legal clarity, the College has not taken this position. Instead, the policy focuses on good and early communication that aims to avoid last minute decisions and intractable disagreements. The policy also does not require physicians to *propose* that a no-CPR order be written. Instead, physicians can be straightforward and directive in their explanation that the order will be written and the reasons why. Only if the patient or substitute decision-maker disagrees with this decision, must physicians engage in a conflict resolution process to try and find consensus.

What are the intended physiologic goals of CPR and what conditions might prevent these from being achieved?

Generally speaking, the physiologic goals of CPR are to provide oxygenated blood flow to the heart and brain. In some cases, patients may have a condition or conditions which would prevent these goals from being achieved. For example, this might include raised intracranial pressure so that blood cannot enter the brain, refractory hypoxemic respiratory failure where it is impossible to oxygenate the blood, or uncorrectable exsanguination where circulation to the brain cannot be attained by chest compressions.

What is the role of the Consent and Capacity Board? How do I find more information?

The Consent and Capacity Board (CCB) is an expert tribunal, comprised of lawyers, psychiatrists, and members of the public and is supported by full-time legal counsel. The CCB has the ability to convene hearings quickly and has the authority to direct substitute decision-makers to make

decision in accordance with a patient's prior capable wishes or best interests. The Supreme Court of Canada has affirmed that the CCB is the appropriate authority to adjudicate disagreements between physicians and substitute decision-makers regarding the withdrawal of life-sustaining treatments and the CCB has heard and decided on cases regarding the writing of a no-CPR order.

The CCB can also provide assistance when wishes are not clear, when it is unclear if a wish applies, or when it is unclear if a wish was expressed while the patient was capable or at least 16 years of age. The CCB can also grant permission to depart from wishes in very limited circumstances.

The CCB's website (www.ccboard.on.ca) has information regarding their services. Physicians may wish to contact the CCB directly for more assistance or seek assistance from legal counsel, either from their institution or from the Canadian Medical Protective Association.

Am I required to certify the death of a patient when it would be difficult for me to do so (e.g., distance, length of time away from practice, outside of practice hours, etc.)?

By law, the medical certificate of death must be completed by a physician who has been in attendance during the last illness of a deceased person, or who has sufficient knowledge of the last illness. In limited circumstances, nurse practitioners are also able to complete and sign a medical certificate of death. When death is expected, the policy recommends planning in advance who will be available to attend to the deceased in order to complete and sign the medical certificate of death. The policy also advises physicians to take into consideration any local or community strategies that are in place to facilitate the certification of death. Where possible, planning in advance may help to overcome any practical challenges associated with completing and signing the medical certificate of death.

How should I respond to a request to hasten death?

A patient's wish or request to hasten death may be a genuine expression of a desire to hasten their death, but it may also be motivated by an underlying and treatable condition such as depression, psychological suffering, unbearable pain or other unmet care needs. Patients may also be attempting to exert control over their lives, expressing acceptance of an imminent death, or seeking information about any options that may exist. For these reasons, the policy requires physicians to respond to these requests in a sensitive manner and to be prepared to engage patients in a discussion to seek to understand their motivation. In some cases, this discussion might reveal ways in which their care can be adjusted to help alleviate the underlying issues. Patients may also be seeking information about medical assistance in dying and physicians should consult the College's *Medical Assistance in Dying* policy for more information.

Where can I find or direct patients to for more information about organ and tissue donation?

Physicians and patients can visit the Trillium Gift of Life Network's website (http://www.giftoflife.on.ca/) for more information on organ and tissue donation in Ontario. The website also includes a link where patients can register to become a donor.

Providing Physician Services During Job Actions

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

Job Actions: Job actions occur when physicians, individually or collectively, take some sort of action (e.g., participate in a work slowdown or a withdrawal of services, etc.) in order to protest or to raise awareness about concerns they have, with the ultimate goal of resolving those concerns.

Job actions can occur for various reasons, including those related to: patient safety, practice environments (e.g., concerns about work environments and/or conditions, such as on-call schedules, available resources, hospital administration, etc.) and/or compensation.

Withdrawal of Physician Services: Withdrawal of physician services occurs when physicians limit the services they provide in the context of a job action. Withdrawal of services can vary in degree, from narrow or localized activities, such as declining to take on-call shifts in circumstances where appropriate coverage would otherwise be lacking, to broad, more significant actions, such as a complete withdrawal of all medical care.

Policy

1. Physicians **must** fulfil their professional responsibilities and uphold the reputation of the profession by providing services to those in need during job actions, as set out in this policy.

2. When contemplating a job action, physicians **must** first explore all alternative options that may be available to resolve the concern that has motivated their desire to withdraw services.

3. If the concern cannot otherwise be resolved, physicians **must** consider the following before making the decision to withdraw their services:

a. what is in the best interests of patients,
b. whether patients will be abandoned,
c. whether the public will be deprived of access to medical care, and
d. whether patients and/or the public will be placed at risk of harm.

4. If after carefully considering the above factors, physicians decide that proceeding with a withdrawal of services is not contrary to their professional responsibilities[1], they **must** mitigate the adverse impact of the withdrawal on patients and/or the public.

5. Notwithstanding the above, during a job action physicians **must** provide medical care that is urgent or otherwise necessary to prevent harm, suffering and/or deterioration. This will include ensuring health care concerns are assessed and appropriately triaged so that urgent and/or necessary medical care can be obtained.

    a. In determining what constitutes urgent and/or necessary medical care to prevent harm, suffering and/or deterioration, physicians **must** use their clinical judgment, informed by the existing health status and specific needs of individuals, and physicians' individual and collective responsibilities to provide care.

[1] Physicians may want to obtain independent legal advice from the Canadian Medical Protective Association (CMPA) or legal counsel regarding their legal responsibilities.

Advice to the Profession: Providing Physician Services During Job Actions

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 provide the people of Ontario with quality health care and are committed to delivering this care in an ethical and professional manner. However, there may be rare instances where physicians may consider withdrawing their services as part of a job action.

Physicians are aware that their decision to withdraw services can have significant negative implications for individual patients, specific patient populations and/or the public at large. Withdrawal of physician services may expose patients and/or the public to risk of harm, and may compromise physicians' ability to fulfill their professional responsibility to patients and their collective responsibility to the public. In addition, when the withdrawal of services puts patients and/or the public at risk of harm, it can negatively impact the public's trust in the profession.

In light of this, and the shared duty of both the College and the profession to protect and serve the public, there are important considerations for any physician contemplating and/or undertaking a job action. This advice document is intended to help physicians determine whether undertaking a job action is appropriate, and the steps they should take to mitigate the impact on patients, in line with the expectations set out in the *Providing Physician Services During Job Actions* policy.

Does the policy restrict physician's ability to withdraw their services during job actions?

The policy does not categorically prohibit job actions. However, in line with the College's mandate to protect and serve the public interest, the policy does set out a number of requirements physicians must meet when contemplating and/or undertaking a withdrawal of services.

In particular, the policy articulates the College's expectation that even during job actions physicians must continue to provide medical care that is urgent, or otherwise necessary to prevent harm, suffering and/or deterioration. This will include ensuring health care concerns are assessed and appropriately triaged so that urgent and/or necessary medical care can be obtained.

Physicians know that completely abandoning patients and communities en masse would never be acceptable as it would leave patients and the public without access to urgent and/or necessary medical care.

Does the policy prevent physicians from advocating for changes that benefit both physicians and patients in the province?

Not at all. In fact, advocating for patients is one of the principles of medical professionalism set out in the College's *Practice Guide* in recognition of the fact that physicians have a crucial role to play in shaping and improving the health-care system.

There are, however, many ways for physicians to advocate for change without withdrawing their services. The policy expects physicians to explore these other options first. If a physician believes that withdrawing services is the *only* way to achieve necessary changes, the policy does not prevent them from doing so, provided that the adverse impact on patients and/or the public is mitigated.

What should a physician consider before making the decision to withdraw services?

Given the significant negative implications a withdrawal of physician services can have on patients and/or the public, the decision to participate in a job action cannot be made lightly. The policy states that when contemplating a job action, physicians must first explore all alternative options that may be available to resolve the concern that has motivated their desire to withdraw services.

The alternative options would vary depending on the nature of the concern and circumstances of each case. For example, in a clinic or hospital setting, physicians could consult with an ombudsperson, relevant committee, senior management, board of directors, etc., in accordance with its established policies/procedures, as applicable. In the context of fee negotiations between the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA), physicians could proceed with the facilitation and conciliation process set out in the MOHLTC-OMA Memorandum of Agreement.

Does a physicians' 'collective responsibility' to the public mean physicians have a duty to care for all Ontarians?

No. Collective responsibility and duty of care are distinct concepts. Collective responsibility refers to the ethical and professional obligations physicians have, as a group, to the public, as articulated in the *Practice Guide* - the commitment that all physicians have to provide quality care to their patients, and to uphold the reputation of the medical profession. This is distinct from the legal duty of care a physician has to a patient.

The policy contains a number of terms like 'best interests' of patients, 'abandoned', 'deprived of access' to medical care, 'risk of harm', and 'mitigate the adverse impact'. How will the College interpret these terms?

The College has not set out concrete definitions of these terms because their meaning will differ, depending on the circumstances and context in which the withdrawal of physician services occurs or is contemplated. In applying these terms to specific situations, the College will be guided by the values and principles of professionalism, as set out in the *Practice Guide*, the spirit of the policy (to ensure individuals are not harmed by physician job actions), and our shared commitment with the profession to serve and protect the public.

For example, it may not be in the 'best interests' of patients if physicians in a remote community participated in a job action for reasons related to physician compensation when, as a result, patients are prevented from accessing necessary medical care.

Some steps physicians may take in that situation to 'mitigate the adverse impact' could include: transferring the care of patients to other physicians and/or facilities, ensuring sufficient coverage is provided for emergency situations, regularly monitoring the impact of the withdrawal on patients and/or the public, etc.

What does the College consider to be medical care that is 'urgent', or otherwise 'necessary' to prevent harm, suffering and/or deterioration?

What is 'urgent' or 'necessary' medical care would depend on the specific circumstances of each case, and is a matter to be determined by a physician's clinical judgment, informed by the existing health status and specific needs of individuals, and physicians' individual and collective ethical responsibilities to provide care.[1]

For example, patients and/or the public would likely be unable to access 'necessary' medical care if every single physician in a rural community or every single physician in a specialty (e.g. all anesthesiologists) stopped treating patients for a significant amount of time.

Is the College's definition of 'necessary' medical care the same as 'medically necessary' services that are insured?

No. In the context of the policy, the College considers 'necessary' medical care to be care that is required to prevent harm, suffering and/or deterioration, as determined by the physician's clinical judgment. The medical care physicians deem 'necessary' may very well

[1] Physicians' individual and collective responsibilities refers to the ethical and professional obligations physicians have, as articulated in the *Practice Guide*.

be insured services; however, it does not mean that ALL insured services are 'necessary' for the purposes of the policy.

Is it okay to discuss concerns about the situation with patients during their appointments?

It is not appropriate to initiate discussions regarding a dispute during clinical encounters with patients. This would include asking them to sign petitions or other types of political advocacy. However, if a patient raises the issue, a physician can neutrally and objectively indicate that there is a current disagreement without dwelling on the issue or trying to influence the patient. Physicians may elect to post materials in their waiting room, but patients should never feel pressured to sign petitions or take any other action.

What will happen if a complaint is made about a physician who withdraws their services during a job action?

As with any complaint received by the College, it will be investigated. A panel consisting of physicians and members of the public will then consider the circumstances of the case and determine whether the physician's conduct or the care provided was appropriate, doing so in accordance with our duty to serve and protect the public interest.[2]

[2] Section 3(2) of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1001, c.18.

Public Health Emergencies

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

Public Health Emergency: A current or impending situation that constitutes a danger of major proportions with the potential to result in serious harm to the health of the public. They are usually caused by forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.[1] They are declared by government and public health authorities at the federal, provincial and municipal levels.[2]

Policy

Providing Physician Services

1. In fulfilling their individual commitment to patients, professional commitment to colleagues, and collective commitment to the public, physicians **must** be available to provide physician services during public health emergencies. Physician services include:
    - providing direct medical care to people in need, and
    - performing administrative or other indirect activities that support the response effort.[3]
2. When deciding what role to take during public health emergencies, physicians **must** do so in accordance with the values, principles, and duties of medical professionalism.
3. Physicians providing direct medical care to people in need **must** do so in accordance with relevant legislation and emergency management plans.
4. Physicians **must** document these patient encounters to the best of their ability given the circumstances.
5. There may be reasons related to the physicians' own health, that of family members or others close to them[4] which may place limits on the physicians' ability to provide direct medical care to

[1] Adapted from *Emergency Management and Civil Protection Act,* R.S.O. 1990, Chapter E.9
[2] See for example: Public Health in Canada (https://www.canada.ca/en/public-health/corporate/mandate/about-agency/federal-strategy.html)
[3] See the *Advice to the Profession: Public Health Emergencies* for further guidance.

people in need during a public health emergency. In those instances, physicians who have a personal health and/or ability limitation **must** engage in indirect activities that support the response effort during public health emergencies.[5]

Planning, Preparation, and Staying Informed

6. Physicians are **advised** to prepare for the occurrence of public health emergencies by, for example, participating in simulation exercises and other emergency planning and preparation activities, and taking advantage of training offered to them for tasks which they may be required to perform during public health emergency.

7. Physicians are **advised** to be proactive and inform themselves of the information available which will assist them in being prepared for a public health emergency. [6]

8. During public health emergencies, physicians **must** make reasonable efforts to access relevant information and stay informed.[7]

Practicing Outside of Scope of Practice

9. During public health emergencies, it may be necessary for physicians to temporarily practice outside their scope, but physicians **must** only do so if:
    a. the medical care needed is urgent,
    b. a more skilled physician is not available, and,
    c. not providing medical care may result in greater risk or harm to the patient or public than providing it.

10. To ensure competence while temporarily practising outside of one's scope of practice, physicians **must** exercise their professional judgement and work with their health care colleagues to determine what appropriate medical care they can provide to persons in need of care, in accordance with relevant legislation and emergency management plans.

11. Once the public health emergency is over, physicians **must not** practise outside of their scope, unless they elect to change their scope of practice in accordance with College policy.[8]

[4] As defined in the College's *Physician Treatment of Self, Family Members and Others Close to Them* policy.
[5] See the *Advice to the Profession: Public Health Emergencies* for further guidance.
[6] Including legislation, emergency management plans developed by federal, provincial and municipal governments, directives from public health agencies, and advice provided by the CMPA.
[7] Governments and public health authorities are responsible for ensuring that physicians receive timely, accurate and complete information both prior to and during public health emergencies.
[8] In non-emergency situations, there are clear expectations for physicians around scope of practice. A physician must practice only in the areas of medicine in which the physician is educated and experienced and must comply with the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy when changing their scope of practice.

Advice to the Profession: Public Health Emergencies

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.

In the event of a public health emergency, the public relies on physicians. Physicians are uniquely positioned to provide care during public health emergencies, and have an ethical duty to provide medical care and/or other physician services. This ethical duty is derived from the values of medical professionalism set out in the *Practice Guide* – compassion, service, altruism and trustworthiness.

Federal, provincial and local responses to public health emergencies require extensive involvement of physicians. Physicians are integral to an effective response and have always provided medical care and other physician services in times of crisis, often placing themselves at risk of harm, above and beyond routine care provision.

This advice document is intended to help physicians interpret their responsibilities during a public health emergency as set out in the *Public Health Emergencies* policy and provide guidance around how these obligations may be effectively discharged.

Examples of Public Health Emergencies

Public health emergencies are current or impending situations that constitute a danger of major proportions with the potential to result in serious harm to the health of the public. They can be the result of a multitude of causes.

Examples of situations or conditions which may lead to the declaration of a public health emergency include, but are not limited to, the following:

Forces of Nature	Infectious Disease	Other Health Risk
Flood Hurricane Earthquake Tornado Blizzard Prolonged extreme heat/cold Drought Environmental disaster	Non-seasonal Influenza outbreak (e.g. Swine flu) Severe Acute Respiratory Syndrome (SARS) Pneumonic Plague Ebola Botulism Cholera	Prolonged toxic air Chemical threats Biological threats Contaminated drinking water Bombs and other explosives Nuclear disaster

Providing Physician Services in a Public Health Emergency

Physician services include direct medical care, as well as administrative or other indirect activities that support the response effort. Decisions about what role to undertake during public health emergencies must be made in accordance with the values, principles and duties of medical professionalism.

Some examples of ways that physicians provide direct medical care during public health emergencies include, but are not limited to:

- assessing people for injuries after an earthquake,
- diagnosing and treating infectious diseases,
- triaging people, and
- administering vaccinations.

Some examples of administrative or indirect activities include, but are not limited to:

- providing leadership and guidance on interpreting the information provided by public health and emergency management officials,
- communicating information to current patients and/or members of their community about the nature and severity of the public health emergency, and
- performing administrative roles, such as participating in coordinating patient flow, transfer or discharge of currently hospitalized patients in order to accommodate those affected by the public health emergency.

Additionally, physicians can lend indirect support by responding to the impact of the public health emergency on physician resources. When physician resources are limited it may help if physicians who are not involved in providing direct care temporarily expand the capacity of their current practice. For these physicians, expanding the capacity of their current practice is a way to relieve the pressure that inevitably increases when limited physician resources are directed towards responding to the public health emergency.

Importantly, Ontario's Good Samaritan legislation offers legal protection to people who give emergency assistance to those who are, or who they believe to be, injured, ill, in peril, or unconscious. Further, the Canadian Medical Protective Association (CMPA) has indicated that it will exercise its discretion to extend assistance to CMPA members who provide medical care during public health emergencies.[1]

[1] CMPA Public Health Emergencies and Catastrophic Events - https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/public-health-emergencies-and-catastrophic-events-the-cmpa-will-help

Documenting Patient Encounters in Public Health Emergencies

As resources may become scarce during public health emergencies, documentation of the facts and circumstances of the patient encounter as well as the rationale for the medical decisions made is recommended, when possible. Document in whatever way possible; if the situation is such that comprehensive charting is not possible, physicians are advised to do the best they can. It is particularly important for physicians temporarily practicing outside of their scope to record this in their documentation of the patient encounter, doing the best that one can.

Planning and Preparation for Public Health Emergencies

It is recommended that physicians prepare for the occurrence of public health emergencies. Physicians are best placed to provide direct medical care during public health emergencies if they maintain their basic and advanced life support skills.

The College recommends that physicians participate in simulation exercises and other emergency planning and preparation activities. For example, mock disaster exercises, public health simulations, developing emergency management plans for practice settings, and/or following hospital/organizational plans. Additionally, physicians are advised to take advantage of training offered for tasks which they may be required to perform during a public health emergency.

Finally, information is available which can assist physicians in being prepared for a public health emergency where they practice and live. Physicians can use the following to prepare for emergency situations:

- federal[2] and provincial[3] legislation;
- emergency management plans developed by federal[4], provincial[5] and municipal governments[6];
- directives from public health agencies; and
- advice provided by the CMPA[7].

[2] *Emergencies Act,* R.S.C., 1985, c. 22 (4th Supp.); *Emergency Management Act,* S.C. 2007, c. 15; *Quarantine Act,* S.C. 2005, c. 20
[3] *Health Promotion and Protection Act,* R.S.O. 1990, Chapter H.7; *Emergency Management and Civil Protection Act* R.S.O. 1990, Chapter E.9; *Good Samaritan Act,* S.O. 2001, Chapter 2
[4] Public Safety Canada: Emergency Management https://www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/index-en.aspx
[5] Ministry of Community Safety & Correctional Services: Emergency Response Plans https://www.emergencymanagementontario.ca/english/emcommunity/response_resources/plans/plans.html
[6] Ministry of Municipal Affairs: List of Ontario Municipalities http://www.mah.gov.on.ca/page1591.aspx

Staying Informed During a Public Health Emergency

In order for physicians to provide the best possible care, governments and public health authorities are responsible for ensuring that physicians receive timely, accurate and complete information both prior to and during public health emergencies.

In addition to the information provided by authorities, individual practice settings may provide access to additional sources of information during an emergency. This may include, but is not limited to, hospital protocols, directives from community settings where medical services are provided, or organizational plans and/or policies.

Temporary Registration for Physicians form Other Jurisdictions

The College has a registration process in place to provide temporary Certificates of Registration to physicians who are licensed in other jurisdictions during public health emergencies. Contact the Registration department for information: (416) 967-2617 or inquiries@cpso.on.ca

Obtaining Temporary Hospital Privileges

Decisions regarding hospital privileges are made at the hospital level. Physicians are encouraged to contact hospitals directly to learn about their privileging process.

Compensation for Services Provided During Public Health Emergencies

Governments, public health agencies, and health care institutions are responsible for ensuring resources are in place to facilitate the provision of medical care during public health emergencies. The role of the College is to regulate the practice of medicine to protect and serve the public interest. The College does not make decisions regarding physician compensation, therefore questions about compensation during public health emergencies should be directed to the Ontario Medical Association (OMA) or the Ontario Health Insurance Program (OHIP).

Postgraduate Trainees and Medical Students

Although still in training, postgraduate trainees are physicians who are regulated by the College, and must follow College policy. The expectations contained in the *Public Health Emergencies* policy apply to postgraduate trainees. Additionally, the *Professional Responsibilities in Postgraduate Medical Education* policy clarifies the roles of physicians engaged in postgraduate medical education programs.

[7] CMPA: Public Health Emergencies and Catastrophic Events https://www.cmpa-acpm.ca/en/membership/protection-for-members/principles-of-assistance/public-health-emergencies-and-catastrophic-events-the-cmpa-will-help

Postgraduate trainees must use their best judgement to determine the extent to which they can provide physician services during a public health emergency given their education, training and skillset. They must also adhere to the terms, conditions and limitations of their Postgraduate Education Certificate.

The Council of Ontario Faculties of Medicine has approved guidelines titled "Residents and Public Health Emergency Preparedness Guidelines" that postgraduate trainees may find helpful.

Medical students are not licensed physicians, and must not assume the role of a physician or any other healthcare provider during public health emergencies. Like any other member of the public, medical students may volunteer to assist in ways that are commensurate with their education, training and skillset.

Health Insurance for Physicians during Public Health Emergencies

Providing care during public health emergencies often involves placing oneself at risk for harm, above and beyond routine care provision. Physicians are responsible for ensuring they have appropriate health insurance coverage. The OMA has death and disability insurance available for physicians and their families. Physicians are advised to contact the OMA for more information about health insurance coverage.[8]

[8] OMA Insurance - http://www.omainsurance.com/Pages/default.aspx

Telemedicine

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

Telemedicine: Both the practice of medicine and a way to provide or assist in the provision of patient care (which includes consulting with and referring patients to other health-care providers, and practising telemedicine across borders) at a distance[1] using information and communication technologies such as telephone, email, audio and video conferencing, remote monitoring, and telerobotics.

Policy

General Expectations

1. Physicians who practise telemedicine **must** continue to meet the existing legal and professional obligations that apply to care that is provided in person.[2] The practice of telemedicine is the practice of medicine, and a physician-patient relationship is established via telemedicine in the same circumstances as when a relationship is established in person.[3]

2. For every patient and in each instance its use is contemplated for patient care, physicians **must** use their professional judgment to determine whether telemedicine is appropriate and will enable them to meet all relevant and applicable legal obligations, professional obligations, and the standard of care.

[1] Patients, patient information and/or physicians may be separated by space (e.g. not in same physical location) and/or time (e.g. not in real time).

[2] Relevant legal obligations include privacy and confidentiality requirements as set out in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A, consent requirements in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, and mandatory liability coverage in s. 50.2 of the General By-Law. Professional obligations are set out in the CPSO's *Practice Guide* and policies (e.g., consent to treatment, confidentiality of personal health information, prescribing drugs, medical records, etc.).

[3] The existence of a physician-patient relationship will be established having regard to the nature and frequency of the treatment provided, whether there is a medical record, whether the physician bills for the services provided, and any other relevant factors.

3. When practising via telemedicine, physicians **must**:

    a. consider the patient's existing health status, specific health-care needs and specific circumstances, and only use telemedicine if the risks do not outweigh the potential benefits and it is in the patient's best interest;
    b. identify what resources (e.g. information and communication technology, equipment, support staff, etc.) are required, and only proceed if those resources are available and can be used effectively;
    c. ensure that the reliability, quality,[4] and timeliness of the patient information obtained via telemedicine is sufficient, and that the patient is accurately identified;
    d. protect the privacy and confidentiality of the patient's personal health information, specifically by:
        i. evaluating whether the information and communication technology and physical setting being used by the physician has reasonable security protocols in place to ensure compliance with physicians' legal and professional obligations to protect the privacy and confidentiality of the patient's personal health information;[5] and
        ii. taking reasonable steps to confirm the information and communication technology and physical setting being used by the patient permits the sharing of the patient's personal health information in a private and secure manner; and
    e. ensure the physical setting in which the care is being delivered is appropriate and safe, including having a plan in place to manage adverse events and/or emergencies.

Expectations for CPSO Members when Practising Across Borders

The following expectations apply to all physicians who are members of the CPSO, regardless of where the physician or patient is physically located when telemedicine is practised.[6]

4. When providing or assisting in the provision of patient care in another province, territory, or country via telemedicine, physicians **must** comply with the licensing requirements of that jurisdiction.[7]

[4] For example, diagnostic images must be of sufficient quality.
[5] Physicians may want to consult the Office of the Information and Privacy Commissioner of Ontario, the Canadian Medical Protective Association, or an information and communication technology and/or privacy expert for up-to-date advice and questions about whether the technology and/or physical setting is secure. Physicians can also ensure their technology has reasonable security protocols by using a facility accredited by the Ontario Telemedicine Network for telemedicine.
[6] The CPSO maintains jurisdiction over its members regardless of where (i.e. physical location) or how (i.e. in-person or via telemedicine) they practise medicine, and will investigate any complaints made about a member, regardless of whether the member or patient is physically located in Ontario.

5. Before consulting with or referring patients to out-of-province physicians for care via telemedicine, physicians **must:**

    a. take reasonable steps to assure themselves that the consultation or referral is appropriate, just as they would when consulting with or referring patients to physicians who are physically located in Ontario;
    b. have reasonable grounds to believe that the out-of-province physician with whom they are consulting or to whom they are referring patients for care via telemedicine is appropriately licensed; and
    c. inform their patients that the out-of-province physician is not physically located in Ontario, and may or may not be licensed in Ontario.

6. Physicians are **advised** to alert patients to the 'patient information sheet' appended to this policy, and communicate the relevant content contained in that document, as appropriate.

Expectations for Non-CPSO Members when Providing Telemedicine in Ontario

The following expectation applies to physicians who are not CPSO members, but who are licensed to practice medicine in another jurisdiction and who provide care via telemedicine to patients located in Ontario.

7. Physicians who are not CPSO members **must** comply with licensing requirements in the jurisdiction in which they hold licensure and provide care in accordance with the standard of care.[8]

[7] The medical regulatory authority of the jurisdiction where the physician and/or patient are physically located may also require that physicians hold an appropriate medical licence in that jurisdiction.

[8] If the CPSO becomes aware of concerns about care provided to an Ontario patient via telemedicine by a non-CPSO member, it may share that information with the regulatory authority that has jurisdiction over the member, so that appropriate action can be taken by that regulatory authority.

Advice to the Profession: Telemedicine

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.

Telemedicine can play an important role in the health-care system for both patients and physicians by improving access to care and increasing efficiencies in the way it is delivered. As technology continues to evolve, it will bring new opportunities and advancements in the delivery of care via telemedicine.

At the same time, this option may not be appropriate in every instance. This advice document is intended to help physicians interpret and understand the College's expectations regarding the appropriate use of telemedicine, as set out in the *Telemedicine* policy.

Can I provide care to patients exclusively via telemedicine?

It will depend on the circumstances of each case, including the specific care being contemplated. As noted in the policy and this advice document, you must use your professional judgment to determine whether telemedicine is appropriate for every patient and in each instance its use is contemplated for patient care. Some situations may be inappropriate for telemedicine, such as cases where an in-person physical assessment is required.

Can I delegate controlled acts via telemedicine?

When practicing telemedicine, you must continue to meet the same legal and professional obligations that apply to care that is provided in person, including the expectations set out in the *Telemedicine* policy and other College policies like the *Delegation of Controlled Acts* policy.

The *Delegation of Controlled Acts* policy outlines expectations for physicians about when and how they may delegate controlled acts. These include (among others) ensuring that:

- the best interests of the patient are the primary consideration in every instance of delegation, and that controlled acts are not delegated solely for monetary or convenience reasons;
- delegation only occurs in the context of an existing physician-patient relationship, unless patient safety and best interests dictate otherwise; and
- the delegate has the appropriate knowledge, skill, and judgment to perform the delegated act and is able to accept the delegation.

In addition, you must ensure that any adverse event that occurs will be managed appropriately, which may involve specific considerations if the delegation has taken place via telemedicine.

Can I prescribe medication (e.g. cannabis, Botox) via telemedicine?

Before authorizing a prescription via telemedicine, you will need to consider whether you are able to meet your legal and professional obligations and the standard of care in relation to the specific patient and the specific care being provided, in the absence of physical interaction with the patient.

With specific reference to prescriptions, you will need to take into account the expectations contained in the College's *Prescribing Drugs* policy. This policy expects (among other things) that the physician will have current knowledge of the patient's clinical status, obtained through an appropriate clinical assessment, which will include an appropriate patient history and appropriate physical examination (and/or any other relevant examinations or investigations).

What should I know when considering opioid prescriptions or treatment via telemedicine?

In addition to the general expectations regarding prescribing, the *Prescribing Drugs* policy also contains expectations specific to prescriptions for narcotic and other controlled substances which must be complied with.

With respect to Methadone Maintenance Treatment (MMT), telemedicine may work best for patients who have achieved stability with their treatment plan and who have already developed a good working relationship with their MMT physician. While telemedicine can support treatment in communities where no other options exist for MMT, it should not generally be viewed as a replacement for in-person interaction where this can be facilitated.

I work in a walk-in clinic where telemedicine is available to patients who self-identify with specific complaints and presentations. What should I keep in mind in these situations?

As in all cases, you need to be alive to the possibility that the specific interaction may be inappropriate for telemedicine. Where a clinic permits patients to choose a telemedicine option based on a self-identified concern, you should be aware that new or additional considerations could arise in the course of the patient interaction that change the nature of the investigation, potentially making telemedicine inappropriate. There may also be situations in which the self-identified complaint presents issues or complications that cannot be completely assessed through telemedicine technology.

Where you feel that telemedicine is inappropriate for the specific patient interaction, or has become inappropriate in the course of the interaction, an in-person consultation should be considered.

Can I use videoconferencing apps such as Skype or FaceTime to provide patient care via telemedicine?

Videoconferencing can be a convenient way to remotely connect to patients, particularly those patients who may be located in rural or remote areas. While videoconferencing apps like Skype and FaceTime are readily available, you will need to assess in each instance whether videoconferencing is appropriate in each patient's particular circumstances, including whether patient privacy and confidentiality can be adequately protected. Relevant considerations may include:

- the privacy (or lack thereof) offered by the physician's and the patient's physical locations,
- any technical limitations (such as low bandwidth, poor screen resolution, or unsecure networks or portals) that may affect the quality of care provided, and
- whether the technology meets appropriate security standards.

If patient privacy cannot be adequately protected, an in-person consultation or alternate technology should be considered – in particular, telemedicine technology available through the Ontario Telemedicine Network.

Further information may be found in the College's *Confidentiality of Personal Health Information* policy and the CMPA document *Videoconferencing consultation: When is it the right choice?*

Uninsured Services: Billing and Block Fees

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

Insured services: Services, including their constituent elements, listed in the *Health Insurance Act* and the Schedule of Benefits that are publicly funded under the Ontario Health Insurance Plan[1] (OHIP), on the condition that the service is being provided to an insured person[2].

Uninsured services: Services provided by physicians that are not publicly funded under OHIP (e.g., prescription refills over the phone, copy or transfer of medical records, etc.). This includes services provided to individuals not insured under OHIP.[3]

Block fee: A fee that is charged to patients to pay for the provision of one or more uninsured services from a predetermined set of services during a predetermined period of time.[4] At the time of payment it will not be possible for the patient to know how many, if any, services will be needed.[5]

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

[2] An insured person is entitled to insured services as per provincial legislation and regulations. In Ontario the *Health Insurance Act* and its regulations set out the definition of insured persons who are covered by OHIP. The College acknowledges that individuals not covered by OHIP may be covered by other publicly funded insurance programs or by another provincial health insurance plan. As there are unique requirements, processes, and challenges related to each of these situations, for the purposes of this policy, the definitions of insured and uninsured services or persons are framed in relation to the *Health Insurance Act* and OHIP.

[3] See the Schedule of Benefits, Section 24 of the *General* R.R.O 1990, Regulation 552 enacted under the *Health Insurance Act*, as well as the Ontario Medical Association's *Physician's Guide to Uninsured Services* for more information about the specific services that are or are not covered by OHIP.

[4] This does not prevent physicians from calling the fee by another name (i.e., Patient Supplemental Plan, Block Billing Plan, etc.), provided that it is not misleading.

[5] Adapted from Section 18(4) paragraph (a) of the *Commitment to the Future of Medicare Act, 2004,* S.O. 2004, c.5 (hereinafter, *CFMA, 2004*).

Policy

1. Physicians **must not** charge:

    a. for the provision of insured services (including the constituent elements of insured services),[6]
    b. any amount in excess to what OHIP has paid or will pay,[7]
    c. for services not performed,[8]
    d. for an undertaking to be available to provide services to a patient,[9] or
    e. for uninsured services where the government has agreed to remunerate physicians for the provision of these services.[10]

2. Physicians are entitled to charge for the provision of uninsured services, but **must** do so in accordance with this policy, other relevant policies, and relevant legislation.[11]

Setting Fees that are Reasonable

3. Physicians **must** ensure that the fees they charge for uninsured services, including block fees, and appointments that are missed or cancelled without the required notice, are reasonable.[12] In doing so physicians **must**:

    a. ensure that fees for individual uninsured services are commensurate with the nature of the services provided and the physicians professional costs, giving consideration to the recommended fees set out in the Ontario Medical Association's *Physicians Guide to Uninsured Services* ("the OMA Guide") and any recommended fees set out by professional specialty association(s);
    b. ensure that the amount charged for a block fee is reasonable in relation to the services and the period of time covered by the block fee; and

[6] See the "Constituent and Common Elements of Insured Services" of the Schedule of Benefits and Sections 10(1) and (3) of the *CFMA, 2004*.
[7] See Sections 10(1) and (3) of the *CFMA, 2004* as well as Sections 18 and 19 of the *Canada Health Act,* R.S.C., 1985, c. C-6.
[8] Section 1(1) paragraph 20 of the *Professional Misconduct*, O. Reg. 856/93 enacted under the *Medicine Act, 1991,* S.O. 1991, C.30 (hereinafter, *Professional Misconduct Regulation*), although see the "Charging for Missed or Cancelled Appointments" section of this policy for more information.
[9] Section 1(1) paragraph 23.2 of the *Professional Misconduct Regulation*.
[10] For example, while telemedicine is an uninsured service, the government has agreed to remunerate physicians providing telemedicine via the Ontario Telemedicine Network. Similarly, the Ontario Fertility Program remunerates physicians for some fertility services that are uninsured services.
[11] This includes but is not limited to the College's Medical Records and Third Party Reports policies as well as, the *Health Insurance Act*, the *Professional Misconduct Regulation*, and the *CFMA, 2004*.
[12] It is an act of professional misconduct to charge a fee that is excessive in relation to the services provided (See Section 1(1) paragraph 21 of the *Professional Misconduct Regulation*).

c. when setting fees for appointments that are missed or cancelled without the required notice, consider what would constitute reasonable cost recovery and what would act as a reasonable deterrent to patients, recognizing the lost opportunity costs to other patients when appointments are missed or cancelled without the required notice.

4. Physicians **must** also consider the patient's ability to pay[13] when charging for uninsured services, individually or by block fee, charging for appointments that are missed or cancelled without the required notice, and collecting outstanding balances. In particular, physicians **must** consider:

   a. the financial burden that these fees might place on the patient and whether it would be appropriate to reduce, waive, or allow for flexibility on compassionate grounds; and
   b. granting exceptions for appointments that are missed or cancelled without the required notice when it is reasonable to do so (e.g., first or isolated incident, intervening circumstances, etc.).

Communicating Fees

5. Physicians **must** ensure that the patient or third party[14] is directly informed of any fee that will be charged prior to providing an uninsured service, except in the case of emergency care where it is impossible or impractical to do so.

6. Prior to providing an uninsured service, physicians **must** also notify the patient or third party if they charge more than the OMA Guide and the excess amount that will be charged.[15]

7. While physicians may rely on staff to provide information about fees and to answer questions, physicians **must** be available to offer explanations and/or answer questions about their fees.

8. Physicians are **advised** to:

[13] 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."
[14] For example, a representative from an insurance company or a lawyer. For more information see the College's Third Party Reports policy.
[15] Section 1(1) paragraph 22 of the *Professional Misconduct Regulation*.

a. support patient education by posting a general notice in their office listing fees for common uninsured services (although this is not a substitute for directly informing patients or third parties of the fees associated with uninsured services), and
b. direct patients to the College's *Patient Information Sheet on Uninsured Services: Billing and Block Fees*.

Charging for Missed or Cancelled Appointments

9. Physicians are permitted to charge for an appointment that is missed or cancelled with less than 24 hours' notice (or in a psychotherapy practice, in accordance with any reasonable written agreement with the patient).[16] Physicians who intend to charge patients in these circumstances **must**:

    a. have a system in place to facilitate the cancellation process,
    b. ensure the patient was informed of the cancellation policy and fees in advance, and
    c. have been available to see the patient at the time of the appointment.

Providing an Invoice

10. Physicians are **advised** to always provide an itemized invoice for any uninsured services that are provided and for which fees are paid,[17] but **must** provide an invoice when asked for one.[18]

Combining Insured and Uninsured Services

11. Physicians who propose or provide insured and uninsured services together or offer uninsured services as an alternative or as a complement to insured services **must**:

    a. clearly communicate which services or elements of a service are associated with a fee and which are not;
    b. describe the differences between the insured and uninsured options in a clear and impartial manner, providing clear and unbiased information about the options available to the patient;[19]

[16] Section 1(1) paragraph 20 of the *Professional Misconduct Regulation*.
[17] This would include any fees charged for missed or cancelled appointments and fees that are charged to patients who have chosen to pay a block fee, but where the fees for some services are merely reduced as a result.
[18] It is an act of professional misconduct to fail to provide an itemized invoice when asked (See section 1(1) paragraph 24 of the *Professional Misconduct Regulation*).
[19] It is an act of professional misconduct to make a misrepresentation respecting a remedy, treatment or device or to make a claim respecting the utility of a remedy, treatment, device or procedure other than a claim which can be supported by reasonable professional opinion (Section 1(1) paragraphs 13 and 14 of the *Professional Misconduct Regulation*).

c. ensure that if their practice structure leads to different wait times for the insured and uninsured services they provide, they are compliant with *Commitment to the Future of Medicare Act, 2004* prohibitions relating to preferential access to insured services; [20] and
d. place the interests of their patients above their own by managing any real or perceived conflicts of interest that might arise in this context, including not referring a patient to a facility in which they or a member of their family has a financial interest without first disclosing that fact, and selling or otherwise supplying any medical appliance or medical product to a patient at a profit.[21]

Collecting Fees and Outstanding Balances

12. Physicians may take action[22] to collect any outstanding fees owed to them, but **must** do so in a professional manner and in accordance with privacy legislation.[23]

13. Physicians who are considering ending the physician-patient relationship due to an outstanding balance **must** comply with the expectations set out in the *Ending the Physician-Patient Relationship* policy.

Offering a Block Fee

14. A block fee may not be appropriate in all practice settings. As such, physicians **must** consider the nature of their practice and specialty before offering a block fee.[24]

15. Physician **must not** charge a block fee in order to cover administrative or overhead costs associated with providing insured services.[25]

16. Physicians **must** ensure the block fee covers a period of not less than 3 months and not more than 12 months.

17. Physicians offering a block fee **must** always provide the patient with the option of paying for each service individually and **must** ensure that patient decisions regarding whether to pay a

[20] Section 17(1) of the *CFMA, 2004*.
[21] See sections 17(1) and 16(d) of *General Regulation*, Part IV, Conflicts of Interest, O. Reg. 114/94 enacted under the *Medicine Act, 1991,* S.O. 1991, C.30.
[22] This may include physicians or their office staff contacting patients or hiring a third party (i.e., collection agency) to assist in the process.
[23] This includes, for example, the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A.
[24] Although section 1(1) paragraph 23 of the *Professional Misconduct Regulation* lists "charging a block fee" as an act of professional misconduct, physicians are able to charge a block fee as this provision has been struck down by the courts in *Szmuilowicz v. Ontario (Minister of Health),* 1995 CanLII 10676 (ON SC) and is therefore not in effect.
[25] See the "Constituent and Common Elements of Insured Services" of the Schedule of Benefits, read in conjunction with section 37.1 (1) of R.R.O 1990, Reg. 552 *General*, enacted under the *Health Insurance Act* and Section 10 of the *CFMA, 2004*.

block fee do not affect their ability or the ability other patients in the practice to access health-care services. In particular, physicians **must not**:

a. require that patients pay a block fee before accessing an insured or uninsured service,[26]
b. treat or offer to treat patients preferentially because they agree to pay a block fee, or
c. terminate a patient or refuse to accept a new patient because that individual chooses not to pay a block fee.[27]

18. To facilitate patient choice, physicians **must**:

a. offer a block fee in writing and in so doing:
    i. indicate that payment of a block fee is optional and that patients may choose to pay for uninsured services as they are provided;
    ii. indicate that the patient's decision to pay for uninsured services individually or through a block fee will not affect their ability to access health-care services;
    iii. identify those services that are covered by the block fee, provide a list of fees that will be charged for each service should the block fee option not be selected, provide examples of those services (if any) that are not covered, and indicate for which services (if any) the fee is simply reduced if the block fee option is selected;
    iv. use plain language and give consideration as to how to address language and/or communication barriers that may impede patients' ability to understand what is being offered;
    v. refrain from using language that is or could be perceived as coercive or suggestive that without payment of the block fee, services will be limited or reduced, or that quality of care may suffer;
    vi. invite patients to consider whether payment of a block fee is in their best interest given their needs or usage of uninsured services; and
    vii. direct patients to the College's *Patient Information Sheet on Uninsured Services: Billing and Block Fees*; [28]

[26] Section 18(2) of the *CFMA, 2004*.
[27] Section 18(2) of the *CFMA, 2004*. See as well the College's *Ending the Physician-Patient Relationship* and *Accepting New Patients* policies.
[28] For example, physicians can direct patients to the College's website or refer patients to the College's Public Advisory Service (1-800-268-7096 ext. 603).

b. ensure that patient questions about the block fee are answered, ensure that help is available to patients to determine if the block fee is in their best interest, and be available to answer questions or provide assistance upon request; and
c. obtain written confirmation if the block fee option is chosen and maintain it as part of the patient's medical record.

19. Physicians **must** give patients the opportunity to rescind their decision to pay a block fee within a week of the original decision. If the patient does rescind their decision, physicians **must** refund the amount charged for the block fee before then charging the patient individually for any uninsured services already provided.

20. If the physician-patient relationship ends, physicians are **advised** to consider whether it would be reasonable to refund a portion of the block fee, considering both the time remaining and the services provided to date.

Using Third Party Companies

21. Physicians using a third party to administer and manage their block fee or payment for uninsured services, **must** ensure that:

a. any communication between the third party and patients identifies the third party by name and indicates they are acting on the physicians behalf; and
b. the third party adheres to the same standards required of physicians, including this policy, other relevant policies, and relevant legislation.

Advice to the Profession: Uninsured Services

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.

Some physician services are not covered by the Ontario Health Insurance Plan (OHIP). These services are often referred to as "uninsured services" and include services such as prescription refills and medical advice over the phone, sick notes for work, the copy and transfer of medical records, immunization for the sole purpose of travel, the completion of insurance and/or medical forms, and a number of medical procedures.

As payment for these services is not subject to the same level of external oversight that is in place for insured services, patients may be particularly vulnerable when paying privately for uninsured services and may be particularly reliant on the honesty and integrity of physicians to ensure that their needs and interests are being put first.

The College's *Uninsured Services: Billing and Block Fees* policy sets out expectations for physicians when billing for uninsured services regardless of practice area or specialty or the types of uninsured services being provided. This advice document is intended to help physicians interpret and understand these expectations to ensure they are effectively discharged.

What services can physicians bill for?

Physicians are not permitted to charge for the provision of insured services, including the constituent elements of an insured service. Examples of constituent elements of insured services include the referral of a patient to a specialist, the administrative processing for a new patient being accepted into a practice, and making arrangements for an appointment.[1]

However, not all physician services are covered by OHIP and physicians are entitled to charge patients or third parties directly for the provision of these uninsured services, unless the government has otherwise agreed to pay them for these services (for example, telemedicine that is provided through the Ontario Telemedicine Network).

For more information regarding which services are insured and which are uninsured, physicians can review Section 24 of the General Regulation enacted under the *Health Insurance Act*, the

[1] For a complete list of the common and specific elements of insured services that are considered to be constituent elements of the insured medical services covered by OHIP, see the preamble to the Schedule of Benefits: Physicians Services under the *Health Insurance Act*.

Schedule of Benefits, and the Ontario Medical Association's *Physician's Guide to Uninsured Services* ("the OMA Guide").

What should physicians charge for uninsured services?

The policy requires that fees for uninsured services, including block fees and fees for appointments that are missed or cancelled without proper notice, be reasonable.

When setting fees, physicians will need to consider both the nature of the service being provided (e.g., sick notes vs. a medical procedure) and their professional costs (e.g., the time involved, whether other staff are involved, etc.). It's important for physicians to be aware that it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided.

The Ontario Medical Association publishes an annual *Physician's Guide to Uninsured Services* which can help physicians set their fees and some specialty associations set out recommended fees as well.

Physicians also need to know that in some instances fees will be set out in law or by order of the Information and Privacy Commissioner.[2]

Finally, physicians may choose to charge patients who miss an appointment or cancel without the required notice, recognizing both the lost opportunity costs to other patients as well as the costs to themselves (e.g., lost opportunity to bill OHIP, or actual costs incurred by the physician). In setting these fees, physicians must consider a variety of factors including what would be reasonable cost recovery for themselves and what would act as a reasonable deterrent for patients.

Why do physicians need to consider their patients ability to pay?

Some patients may experience great difficulty paying for the health care services that they need. Recognition of this fact is embedded in the Canadian Medical Association's Code of Ethics, which states that physicians will need to consider not just the nature of the service being provided, but also the patient's ability to pay when setting their professional fees.[3] The College's expectation is consistent with this position.

[2] See Section 37(5) of the *Workplace Safety and Insurance Act, 1997,* S.O. 1997 c.16, Sched. A and Information and Privacy Commissioner orders HO-009 and HO-14. See as well the College's Medical Records and Third Party Reports policies for further information.

[3] Canadian Medical Association's Code of Ethics #16: "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."

This does not mean, however, that physicians are required to provide uninsured services for free. Rather, the policy requires physicians to give consideration to whether it would be appropriate to reduce, waive, or allow for flexibility based on compassionate grounds. Whether it is appropriate to adjust fees on compassionate grounds will depend on a variety of factors including the nature of the service being provided and the specific financial circumstances of the patient.

For example, physicians may weigh these factors differently depending on whether they are providing elective cosmetic procedures or employer required sick notes, or whether a patient is receiving disability support payments or is gainfully employed.

The policy recognizes that physicians are entitled to charge for the uninsured services they provide, but aims to strike a balance between this entitlement and the reality that some patients will have real difficulty paying for services that they need.

How can physicians assess a patient's ability to pay?

In some practice settings, physicians may naturally become aware of information relevant to a patient's ability to pay during the course of the physician-patient relationship (e.g., occupation, challenges faced, etc.).

Physicians can also invite patients to self-identify as being in financial need if they are at all concerned about being able to pay a fee. This can be done by the physician, through their office staff, or even in any written notice about fees for uninsured services. With this information in hand, physicians can use their professional judgment to determine if it would be appropriate under the circumstances to reduce, waive, or allow for flexibility with respect to the fee.

What should be kept in mind when insured and uninsured services are bundled or offered as alternatives to one another?

Physicians sometimes propose or provide insured and uninsured service together or offer uninsured services as an alternative or adjunct to insured services. These situations are ripe for confusion and patients are particularly reliant on the honesty and integrity of their physicians to ensure their needs and interests are being put first, and that they have clear information about their clinical options and any corresponding fees.

As such, clear communication is essential to these discussions. In these situations physicians must clearly communicate which services or elements of a service are associated with a fee and which are not and must describe the patient's options in a clear and impartial manner.

Physicians also have to be particularly careful to ensure that if their practice structure leads to different wait times for the insured and uninsured services they provide or when insured

services are bundled with uninsured services, that doing so complies with the *Commitment to the Future of Medicare Act, 2004* (*CFMA*). The *CFMA* prohibits physicians from charging or accepting payment or benefit in exchange for preferential access to insured services.

Physicians are encouraged to obtain independent legal advice about their practice structure if they are at all unsure about whether it complies with the *CFMA*.

What happens if a patient accumulates a number of outstanding fees?

Physicians are entitled to seek payment for the uninsured services they provide and can take action to collect any fees that are owed to them. This could include, for example, using office staff to remind patients of any outstanding fees or hiring a collection agency. However, physicians must always pursue payment in a professional manner and must consider whether it would be appropriate to reduce, waive, or allow for flexibility in the amount owed based on compassionate grounds.

Importantly, failure to pay outstanding fees cannot be used as grounds for denying a patient access to insured services. Physicians can, however, use their professional judgment to determine whether to withhold access to additional uninsured services when the patient has an outstanding balance, giving consideration to both the patient's need for those services and their ability to pay the outstanding balance.

In circumstances where patients have refused to pay an outstanding fee, or have accumulated a number of unpaid fees without reasonable justification for non-payment (such as evidence of financial hardship), if physicians are considering ending the physician-patient relationship they must do so in compliance with the expectations set out in the College's *Ending the Physician-Patient Relationship* policy.

What are the benefits of a block fee and when can physicians offer them?

A block fee may be a more convenient and/or economical way for patients to pay for uninsured services, and for physicians to administer fees for these services. Generally speaking, a block fee allows patients to pay a one-time flat fee that covers them for any uninsured services they need throughout a given time period. This also simplifies the processing of fees for physicians as they just need to collect one fee. Physicians are not required to offer a block fee, but may do so if they wish.

However, a block fee may not be appropriate for all practice settings where uninsured services are provided. Whether a block fee is appropriate will depend on a variety of factors including, but not necessarily limited to, the nature of the physician's practice and their specialty. For example, if the anticipated duration of care is a single visit, it is unlikely that a block fee would

be necessary. Additionally, if it is known precisely how many uninsured services a patient will need, this would not align with the definition of a block fee as set out in the *CFMA* which states that at the time of payment it is not possible to know how many services will be needed.

Patients may sometimes be confused about what a block fee is and what it means for their care. For these reasons, the policy sets out a number of expectations for physicians who choose to offer their patients this option, all aiming to help patients make fully informed decisions about how they would like to pay for uninsured services.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Boundary Violations – Draft Policy for Consultation

Date of Meeting: May 31, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Briefing Note

May 2019

TOPIC: Boundary Violations – Draft Policy for Consultation

FOR DECISION

ISSUE:

- The College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy is currently under review.
- A new draft policy entitled *Boundary Violations* has been developed along with a companion document entitled *Advice to the Profession: Maintaining Appropriate Boundaries*. These documents have been drafted in accordance with the Policy Redesign strategy that was approved by Council in December 2018.
- Council is provided with an overview of the policy review process undertaken to-date, as well as the draft policy and advice to the profession document.
- 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.

BACKGROUND:

- The current *Maintaining Boundaries and Preventing Sexual Abuse* policy was last reviewed and approved by Council in 2008, with minor housekeeping amendments made in 2017 and 2018 in order to respond to legislative changes.
- A Working Group was struck to undertake the policy review process. The members of the Working Group are Ms. Lisa McCool-Philbin (Chair of the Working Group), Dr. Carol Leet, Dr. Barbara Lent (non-Council members) and Dr. Peeter Poldre. The Working Group is also supported by Alice Cranker (Legal Counsel) and Dr. Peter Prendergast (Medical Advisor).
- As per the usual policy review processes, a comprehensive literature review[1] was undertaken and a preliminary external consultation[2] on the current policy was held in the

[1] Including a review of scholarly articles, research papers, and an international jurisdictional review.
[2] 40 responses were received to the preliminary consultation (17 written submissions and 23 online surveys). A summary of the feedback received was provided to Council in December 2017 as part of the Policy Report.

fall of 2017. Relevant decisions of the Inquiries, Complaints, and Reports Committee were also reviewed, and feedback was obtained from the College's Physician and Public Advisory Service (PPAS), the Patient Relations Committee, and the Western Boundaries Course Program Director.

- Specific findings and themes that emerged from the research and feedback are provided where relevant below, as key additions and revisions are outlined.

CURRENT STATUS:

- In response to the research and feedback provided, and in keeping with the policy redesign strategy, the Working Group has developed a draft *Boundary Violations* policy (**Appendix A**) and a draft *Advice to the Profession: Maintaining Appropriate Boundaries* companion document (**Appendix B)**.

A. Draft Boundary Violations Policy

- The draft policy maintains the expectations set out in the current policy; however, a few clarifications and additions have been made. The policy has also been re-organized and new headings have been added to make it clearer and easier for physicians to find the specific expectations for each issue.

Definitions

- In response to feedback, including from PPAS and the Western Boundaries Course Program Director, a comprehensive definitions section was added to help clarify the meaning of the following terms: boundary, boundary violations, patient and sexual abuse.

Sexual Relations with Patients after the Physician-Patient Relationship has Ended

- The current policy states that when the physician-patient relationship involves a significant component of psychotherapy, sexual relations with the patient is likely inappropriate at any time after termination. It does not set out a specific time period.

- The draft policy has been revised to reflect the substance of the College's proposed regulation (approved by Council in May 2018) that would extend the period of time for a provider-patient relationship to 5 years after the individual ceased to be the physician's patient in those instances where psychotherapy that is more than minor or insubstantial has been provided.

- Similarly, the College of Registered Psychotherapists of Ontario approved a policy in June 2018 which prohibits sexual contact between psychotherapists and former clients for a period of 5 years.

Third Parties

- The current policy's expectation that physicians "should" give patients the option of having a third party present for intimate examinations was updated to a "must" in order to align with current drafting conventions.

- In response to feedback from the Ontario Medical Association (OMA) and the OMA Section on General and Family Practice, a revision was made to allow physicians to refuse to perform an intimate examination if a third party is not available or the patient refuses to have a third party present. The draft policy also notes that the physician must provide patients with options when an examination is refused by either party.

Non-Sexual Boundaries

- The current policy does not set out expectations regarding non-sexual boundary violations. The draft policy has been revised to addresses this issue, setting out expectations related to social and financial/business relationships between physicians and patients.

- While the small amount of online survey feedback received was generally unsupportive of this addition, PPAS and the Western Boundaries Course Program Director suggested there would be value in doing so. In particular, the Program Director noted that there has been a recent shift, with many participants in the program having been involved in non-sexual boundary issues. The Working Group ultimately felt this was an important revision to make and was consistent with other medical regulators.

Guidelines

- The guidelines on maintaining proper boundaries in the current policy have been reviewed and where appropriate incorporated into the draft policy as requirements for physicians. Examples include: showing sensitivity and respect for a patient's privacy and comfort, explaining the reason for an examination, using proper examination techniques, etc. This revision is consistent with online survey feedback, which was supportive of these guidelines.

B. Draft Advice to the Profession: Maintaining Appropriate Boundaries

- The draft *Advice to the Profession: Maintaining Appropriate Boundaries* companion document does not set out any new expectations for physician conduct. Rather it provides additional information, rationale, and answers to frequently asked questions.

- While this document is provided for Council's review and input and will be distributed as part of the consultation in order to solicit feedback on the draft, it 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.

- In particular, the draft advice document repurposes existing contextual content from the current policy, including: the power imbalance inherent in the physician-patient relationship, reasons why it is not appropriate to have sexual relations with patients after the physician-patient relationship has ended, etc.

- The draft advice document also includes answers to frequently asked questions that were identified in the consultation feedback or by the Working Group including, the use of third parties and issues that arise in small communities.

- A resources section is also included and provides additional guidance for physicians with respect to maintaining appropriate boundaries and avoiding sexual abuse complaints.

NEXT STEPS:

- Subject to Council's approval, a consultation on the draft policy will be held following the May 2019 Council Meeting. The companion advice document, being a communications tool and therefore not requiring formal approval, will accompany the draft policy as part of the consultation.

- Feedback received through the consultation will be shared with the Executive Committee and Council in the fall of 2019.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft
    a. *Boundary Violations* policy?
    b. *Advice to the Profession: Maintaining Appropriate Boundaries* document?

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

Contact: Lynn Kirshin, Ext. 243
Date: May 10, 2019

Attachments:
Appendix A: Draft Boundary Violations Policy
Appendix B: Draft Advice to the Profession: Maintaining Appropriate Boundaries

Boundary Violations

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

Boundary: defines the limit of a safe and effective professional relationship between a physician and a patient. There are both sexual boundaries and non-sexual boundaries within a physician-patient relationship.

Boundary Violation: occurs when a physician does not establish and maintain the limits of a professional relationship with their patient. There are sexual boundary violations and non-sexual boundary violations.

Patient: In general, a factual inquiry must be made to determine whether a physician-patient relationship exists, and when it ends. The longer the physician-patient relationship and the more dependency involved, the longer the relationship will endure.

However, for the purposes of the sexual abuse provisions of the *Health Professions Procedural Code* (*HPPC*), a person is a physician's patient if there is direct interaction and **any** of the following conditions are met:

- the physician has charged or received payment from the person (or a third party on behalf of the person) for a health care service provided by the physician,
- the physician has contributed to a health record or file for the person,
- the person has consented to the health care service recommended by the physician, or
- the physician prescribed the person a drug for which a prescription is needed.[1,2]

[1] O. Reg. 260/18 under the *Regulated Health Professions Act, 1991,* S.O. 1001, c.18 (*RHPA*).

[2] A person is not a physician's patient if **all** of the following conditions are met:

- There is a sexual relationship between the person and the physician at the time the health care service is provided to the person;
- The health care service provided by the physician to the person was done due to an emergency or was minor in nature; and
- The physician has taken reasonable steps to transfer the person's care, or there is no reasonable opportunity to transfer care. (O. Reg. 260/18 under the *RHPA*)

In addition, for the purposes of the sexual abuse provisions of the *HPPC*, the physician-patient relationship endures for one year from the date on which the person ceased to be the physician's patient.[3]

Sexual Abuse: The *HPPC* defines sexual abuse as follows:

- sexual intercourse or other forms of physical sexual relations between a physician and their patient;
- touching, of a sexual nature, of a patient by their physician; or
- behaviour or remarks of a sexual nature by a physician towards their patient. [4]

Policy

1. Physicians **must** establish and maintain appropriate boundaries with their patients.

Sexual Boundary Violations

2. Physicians **must not** engage in sexual relations with a patient, touch a patient in a sexual manner or engage in behaviour or make remarks of a sexual nature towards a patient.[5]

3. To help ensure sexual boundaries are maintained and that sexual boundary violations do not occur, physicians **must**:

    a. **Not** make any sexual comments or advances towards a patient.
    b. **Not** respond sexually to any form of sexual advance made by a patient.
    c. Explain to patients in advance, the scope and rationale of any examination, treatment or procedure.
    d. Only touch a patient's breasts, genitals or anus when it is medically necessary, and use appropriate examination techniques when doing so.
    e. Use gloves when performing pelvic, genital, urinary, perineal, perianal, or rectal examinations.
    f. Show sensitivity and respect for a patient's privacy and comfort by:

        i. Providing privacy when patients dress or undress.
        ii. Providing patients with a gown or drape during the physical examination or procedure if clothing needs to be removed, and only exposing the area specifically related to the physical examination or procedure.

[3] Section 1(6) of the *HPPC*, Schedule 2, to the *RHPA*.

[4] Touching, behaviour or remarks of a clinical nature appropriate to the service provided do not constitute sexual abuse (Subsections 1(3) and (4) of the *HPPC*). It is an act of professional misconduct for a physician to sexually abuse a patient (Section 51(1), paragraph (b.1) of the *HPPC).*

[5] Such activity constitutes sexual abuse under the *HPPC*.

iii. Ensuring that the gown or draping adequately covers the area of the patient's body that is not actively under examination.
iv. During an examination, only assisting patients with the adjustment or removal of clothing or draping if the patient agrees or requests the physician to do so.

g. **Not** ask or make comments about a patient's sexual history, behaviour or performance except where the information is relevant to the provision of care.
h. **Not** make any comments regarding their own sex life, sexual preferences or fantasies.
i. **Not** socialize or communicate with a patient for the purpose of pursuing a sexual relationship.
j. Use their professional judgment when using touch for comforting purposes. Supportive words or discussion may be preferable to avoid misinterpretation.

Third Party Attendance at Intimate Examinations

4. When performing intimate examinations[6], physicians **must** explain the indication for the examination and consider the patient's comfort at all times. In doing so, physicians **must** give patients the option of having a third party present during an intimate examination, including bringing their own third party if the physician does not have one.

5. If a patient requests a third party, physicians **must** provide one if available.

6. If no third party is available or if there is no agreement on whom the third party should be and the examination is non-emergent, physicians **must** suggest the following options to the patient:
    a. either the physician or the patient may withdraw from the examination until a mutually acceptable third party is available and the examination can be rescheduled, or
    b. where possible the physician can refer the patient to another physician who has a third party available for the examination.

Sexual Relations after the Physician-Patient Relationship has Ended

7. If physicians engage in sexual relations with a patient or engage in sexual behaviour or make remarks of a sexual nature towards their patient within one year after the date upon which the individual ceased to be the physician's patient, this will constitute sexual abuse under the *HPPC*.[7] Therefore, physicians **must not** engage in sexual relations with a patient or engage in sexual behaviour or make remarks of a sexual nature towards their patient during this time period.

[6] Intimate exam includes breast, pelvic, genital, urinary, perineal, perianal and rectal examinations of patients.
[7] Subsections 1(3) and (6) of the *HPPC*, Schedule 2, to the *RHPA*. The *HPPC* provides for mandatory revocation for specific acts of sexual abuse including sexual intercourse. For a complete list, see *Advice to the Profession: Maintaining Appropriate Boundaries*.

8. Where the treatment provided by the member involved psychotherapy that is more than minor or insubstantial a physician **must not** engage in sexual relations or engage in sexual behaviour or make remarks of a sexual nature towards their patient for a minimum of five years after the date upon which the individual ceased to be the physician's patient.[8]

9. Even after the one or five year time period has passed, it may still be inappropriate for a physician to engage in sexual relations with a former patient.[9] Prior to engaging in sexual relations with a former patient, a physician **must** consider the following factors:

- the length and intensity of the former professional relationship,
- the nature of the patient's clinical problem,
- the type of clinical care provided by the physician,
- the extent to which the patient has confided personal or private information to the physician, and
- the vulnerability the patient had in the physician-patient relationship.

Sexual Relations between Physicians and Persons Closely Associated with Patients[10]

10. It may be inappropriate for a physician to engage in sexual relations with a person closely associated with a patient. The College may find that this behaviour constitutes professional misconduct.[11] Prior to engaging in sexual relations with a person closely associated with a patient, a physician **must** consider the following factors:

- the nature of the patient's clinical problem,
- the type of clinical care provided by the physician,
- the length and intensity of the professional relationship between the physician and the patient,
- the degree of emotional dependence the individual associated with the patient has on the physician, and

[8] Physicians may be found to have committed disgraceful, dishonourable or unprofessional conduct if they engage in sexual relations with a patient in these circumstances. The Courts have found that certain physician-patient relationships may endure subsequent to the end of the formal relationship, for example, in the case of a long-standing psychotherapeutic relationship.

[9] See footnote 8.

[10] Individuals who possess one or more of the following features:

- They are responsible for the patient's welfare and hold decision-making power on behalf of the patient.
- They are emotionally close to the patient. Their participation in the clinical encounter, more often than not, matters a great deal to the patient.
- The physician interacts and communicates with them about the patient's condition on a regular basis, and is in a position to offer information, advice and emotional support.

Examples of such individuals include but are not limited to: patients' spouses or partners, parents, guardians, substitute decision-makers and persons who hold powers of attorney for personal care.

[11] Allegations of professional misconduct could be made under the following grounds: act or omission relevant to the practice of medicine that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and/or conduct unbecoming a physician (Section 1(1), paragraphs 33 and 34 of the *Medicine Act, Professional Misconduct Regulation).*

- the degree to which the patient is reliant on the person closely associated with them.

Mandatory Duty to Report Sexual Abuse[12]

11. Physicians must comply with the reporting requirements of the *HPPC*.

    a. Physicians **must** report if they have reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different regulated health college has sexually abused a patient.

    b. Physicians or others who operate a facility **must** report if they have reasonable grounds to believe that a member of a regulated health college practising in the facility has sexually abused a patient.

Non-Sexual Boundary Violations

12. Physicians **must not** exploit the power imbalance inherent in the physician-patient relationship.

13. Physicians' obligations to establish and maintain appropriate boundaries with patients are not limited to sexual interactions. Physicians **must** establish and maintain appropriate boundaries with patients at all times, including with respect to social or financial/business matters.

14. Physicians **must** consider the impact on the physician-patient relationship and on others in their practice when engaging with a patient in a non-clinical context (social or financial/business relationships).

For further information about maintaining appropriate boundaries, please see the Advice to the Profession: Maintaining Appropriate Boundaries document (link to document will be provided).

[12] Sections 85.1 to 85.6 of the *HPPC*. Reports must be in writing to the Registrar of the College to whom the alleged abuser belongs.

Advice to the Profession: Maintaining Appropriate Boundaries

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 physician-patient relationship is dependent upon **trust**. When a patient seeks care from a physician, the patient must trust that the physician will treat them in a professional manner.

There is an inherent power imbalance within this relationship which is a result of a number of factors:

- A patient depends on the physician's knowledge and training to help them with their health issues.
- A patient shares highly personal information with the physician that they rarely share with others.
- The clinical situation often requires that the physician conduct physical examinations that are of a sensitive nature.
- A patient's vulnerability is heightened when they are unwell, worried or undressed.

As such, a physician must only act in the patient's best interests and must take responsibility for establishing and maintaining boundaries within a physician-patient relationship.

The College has developed this document and the *Boundary Violations* policy to provide expectations and guidance to physicians regarding boundary violations and to help physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991* (*RHPA*) regarding sexual abuse.

Frequently Asked Questions about Sexual Boundary Violations

What if my patient agrees to or initiates a sexual relationship?

The physician-patient relationship is not equal – there is a power imbalance as described above. Even if a patient has agreed to a sexual relationship; the sexual contact will still be considered sexual abuse under the *RHPA*.

What is the difference between a boundary crossing and a boundary violation?

While the *Boundary Violations* policy sets out firm expectations about boundary violations, boundaries can also be crossed. Boundary crossings are minor deviations from traditional therapeutic activity that are non-exploitative and may even appear to help the therapeutic relationship. For example, accepting a small gift from a patient or holding of the hand of a grieving patient. While these actions may be well-intentioned, it is important for physicians to consider what these actions can mean and their impact on the physician-patient relationship or on other patients in their practice. Repeated boundary crossings, though not necessarily boundary violations themselves, may lead to boundary violations.

Boundary violations, on the other hand, occur when a physician does not maintain the professional limits of a physician-patient relationship and depending on the type of boundary violation can be detrimental to the physician-patient relationship and cause patients harm.

What if I am not able to provide a third party for my patient?

The *Boundary Violations* policy outlines what the College expects of a physician who is not able to provide a third party for their patient when conducting an intimate examination.

A physician may want to consider informing patients (through their administrative staff or themselves) when booking appointments that they are not able to offer a third party, but if the patient would like they may bring their own third party to the appointment.

What should I document in relation to third parties?

A physician is advised to document in the patient's record if a third party is present for the examination or if a third party has been offered by the physician and declined by the patient.

How can I provide privacy for my patients?

As stated in the *Boundary Violations* policy, physicians must provide privacy when a patient undresses and dresses. This can be achieved by having an appropriate place for a patient to undress and dress out of view of anyone, including the physician. For example, a separate examination room outside of which the physician can remain while a patient is changing or a

suitable curtain between the physician and the patient. Merely turning around and facing away from a patient without a curtain is not acceptable.

Why might it not be appropriate for a physician to have sexual relations with a patient even after the physician-patient relationship has ended?

At all times, a physician has an ethical obligation not to exploit the trust, knowledge and dependence that develops during the physician-patient relationship for the physician's personal advantage. This dependence does not disappear once the physician-patient relationship has ended – the power imbalance can persist after a person ceases to be a physician's patient.

As such, for the purposes of sexual abuse, the law treats the physician-patient relationship as continuing one year past the last physician-patient encounter. It is also the College's position that if psychotherapy that is more than minor or insubstantial was provided by a physician, that physician must not engage in a sexual relations with a patient for at least five years after the date of the last physician-patient encounter.

Prior to engaging in sexual contact, physicians are advised to verify that they have not provided treatment to the individual within the prior year or the previous five year period if they have provided psychotherapy to the individual. Even after these time periods have elapsed, sexual relations may be considered professional misconduct.

A physician who is considering having sexual relations with a former patient must use their professional judgment, acting cautiously as they consider the potentially complex issues relating to trust, power dynamics and any transference concerns. As well, it is important for a physician to ensure that the former patient has a good understanding of the dynamics of the physician-patient relationship and the boundaries applicable to that relationship.

Where a physician is in doubt as to whether the physician-patient relationship has ended, they should refrain from any relationship with the patient until they seek advice, for example, from legal counsel.

Why might it not be appropriate for a physician have a sexual relationship with a person closely associated with a patient?

Sexual relations between physicians and individuals who are closely associated with a physician's patients may also raise concerns about breach of trust and power imbalance and may be considered professional misconduct.

In addition to the risk of exploitation, sexual relations between a physician and a person closely associated with a patient can detract from the goal of furthering the patient's best interests. It has the potential of affecting the objectivity of the physician's and the closely associated person's decisions with respect to the health care provided to the patient.

What are the consequences for sexually abusing a patient?

In some instances, physicians who are found to have sexually abused a patient will have their certificate of registration revoked and they cannot reapply for a period of 5 years. When a certificate is revoked, the physician cannot engage in the practice of medicine.

These instances include the following:

- sexual intercourse;
- genital to genital, genital to anal, oral to genital, or oral to anal contact;
- masturbation of the member by, or in the presence of, the patient; masturbation of the patient by the member; encouraging the patient to masturbate in the presence of the member; or
- touching of a sexual nature of the patient's genitals, anus, breast or buttocks.[1]

A physician's certificate of registration will also be revoked in the following situations:

- when the physician has been found guilty of professional misconduct by the governing body of another health profession in Ontario, or by the governing body of a health profession in a jurisdiction other than Ontario; and
- the misconduct includes or consists of the specific acts of sexual abuse described above.[2]

If a physician's certificate is revoked because they were found to have sexually abused a patient, that physician cannot reapply for a new certificate until five years after the date their certificate of registration was revoked.[3]

In all other instances of sexual abuse, the Discipline Committee is required to, at a minimum, reprimand the physician and order a suspension of their certificate of registration. In these instances, the Committee has the power to order revocation of the physician's certificate, although such revocation is not mandatory.[4] The Committee also has the power to order terms,

[1] Section 51(5) of the *HPPC*.
[2] Section 51(5.2) of the *HPPC*.
[3] Section 72(3) of the *HPPC*.
[4] Section 51(5), paragraph 2 of the *HPPC*.

conditions and limitations on the physician's certificate of registration and to require the physician to reimburse the College for funding for therapy and counselling that was provided to the patient.[5]

Frequently Asked Questions about Non-Sexual Boundary Violations

How do non-sexual boundary violations impact the physician-patient relationship?

Non-sexual boundary violations can occur when a physician has a social relationship and/or a financial/business relationship with a patient.

It is important for physicians to be aware of the increased risk associated with managing a dual relationship with a patient, including the potential for compromised professional judgment and/or unreasonable patient expectations. The following activities *may* have the potential to cause harm particularly when the physician uses the knowledge and trust gained from the physician-patient relationship.

Social relationships can include the following activities:

- Giving or receiving inappropriate or elaborate gifts;
- Asking patients directly, or searching other sources, for private information that has no relevance to the clinical issue;
- Asking patients to join faith communities or personal causes; or
- Engaging in leisure activities with a patient.

Financial/business relationships can include the following activities:

- Lending to/Borrowing money from patients,
- Entering into a business relationship with a patient, or
- Soliciting patients to make donations to charities or political parties.

What should I do when my patients are part of my social network?

Living and working in a small community increases the likelihood that a physician will be invited to, or engaged in, social events and activities with patients. A similar scenario can occur, for example, when a physician and patients belong to the same ethnic group or religious faith and attends the same social or religious events.

[5] Section 52 (2) of the *HPPC*.

As set out in the answer above, physicians need to be aware of the increased risk associated with managing a dual relationship with a patient.

The College's Physician Treatment of Self, Family Members, or Others Close to Them policy also contains important information with respect to this issue.

Resources

The information below provides additional guidance for physicians with respect to maintaining appropriate boundaries and avoiding sexual abuse complaints.

Dialogue Articles

Dialogue, the College's quarterly publication for members, regularly addresses themes or issues relating to boundary violations, including sexual abuse. While some expectations may have changed since these articles were published, they contain helpful advice. Some examples are linked below:

- Practice Points, Issue 4 2018
- Bill 87 – Protecting Patients Act, Issue 1, 2017
- Mandatory Reporting for Sexual Abuse, Issue 4, 2016

Discipline Committee Findings

Past findings of the College's Discipline Committee can also be instructive as to what behaviours have resulted in findings of sexual abuse and/or disgraceful, dishonourable or unprofessional conduct.

The lists below are not exhaustive and the Discipline Committee would examine the facts of a specific case to see whether the conduct amounts sexual abuse or disgraceful, dishonourable or unprofessional conduct.

The Discipline Committee has made findings of sexual abuse in situations which include the following conduct:

- Remarks of a sexual nature to a patient including comments sexualizing the patient's appearance where there is no therapeutic value in the remarks,
- Stroking a patient's buttocks as they were leaving an appointment,
- Sexual touching while the patient was under anesthetic, and

- Kissing a patient.

Additionally, the Discipline Committee has determined that the following types of behaviour amounted to disgraceful, dishonourable or unprofessional conduct.

- Borrowing money from a patient;
- When providing counselling: hugging and providing a kiss on the cheek, meeting outside of the office on three occasions including at a restaurant;
- Failing to provide adequate explanation and obtaining informed consent prior to and during a sensitive examination
- Failing to provide adequate coverage for an examination resulting in unwanted exposure;
- Repeated, unwanted touching of nursing colleagues; and
- Engaging in a sexual relationship with a patient too soon after the termination of the doctor-patient relationship.

CPSO's Professionalism and Practice Program

How a doctor delivers care is just as important as the care provided. To that end, the CPSO has partnered with medical schools across Ontario to develop modules on key professionalism topics. These modules include PowerPoint presentations, and case studies ground in real life issues and trends seen by the CPSO. They are also grounded in relevant frameworks, such as CanMEDs. We encourage medical students — and anyone else interested in medical professionalism —to visit the Professionalism and Practice area on our website and to download the Boundaries and Sexual Abuse Module.

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 boundary issues. However, the CMPA has a number of resources on the issues generally that physicians may find helpful.

For example:

Recognizing Boundary Issues

Is it Time to Rethink Your Use of Chaperones?

Rural Practice – Strategies to Reduce Medico Legal Risk

Good Practice Guide: Respecting Boundaries

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Disclosure of Harm – Draft Policy for Consultation

Date of Meeting: May 31, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Briefing Note

May 2019

TOPIC: Disclosure of Harm – Draft Policy for Consultation

FOR DECISION

ISSUE:

- The College's *Disclosure of Harm* policy is currently under review.
- A new draft policy entitled *Disclosure of Harm* has been developed, along with a companion document entitled *Advice to the Profession: Disclosure of Harm*. These documents have been drafted in accordance with the Policy Redesign strategy approved by Council in December 2018.
- Council is provided with an overview of the policy review process undertaken to date, as well as the draft policy and advice document.
- Council is asked to approve the draft policy for external consultation. The advice document will accompany the draft policy as part of the consultation process.

BACKGROUND:

- The current *Disclosure of Harm* policy was approved by Council in 2010. The current review launched in mid-2018 and is supported by Dr. Angela Carol (Medical Advisor) and Carolyn Silver (Legal Counsel).
- Per the usual policy review process, a preliminary consultation on the current policy was held in fall 2018.[1] A literature review of scholarly articles and research papers, as well as a jurisdictional review of medical regulatory authorities, was also completed.
- Relevant statistical information regarding matters before the Inquiries, Complaints, and Reports Committee were also reviewed and feedback on the current policy was obtained from the College's Public and Physician Advisory Service.

[1] 63 responses were received to the preliminary consultation (5 through the online discussion page, 4 via email, and 54 via online survey). An overview of the feedback was provided to Council in December 2017 as part of the Policy Report.

- Relevant findings and themes that emerged from the research and feedback are provided below, as key additions and revisions are outlined.

CURRENT STATUS:

- A draft *Disclosure of Harm* policy (**Appendix A**) and *Advice to the Profession: Disclosure of Harm* companion document (**Appendix B**) have been developed in response to the research and consultation feedback, and in keeping with the Policy Redesign strategy.

A. Draft *Disclosure of Harm* Policy

- The draft policy generally maintains the expectations set out in the current policy, though clarifications have been made to reflect current terminology in the area of patient safety and disclosure. The policy has also been re-organized and new headings have been added to make it clearer and easier for physicians to find the specific expectations for each issue.

Definitions and obligation to disclose

- In response to feedback, the draft policy incorporates terminology that aligns with the World Health Organization (WHO)'s *Conceptual Framework for the International Classification of Patient Safety*.

- The draft policy also provides definitions for the aligned terminology, including "harm", "harmful incident", "no harm incident", and "near miss incident".

- As a result, the disclosure expectations in the draft policy have been reframed to align with the three categories of harm or potential harm to patients, in accordance with the WHO framework: harmful incident, no harm incident, and near miss incident.

    - The current policy requires disclosure of "an unintended outcome arising during the course of treatment, which may be reasonably expected to negatively affect a patient's health and/or quality of life."

    - Feedback from the consultation, including from the Ontario Medical Association (OMA), suggested that this definition is unclear and inconsistent with current terminology around patient safety and disclosure.

To whom to disclose

- In response to feedback from the Information and Privacy Commissioner, the draft policy now includes an expectation regarding disclosure where a patient has died and there is no estate trustee, which aligns with the parallel requirement regarding disclosure of critical incidents in Regulation 965 under the *Public Hospitals Act*.

What to disclose

- The current policy sets out what information must be disclosed, which is intended to align with the parallel requirement regarding disclosure of critical incidents in Regulation 965. The draft policy has been updated to address revisions to the Regulation made in 2016.

- The draft policy also includes a new expectation that requires physicians to consider whether an apology is appropriate in the circumstances. This new expectation reflects online survey feedback, as well as best practices identified by the literature review.

Who must disclose

- The current policy notes that where care is provided by a team, it is acceptable for one provider to disclose on behalf of the team, though each physician involved in the care has a responsibility to ensure that disclosure occurs. While the spirit of this expectation is maintained, the draft policy shifts the onus for ensuring disclosure onto the Most Responsible Physician (MRP), to clarify and streamline this responsibility.

Postgraduate learners

- The current policy advises postgraduate learners to maintain active involvement in the disclosure process, as appropriate, in the interest of professionalism and training. While the spirit of this expectation is maintained, the draft policy shifts the onus onto the MRP to facilitate this opportunity, where appropriate, reflecting the realities of the MRP-learner dynamic.

Subsequent physicians

- The draft policy maintains the current expectation of subsequent physicians, but removes reference to "non-treating physicians" to eliminate redundancy.

- In response to OMA feedback, the draft policy also includes a new expectation that subsequent physicians disclose, to the extent they can, incidents where the previous physician is no longer available. The current policy is silent on this issue.

B. Draft *Advice to the Profession: Disclosure of Harm* Document

- The draft *Advice to the Profession* document does not set out any new expectations for physician conduct. Rather, it provides information to help physicians interpret and understand their disclosure obligations.

- While this document is provided for Council's review and input, and will be distributed as part of the general consultation to solicit feedback on the draft, it 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.

- In particular, the draft advice document repurposes existing contextual content from the current policy that was identified during the preliminary consultation as useful to physicians. This includes the principles underlying disclosure expectations, timing of disclosure obligations, role and value of apologies, and content under "Additional tips".

- The document also adds some new content, such as the examples of the types of incident that must be disclosed under the policy. This was added in response to feedback received during the consultation.

NEXT STEPS:

- Subject to Council's approval, a consultation on the draft policy will be held following the May 2019 Council Meeting. The companion advice document, as a communications tool not requiring formal approval, will accompany the draft policy as part of the consultation.

- Feedback received through the consultation will be shared with Council in the fall of 2019.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the draft
    a. *Disclosure of Harm* policy?
    b. *Advice to the Profession: Disclosure of Harm* document?

2. Does Council recommend that the draft *Disclosure of Harm* policy be released for external consultation?

Contact: Heather Webb, ext. 753
Date: May 10, 2019

Attachments:

Appendix A: Draft *Disclosure of Harm* Policy
Appendix B: Draft *Advice to the Profession: Disclosure of Harm*

Appendix A

Disclosure of Harm

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

Disclosure: the acknowledgement and discussion of harm or potential harm with the patient, substitute decision-maker, and/or estate trustee, as the case may be.

Harm: an outcome that negatively affects a patient's health and/or quality of life.

Harmful incident: an incident that has resulted in harm to the patient (also known as an "adverse event").

No harm incident: an incident with the potential for harm that reached the patient, but no discernible harm has resulted.

Near miss incident: an incident with the potential for harm that did not reach the patient due to timely intervention or good fortune (also known as a "close call").

Policy

Obligation to disclose[1]

1. Physicians **must** ensure that harmful incidents are disclosed.[2]

2. Physicians **must** ensure that no harm incidents are disclosed.

3. Physicians **must** consider whether to disclose near miss incidents, taking into account whether:

    a. a reasonable person in the patient's position would want to know about the incident; and

[1] For further information regarding the conduct of effective disclosure discussions, physicians may wish to consult the CMPA's *Disclosing harm from healthcare delivery: Open and honest communication with patients*.

[2] Physicians who work in hospitals or other health care facilities may be subject to additional disclosure requirements as established by their particular institution, as well as the requirements of Regulation 965, made under the *Public Hospitals Act*, relating to the disclosure of "critical incidents."

b. the patient is aware of the incident and an explanation will reduce concern and promote trust.

To whom to disclose

4. Physicians **must** disclose directly to the patient or, where the patient is incapable with respect to the treatment, to the patient's substitute decision-maker.

5. If the patient has died, the physician **must** disclose to the patient's estate trustee (or, if there is no estate trustee, the person who has assumed responsibility for the administration of the patient's estate) and to the substitute decision-maker, if any.

When to disclose

6. Physicians **must** disclose as soon as is possible after the incident occurs.

7. Disclosure is an ongoing obligation, and physicians **must** disclose additional relevant information as it becomes available over time.

What to disclose

8. As part of disclosure, physicians **must** communicate the following information:

   a. the facts of what occurred and a description of the cause(s) of the incident;
   b. any consequences for the patient, as they become known;
   c. actions that have already been taken and those that are recommended to address any actual or potential consequences to the patient, including options for follow-up care; and
   d. actions being taken, if any, to avoid or reduce the risk of the incident recurring.

9. Physicians **must** consider whether an apology is appropriate, taking into consideration the nature of the incident and the consequences of the incident for the patient.[3]

Who must disclose

10. Where the incident has occurred during the course of care delivered by a sole physician, that physician **must** disclose.

11. Where the incident has occurred during the course of team-based care, the Most Responsible Physician (MRP)[4] **must** determine, in conjunction with the health care team, who is in the most appropriate position to disclose.

    a. Regardless of which team member discloses, the MRP **must** ensure that disclosure occurs.

[3] See *Advice to the Profession: Disclosure of Harm* [hyperlink] for further information regarding apologies.
[4] The MRP is the physician who has final accountability for the medical care of a patient when the trainee is providing care.

Appendix A

12. Physicians **must** use their professional judgment in determining whether to include in the disclosure, as appropriate, other health care providers involved in the patient's care, someone trained in the disclosure process, and/or someone with particular expertise in the patient's condition.

Postgraduate learners

13. Postgraduate learners **must** inform the MRP and their clinical preceptor of any incident that requires disclosure.

14. In the interest of professionalism and ongoing education, MRPs **must** encourage the postgraduate learners' active involvement in the disclosure process, as appropriate in the circumstances.

Subsequent physicians

15. Where subsequent physicians have reason to believe that an incident warranting disclosure has not in fact been disclosed, they **must** discuss the matter with the previous physician and ensure that disclosure takes place.

16. If the previous physician is unavailable (for example, due to retirement or death), the subsequent physician **must** disclose, to the extent that they have the appropriate knowledge about the incident to do so.

Documentation

17. Physicians **must** record the facts of what occurred and a description of the cause(s) of the incident, as well as all disclosure discussions, in the patient's medical record.

Appendix B

Advice to the Profession: Disclosure of Harm

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.

Despite the best efforts of health professionals, the delivery of medical care can sometimes result in unexpected outcomes and expose a patient to harm or potential harm. Harm is not always preventable, nor is it necessarily an indicator of substandard care, but its impact can deeply affect patients and their families.

Physicians may also be significantly impacted when their patients experience negative health care outcomes. Physicians sometimes feel ill-equipped to disclose and discuss the harm that has occurred with patients and families, and may also struggle to find the support they need to conduct these conversations effectively.[1]

This document is intended to help physicians interpret their disclosure obligations as set out in the *Disclosure of Harm* [hyperlink] policy and provide guidance around how these obligations may be effectively discharged.

Why disclose? Legal and ethical imperatives

Physicians have a legal duty to disclose errors made in the course of medical treatment. The courts have also found that where a medical error is not fully disclosed, the non-disclosure can negate the patient's ability to provide valid consent for subsequent treatment.[2]

The professional expectations set out in the policy build upon these legal obligations. The expectations reflect the underlying principle that full disclosure helps foster openness, transparency, and good communication in the delivery of medical treatment. These are integral to promoting patient autonomy and maintaining trust, both in the physician-patient relationship and the medical profession generally.

Physicians and other health care practitioners may often feel that disclosure may decrease trust in the profession and increase the likelihood of litigation. However, the opposite appears to be the case:

[1] Canadian Patient Safety Institute, *Canadian Disclosure Guidelines: Being Open with Patients and Families* (2011) p. 16.

[2] *Gerula v. Flores*, 1995 CanLII 1096 (ONCA). Physicians who work in hospitals or other health care facilities may be subject to additional disclosure requirements as established by their particular institution, as well as the requirements of Regulation 965, made under the *Public Hospitals Act*, relating to the disclosure of "critical incidents."

research suggests that an open, honest disclosure discussion – including an apology, where appropriate – can have a positive impact on patient trust and reduce the risk of litigation.[3]

Finally, on a practical level, disclosure can help physicians and health care institutions prevent future incidents, thereby improving overall quality of care and patient safety outcomes. Disclosure also ensures that the patient can access, and make informed decisions about, timely and appropriate interventions that may be required as a result of an unexpected health care outcome.

What incidents must be disclosed?

In considering what kinds of incidents must be disclosed, remember that the purpose of disclosure is not to attribute blame. Rather, disclosure aims to provide patients with a full understanding of all aspects of their health care, as well as the information they need to make autonomous, informed medical decisions.

Harm to patients may arise in a number of ways, including through:

- the natural progression of the patient's medical condition;
- a recognized risk inherent to the investigation or treatment; and
- events or circumstances, such as individual or systemic failures, that resulted in unnecessary harm to the patient (also known as "patient safety incidents").

While harm can occur in many ways, the policy expectations and this advice document are primarily meant to help physicians navigate disclosure discussions in situations where something has gone wrong with a patient's care, rather than situations where the patient's condition worsens due to a progressive illness.

1) Harmful incidents

A "harmful incident" is an incident that led to patient harm. Patients expect, and are entitled to know about, any harm they have experienced. Physicians must disclose *all* incidents that have resulted in harm to the patient, no matter the cause. These situations are also sometimes known as "adverse events."

2) *No harm incidents*

A "no harm incident" is a situation where an incident with the potential for harm has reached the patient, even though the patient has not experienced any immediate or discernible harmful effects. For example:

- A patient is mistakenly administered the wrong vaccine or an expired vaccine.

[3] Gerald B. Robertson and Justice Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th Ed. (2017), p. 263; American Academic of Pediatrics, "Policy Statement: Disclosure of Adverse Events in Pediatrics" (December 2016) *Pediatrics*, 138:6.

- A patient with a known allergy to penicillin is administered penicillin, but there is no allergic reaction.

No harm incidents must also be disclosed to patients in order to promote the principles of honesty and respect for patient autonomy in health care, as well as the physician's duty to act in the patient's best interests. Where a potentially harmful incident has reached a patient, there must be certainty about whether harm has occurred, and this certainty can only be achieved by discussing the incident with the patient. Acknowledgment of the incident will also allow the patient, family, and health care team to monitor and potentially intervene to prevent potential future harm.

Moreover, disclosure may be necessary to the informed consent process to ensure that the patient can make fully informed decisions with respect to any subsequent treatment.

3) *Near miss incidents*

A "near miss incident" is a potentially harmful incident that did not touch the patient due to timely intervention or good fortune. These are also known as "close calls." For example:

- The wrong unit of blood was being connected to a patient's intravenous line, but the error was detected before the infusion began.
- A medication error is made but is caught by the pharmacist prior to dispensing to the patient.

Physicians must consider whether a near miss needs to be disclosed to the patient, using their professional judgment in the specific clinical context, taking into account the factors set out in the policy.

Disclosure as an ongoing obligation

Disclosure is an ongoing obligation, which means that physicians must disclose relevant information on a timely basis. As required by the policy, the initial disclosure must occur as soon as possible, with additional information being disclosed as it becomes available.

Full disclosure may therefore require a series of discussions, depending on the nature and complexity of the incident, and taking into account the time it could take for harm to develop following the incident.

The nature of the information disclosed will depend on how much time has passed since the incident occurred, the stage of the investigation, and the condition of the patient. For example, at an early stage, physicians might choose to focus on the circumstances that caused the incident and any immediate implications for the patient's treatment plan, with a commitment to follow up once further investigation occurs or more facts are discovered. At all stages, it is important for physicians to communicate only what is known and to avoid speculation.

Subsequent and non-treating physicians are also subject to disclosure obligations. Where you are concerned that an incident warranting disclosure has not been disclosed, you must discuss the matter with the previous physician. A constructive and respectful discussion may help clarify the particular facts

and circumstances of the incident and the evolution of the case. If you continue to have concern about the clinical care or outcome, consider working with the previous physician in a sensitive manner to create a plan for disclosure. Ultimately, you may be responsible for disclosure to the extent that you have sufficient knowledge about the incident to do so.

The role of apologies

A full and sincere apology may contribute to a successful disclosure discussion.[4] Such an apology can be greatly appreciated by patients and their family, and can assist in promoting trust and reducing litigation risk.[5] Patients also say that the manner in which an apology is delivered can be extremely important; the most effective apologies demonstrate sincerity, empathy, and genuine concern for the patient's well-being.[6] Apologies should therefore be tailored in each individual circumstance, avoiding a formulaic approach.

Physicians sometimes hesitate to apologize to patients because of concern about legal implications. It is important to note that an apology is not an admission of legal liability. In Ontario, the law states that apologies made for harm that occurs during treatment cannot be used as evidence of liability against a physician in a civil proceeding, administrative proceeding, or arbitration.[7] At the same time, apologizing does not absolve physicians of harm that has occurred, nor does it shield them from a finding of liability in the future.

Aside from potential litigation, physicians have identified a number of additional barriers to an apology, including a lack of training and self-confidence in conducting the disclosure discussion effectively. It is common, in the context of a difficult disclosure conversation, to feel uncertain about what to say to patients and their families, and the confidence required to conduct these conversations effectively is often obtained through practice and training. You may wish to access further educational resources and materials regarding the delivery of apologies (and disclosure generally), including the following:

- *Canadian Disclosure Guidelines: Being Open with Patients and Families*, Canadian Patient Safety Institute (2011)
- *Disclosing harm from healthcare delivery: Open and honest communication with patients*, Canadian Medical Protective Association (2015)

Additional tips: Disclosing and apologies

- Reassure the patient or substitute decision-maker that you will do everything you can to address their concerns.
- Outline a plan for prompt and thorough intervention to mitigate the harm.

[4] McLennan et al., "Apologies in medicine: Legal protection is not enough" (2015) *CMAJ*, 187(5), p. E157; Wolk et al., "Institutional disclosure: Promise and problems" (2014) *Journal of Healthcare Risk Management*, 33:3, p. 30.
[5] Levinson et al., "Disclosure of Medical Error" (2016) *JAMA*, 316:7, p. 765; American Academic of Pediatrics.
[6] McLennan et al, p. E157; Wolk et al., p. 30.
[7] *Apology Act, 2009*, S.O. 2009, c. 3.

Appendix B

- Consider whether it would be appropriate to transfer the patient to the care of another physician.
- Consider the patient's cultural and ethnic identity, as well as their language of choice, and enable access to family and/or interpretive support where possible.
- Convey sincerity through tone of voice, body language, gestures, and facial expression.
- Consider contacting your medical malpractice provider and/or the CPSO's Physician Advisory Service for advice prior to proceeding with disclosure.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Prescribing Drugs – Draft for Consultation

Date of Meeting: May 31, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Briefing Note

May 2019

TOPIC: Prescribing Drugs Policy – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Prescribing Drugs* policy is under review in accordance with the regular policy review cycle.

- An updated draft of the policy has been developed and is presented for Council's consideration. Council is asked for feedback on the draft policy and whether it approves releasing the draft for external consultation.

BACKGROUND:

- The current *Prescribing Drugs* policy was last reviewed and approved by Council in December, 2012. Minor housekeeping amendments were undertaken in 2016[1] and 2017[2] in response to issues arising from the emerging "opioid crisis".

- This policy is now under review as part of the College's normal policy review cycle.

- A Working Group has been struck to undertake this review, consisting of Dr. Scott Wooder (Working Group Chair), Dr. Steven Bodley, Dr. Janet Van Vlymen, and Pierre Giroux.[3] The Working Group has been supported by Jessica Amey (Legal Counsel) and Dr. Angela Carol (Medical Advisor).

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[1] Guidance was added to the policy related to the provision of naloxone (since rescinded), and updates were added to reflect the (then) new fentanyl "patch-for-patch" regulations.
[2] The policy was updated to include references to the *Canadian Guideline for Opioids for Chronic Non-Cancer Pain*, as well as commitments made by the College at the National Opioid Summit (November, 2016).
[3] Lynne Cram was a member of the Working Group during the early stages of this review, but recently recused herself from further participation.

- As per the usual policy review process, preliminary research was undertaken[4] along with a consultation soliciting feedback on the current policy (the consultation was held in the winter of 2017/2018 and resulted in 87 responses[5]).

- Additionally, the Working Group met with (and obtained direct feedback from) representatives of the Safer Opioid Prescribing Program and the Ontario College of Pharmacists.

- Specific findings and themes that emerged from the research and feedback are provided where relevant below, as key additions and revisions are outlined.

CURRENT STATUS:

- Following extensive research, consultation, and group discussion, the Working Group has developed an updated draft of the *Prescribing Drugs* policy **(Appendix A)**. An overview of the key features of the draft is set out below.

Key Features of the Draft

- The draft policy continues to address the majority of substantive policy topics addressed by the current policy and retains the majority of the policy's mandatory expectations (i.e. expectations that begin with the phrase "physicians must").

- Significant updates and additions have also been made to ensure accuracy and comprehensiveness, to reflect the research undertaken to-date, in response to feedback received from external stakeholders and the Working Group, and to ensure alignment with the principles of the College's policy redesign strategy.

Policy Redesign

- In keeping with the policy redesign strategy, the draft has been developed with a focus on clarity, directness, and brevity. As examples:

    - While retaining the majority of the current policy's substantive mandatory expectations, the draft policy is approximately **70% shorter** as compared to the current policy (based on word count). This reduction in length was accomplished by carefully reevaluating the value of existing non-mandatory content (e.g. "advice", "recommendations", and additional contextual detail).

[4] Including a review of scholarly articles; research papers; relevant decisions of the Inquiries, Complaints, and Reports Committee (ICRC); feedback obtained from the College's Physician and Public Advisory Service (PPAS); and an international jurisdictional review.
[5] 25 written submissions and 62 online surveys. A summary of the feedback received was provided to Council in February, 2018, as part of the Policy Report.

  - The draft policy now exclusively uses the word "must" to unambiguously signify the "mandatory" nature of the policy's expectations. In some cases, this required the Working Group to deliberate on existing expectations that used older, more ambiguous terminology (such as "physicians **should**…").

- Following careful consideration, the Working Group has not proposed an *Advice to the Profession* document to accompany the policy. It is the view of the Working Group that the policy's key issues are adequately addressed within the policy itself, in the policy's endnotes, and elsewhere (for example, in other College policies or in the guidance of other organizations). Going forward, should issues be identified that would appropriately be addressed in an advice document, the Working Group will revisit this decision.

Responding to Stakeholder Feedback: Requests for Clarification

- While the draft policy proposes to remove a significant amount of existing content, some additional content (including expectations) has been added to address key areas of uncertainty. For example:

  - in response to questions about how to respond to patient noncompliance with a prescription monitoring plan, new expectations have been added (provision 19); and
  - in response to questions about the prohibition against blanket no-refill policies, some additional explanation has been added (provision 24).

Updates to the Section on Prescribing Narcotics and Controlled Substances (including Opioids)

- While the central expectations of this section of the policy have been retained, a number of significant revisions have been undertaken to improve clarity and to more effectively communicate the College's expectations. For example, the draft policy:

  - removes all unnecessary overlap with guidance and/or expectations communicated in existing clinical practice guidelines;
  - no longer recommends the use of narcotic prescribing contracts (also known as treatment agreements), as these are not supported by strong empirical evidence;
  - includes additional expectations for physicians with respect to establishing treatment goals and realistic patient expectations (provision 30, d); and
  - includes a new section outlining specific expectations for tapering and discontinuation (provisions 34 and 35).

- In response to stakeholder questions, some additional detail has also been added to help physicians fulfill the requirement to review a patient's prescribing history in advance of prescribing opioids for chronic pain (provisions 31 and 32).

The "Guidelines" Section of the Policy has been Removed

- Following a careful review of the "advice" communicated in the Guidelines section of the existing policy, the Working Group has directed that this content be removed from the draft. In making this decision, the Working Group noted that the Guidelines section of the policy:

    1. did not articulate mandatory expectations,
    2. did not communicate advice that was not already communicated elsewhere, and
    3. did not communicate advice that was not already (or more appropriately) communicated by another organization.

NEXT STEPS:

- Subject to Council's approval, the draft policy will be released for 60 days of external consultation between June and July, 2019.

- Feedback received through the consultation will be used to further refine the policy, which will be brought back to Council for final approval at a future meeting.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft *Prescribing Drugs* policy?

2. Does Council approve releasing the draft *Prescribing Drugs* policy for external consultation?

Contact: Cameron Thompson, Ext. 246

Date: May 10, 2019

Attachments:

Appendix A: Draft *Prescribing Drugs* policy

Prescribing 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

1. Physicians **must** comply with the requirements for prescribing that are set out in this policy, as well those contained in any other relevant College policies[1] and legislation[2].

Before Prescribing

2. Physicians **must** only prescribe a drug if they have the necessary knowledge, skill, and judgment to do so safely and effectively.[3]

3. Before prescribing a drug, physicians **must**:

   a) undertake an appropriate clinical assessment of the patient (limited exceptions are set out in provisions 4 and 5 of this policy);[4]
   b) make a diagnosis or differential diagnosis, and/or have a clinical indication based on the clinical assessment and any other relevant information;
   c) consider the risks and benefits of prescribing the chosen drug (including the combined risks and benefits when prescribing multiple drugs, and the risks and benefits when providing long-term prescriptions); and
   d) obtain informed consent.[5]

[1] Other relevant policies include (among others): Cannabis for Medical Purposes, Confidentiality of Personal Health Information, Consent to Treatment, Medical Records, and Telemedicine.
[2] Relevant legislation includes, but may not be limited to: the *Food and Drugs Act*, R.S.C, 1985, c. F-27; the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*); the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 (hereinafter *NSAA*); and the *Drug and Pharmacies Regulation Act*, R.S.O.1990, c. H.4 (hereinafter *DPRA*).
[3] Sections 2(1)(c), 2(5), O. Reg. 865/93, Registration, enacted under the Medicine Act, 1991, S.O. 1991, c.30; Changing Scope of Practice policy; The Practice Guide.
[4] An appropriate clinical assessment includes an appropriate patient history, as well as any other necessary examinations or investigations.

Relying on an Assessment Undertaken by Someone Else / Prescribing with no Prior Assessment

4. Physicians are permitted to prescribe on the basis of an assessment conducted by someone else.[6] When doing so, physicians **must**:

    a) have reasonable grounds to believe that the person who conducted the assessment had the appropriate knowledge, skill, and judgment to do so;[7] and
    b) evaluate the assessment and judge it to be appropriate.

5. If no prior assessment of the patient has been undertaken, physicians **must** only prescribe:

    a) for the sexual partner of a patient with a sexually transmitted infection who would not otherwise receive treatment, and where there is a risk of further transmission;
    b) prophylaxis (e.g., oseltamivir) as part of a public health program operated under the authority of a Medical Officer of Health; and/or
    c) post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne pathogen.

Content of Prescriptions

6. Physicians **must** ensure that the following information is included on every written or electronic prescription:

    a) the prescribing physician's printed name, signature (or electronic signature), and address;
    b) the patient's name;
    c) the name of the drug;
    d) the drug strength and quantity;
    e) the directions for use;
    f) the full date the prescription was issued (day, month, and year);
    g) refill instructions, if any;
    h) if the prescription is for a monitored drug[8], the prescribing physician's CPSO number[9] and an identifying number for the patient[10] (unless certain conditions set out in regulation are met)[11];

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[5] For more information on consent, please refer to the College's Consent to Medical Treatment policy.
[6] The prescribing physician is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment.
[7] In most circumstances, this will require that the physician know the person conducting the assessment and be aware of his or her qualifications and training. In some limited circumstances, such as large health institutional settings, the physician may be able to rely upon his or her knowledge of the institution's practices to satisfy him or herself that the person conducting the assessment has the appropriate knowledge, skill and judgment.

i) if the prescription is for a fentanyl patch, additional requirements apply (these are set out in provision 36 and 37 of this policy); and
j) any additional information required by law.

7. Physicians **must** use their professional judgment to determine whether it is necessary to include any additional information on the prescription (for example, the patient's weight where this information would affect dosage, or the patient's date of birth where this information would assist in confirming the patient's identity).

8. Physicians **must** ensure that written prescriptions are legible.

Authorizing and Transmitting Prescriptions

9. Physicians **must** authorize every prescription in one of three ways: with a written signature, electronically, or verbally[12].
   a) When authorizing prescriptions with a written signature, physicians **must** ensure that the signature is authentic and unaltered (electronic signatures may be acceptable if they meet the requirements of the Ontario College of Pharmacists[13]).[14]
   b) When authorizing prescriptions electronically, physicians **must** authorize the prescription themselves. Physicians **must not** permit other members of staff to authorize a prescription unless there is a direct order or medical directive in place, and if so, there **must** be a mechanism within the system to identify who authorized the prescription and under what authority.

10. Physicians **must not** create duplicate copies of a prescription (except for the purposes of retaining a copy in the patient's medical record). If physicians wish to provide a copy of the prescription to their patients for information purposes, it **must** be provided in a format that does not resemble a prescription (e.g. paper receipt).

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[8] See Section 2 of the *NSAA* for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website at: http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx.
[9] NSAA.
[10] For example, a Health Card number. See the full list of approved forms of identification here: http://www.health.gov.on.ca/en/public/programs/drugs/ons/publicnotice/identification_list.aspx.
[11] See Sections 3 and 6 of the *General*, O. Reg., 381/11, enacted under the *NSAA*.
[12] There are some limitations on the use of verbal prescriptions (for example, narcotics cannot be authorized verbally[12]). Physicians can contact the pharmacist if they are uncertain about whether a particular verbal prescription is permitted. The Ontario College of Pharmacists (OCP) created a summary of federal and provincial laws governing verbal prescription requirements, which can be found here: http://www.ocpinfo.com/library/practice-related/download/Prescription%20Regulation%20Summary%20Chart%20(Summary%20of%20Laws).pdf.
[13] For more information, see the Ontario College of Pharmacists' website: http://www.ocpinfo.com/regulations-standards/policies-guidelines/unique-identifiers/
[14] Section 40(4) a) of the *DPRA*.

11. Regardless of the method of transmission, physicians **must** ensure that patient privacy and confidentiality are protected.[15]

Respecting Patient Choice When Choosing a Pharmacy

12. Physicians **must** respect the patient's choice of pharmacy.

13. Physicians **must not** attempt to influence the patient's choice of pharmacy, unless doing so is in the patient's best interest and does not create a conflict of interest.

Communicating with Pharmacists

14. Physicians **must** respond in a timely[16] manner when contacted by a pharmacist or other health-care provider involved in the care of a patient.

Documentation

15. In addition to complying with the general requirements for medical records[17], physicians **must** specifically document all relevant information regarding the drugs they prescribe. Physicians **must** do this by either retaining a copy of the prescription in the patient's medical record or by documenting the information contained in the prescription (as set out in provision 6, a-j of this policy).

16. Physicians **must** also document the type of prescription it is (e.g. verbal, handwritten, or electronic) and comply with any applicable requirements for the documentation of patient consent, as set out in the College's *Consent to Treatment* policy.

Monitoring Drug Therapy

17. Physicians **must** ensure that appropriate monitoring protocols are in place to identify emerging risks or complications arising from the drugs they prescribe.

18. Physicians **must** inform patients of:

    a) the follow-up care required to monitor whether changes to the prescription are necessary; and

[15] Obligations with respect to the security of personal health information are set out in Sections 12 and 13 of *PHIPA*. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's Guidelines on Facsimile Transmission Security.
[16] The timeliness of the communication will depend on a variety of factors, including the degree to which any delay may impact patient safety.
[17] Sections 18-21 of the *Medicine Act, General Regulation*. For full details of the requirements concerning medical records, see the CPSO's Medical Records policy.

b) the patient's role in safe medication use and monitoring effectiveness.

19. If patients do not comply with an agreed-upon plan for prescription monitoring, physicians **must** consider whether continued prescribing is safe and appropriate by weighing the risks of continuing prescribing against the risks of discontinuing prescribing.

20. If, in the physician's judgment, drug therapy is not effective or the risks outweigh the benefits, physicians **must** consider discontinuing the prescription (specific expectations for discontinuing narcotics and controlled substances are set out in provisions 34 – 35 of this policy).

21. Whenever possible, physicians **must** only discontinue prescribing following discussion with the patient.

Prescription Refills (also known as Repeats or Renewals)

22. Physicians **must** review and authorize all requests to refill a prescription unless this task is delegated to staff[18] or the person authorizing the refill is a regulated health professional with the authority to prescribe.

23. Physicians **must** ensure that all requests for refills and all authorized refills are documented in the patient's medical record.

24. Physicians **must** ensure that procedures are in place to monitor the ongoing appropriateness of the drug when prescribing refills (for example, by conducting periodic re-assessments).

25. Physicians **must not** adopt blanket "no refill" policies.[19] While some physicians may rarely, if ever, write prescriptions with refills, physicians **must** decide whether or not to prescribe refills on a case-by-case basis with consideration for the circumstances of each patient.

Redistributing Returned Drugs

26. Because the integrity of the drugs cannot be ensured, physicians **must not** redistribute drugs that have been returned by a patient.

[18] If physicians are delegating this responsibility to staff, they must do so in accordance with the CPSO's Delegation of Controlled Acts policy.
[19] A blanket "no-refill policy" means that a physician will not authorize refills for any patient, for any drug, in any circumstances. A blanket no-refill policy is a rigid position that prevents physicians from exercising their independent clinical judgment. This approach is not consistent with patient-centered care and has no clinical basis.

27. Physicians **must** dispose of returned drugs in a safe and secure manner (e.g. at the pharmacy).

Drugs That Have Not Been Approved for Use in Canada ('Unapproved Drugs')

28. Physicians **must not** prescribe drugs that have not been approved for use in Canada (i.e., drugs for which Health Canada has not issued a Notice of Compliance) except in the limited circumstances permitted by Health Canada.[20]

Distributing Drugs without a Prescription (e.g. Drug Samples)

29. When providing drugs to patients without a prescription[21] (e.g. drug samples), physicians **must** continue to meet all of the relevant requirements that apply to prescribing generally, including those related to patient assessment, documentation, and prescription monitoring.

30. When providing drugs to patients without a prescription, physicians **must** ensure that no form of material gain is obtained for the physician or for the practice with which they are associated (this includes selling or trading).

Narcotics and Controlled Substances

Narcotics and controlled substances[22] (including prescription opioids and methadone) can help support the safe, effective, and compassionate treatment of acute or chronic pain, mental illness, and addiction. However, these drugs require special consideration given that they are susceptible to diversion, misuse, and/or abuse, and many carry a risk of dependence and overdose.

Before Prescribing Narcotics and Controlled Substances

31. Before initiating a prescription for a narcotic or controlled substance (or continuing a prescription initiated by another prescriber), physicians **must**:

[20] For more information, see Health Canada's Notice of Compliance webpage. There are two circumstances when access to an unapproved drug can be obtained for patient use. The first is when drugs have been authorized by Health Canada for research purposes as part of a clinical trial. The other is when drugs have been authorized under Health Canada's Special Access Programme.
[21] Small amounts of drugs are sometimes provided to patients without a formal prescription for the immediate treatment of acute symptoms or to evaluate the clinical effectiveness of the treatment.
[22] Narcotics and Controlled Substances are defined in the in the *CDSA* and the *NSAA*. They include narcotic analgesics (e.g. Tylenol 3 and OxyNEO), methadone, and non-narcotic controlled drugs such as methylphenidate (e.g. Ritalin), benzodiazepines (e.g. Valium), and barbiturates (e.g. phenobarbital).

a) consider whether the narcotic or controlled substance is the most appropriate choice for the patient;
    i. if there are no appropriate or reasonably available alternatives, physicians **must** document this fact in the patient's medical record;
b) consider the potential risks associated with prescribing, and take reasonable steps to mitigate those risks, consistent with any relevant practice standards, quality standards, and clinical practice guidelines;[23]
c) take reasonable steps to review the patient's prescription history as it relates to narcotics and controlled substances;
    i. for example, by contacting the patient's pharmacist or other treating physicians, or by reviewing digital sources of information regarding the patient's prescription history[24];
d) establish treatment goals with the patient, including realistic goals for improvement and a plan for discontinuing prescribing should the risks outweigh the benefits; and
e) obtain informed consent;
    i. in order for consent to be informed, physicians **must** inform patients of the risks associated with the drug being prescribed, including any risk of dependence, withdrawal, diversion, and overdose.

Initiating a Prescription for Opioids for Chronic Pain

32. In addition to the expectations set out in provision 31 of this policy, physicians who prescribe opioids for chronic pain **must** be aware of and seek access to digital sources of information regarding patients' opioid prescription history when such sources are available.

    a) For example, many physicians are now able to access a patient's opioid prescription history via the Digital Health Drug Repository[25].

33. When a patient's opioid prescription history is available and accessible to the physician, the physician **must** access and review it prior to initiating a new prescription for opioids for chronic pain and use this information to help inform decision-making.

[23] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.

[24] For example, physicians in many parts of Ontario can now access a patient's prescription drug history (including narcotics and controlled substances) via the Digital Health Drug Repository. For more information about accessing the Digital Health Drug Repository, see the Digital Health Drug Repository Fact Sheet.

[25] For more information about the Digital Health Drug Repository, and in order to gain access, see the Digital Health Drug Repository Fact Sheet.

When Prescribing Narcotics and Controlled Substances

34. When prescribing narcotics or controlled substances (or continuing a prescription initiated by another prescriber) physicians **must**:

    a) meet the general requirements for prescribing that are set out in this policy, as well as any other relevant policies and/or legislation;
    b) consider any relevant practice standards, quality standards, and clinical practice guidelines, and apply them as appropriate (for example, to determine a safe and effective dose);[26] and
    c) inform patients of how to safely secure, store, and dispose of any unused medication (especially in circumstances where locked storage is considered critical, such as prescription opioids and methadone).

Tapering and Discontinuing Narcotics and Controlled Substances

35. Physicians **must not** taper patients inappropriately or arbitrarily. Physicians are reminded that it is not always possible or appropriate to taper below a specific dose, nor is it usually appropriate to suddenly or rapidly taper prescriptions.

36. When tapering or discontinuing narcotics and controlled substances, physicians **must**:

    a) proceed with consideration for the safety and well-being of the patient;
    b) consider and apply, as appropriate, relevant practice standards, quality standards, and clinical practice guidelines;[27]
    c) explain to the patient the rationale for tapering or discontinuation and provide a good-faith opportunity for discussion;
    d) whenever possible, make decisions with respect to tapering or discontinuation in collaboration with the patient; and
    e) carefully document their decision-making and any discussions with the patient.

[26] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.

[27] With respect to the prescribing of opioids for chronic non-cancer pain, relevant guidelines and standards include the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any applicable Quality Standards developed by Health Quality Ontario. Relevant guidelines for the clinical management of opioid use disorder include the CRISM National Guideline for the Clinical Management of Opioid Use Disorder.

Prescribing Fentanyl Patches

37. When prescribing fentanyl patches, physicians **must** include the following additional information on every prescription:[28]

    a) the name and address of the pharmacy where the patient has chosen to fill the prescription; and
    b) a notation that it is the patient's first prescription for fentanyl patches when the following conditions are met: 1) the physician has not previously prescribed fentanyl patches to that patient, and 2) the physician is reasonably satisfied[29] that the patient has not previously obtained a prescription for fentanyl from another prescriber.

38. Physicians **must** also notify the pharmacy directly, either by telephone or by faxing a copy of the prescription.

"No Narcotics" Prescribing Policies

While some physicians may rarely, if ever, prescribe narcotics or controlled substances in practice[30], arbitrarily refusing to prescribe these drugs in all cases and without consideration for the circumstances of the patient may lead to inadequate patient care.

39. Unless the prescribing of narcotics and controlled substances falls outside of the physician's scope of practice or clinical competence[31], or the physician has a restriction imposed by the College prohibiting prescribing, physicians:

    a) **must not** adopt a blanket policy refusing to prescribe narcotics and controlled substances without exception, and
    b) **must** decide whether to prescribe on a case-by-case basis with consideration for each patient.

Reporting the Loss or Theft of Narcotics or Controlled Substances

40. Physicians **must** report the loss or theft of narcotics and/or controlled substances from their possession to the Office of Controlled Drugs and Substances, Federal Minister of Health, within 10 days.[32]

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[28] *Safeguarding our Communities Act, 2015*. Physicians can find more information about their obligations under the Act in the College's *Patch-for-Patch Fentanyl Return Program: Fact Sheet*.
[29] A physician may be reasonably satisfied based on his or her discussions with the patient, as well as any other information available to the physician.
[30] For example, because the physician practices in an emergency room setting and is unable to provide appropriate follow-up care and monitoring
[31] Physicians with primary care practices are reminded that given their broad scope of practice, there are few occasions where scope of practice would be an appropriate ground to refuse to prescribe all narcotics and controlled substances.

Drug Storage

Where physicians stock narcotics and controlled substances, they **must** be securely and appropriately stored in the office to prevent theft/loss.

[32] Section 55(g) of the *CDSA*, *Narcotic Control Regulations*; Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, S.O.R./2000-217, enacted under the *CDSA*. These obligations are also set out in the CPSO's Mandatory and Permissive Reporting policy.

Council Briefing Note

May 2019

TOPIC: Transparency

FOR DECISION

ISSUE:

Intensive work on the College's transparency initiative ended in 2015. However, in light of Toronto Star coverage, the issue of posting charges and findings of guilt from other jurisdictions needs to be revisited. This briefing note sets out the current status and decision for Council.

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 and 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).

CURRENT STATUS:

Currently, only charges, bail conditions and findings of guilt under the *Criminal Code, Controlled Drugs and Substances Act* and *Health Insurance Act* are 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] They uncovered some serious criminal offences in other jurisdictions (e.g., U.S.), and drew attention to the fact that these are not made public by the College.

If a change to include posting information from international jurisdictions is made, a by-law change would be required. The proposed by-law would also need to be circulated (see Appendix A).

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[1] Medical Disorder, The Veil of Secrecy, When Doctors Lie, 2018 http://projects.thestar.com/doctor-discipline/

RECOMMENDATION

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 *Controlled Drugs and Substances Act (Canada)* that occur on or after January 1, 2019 be posted on the public register, if known to the College.

CONSIDERATIONS:

- It is a reasonable expectation of the public for this information to be available.
- The College asks members on the Annual Renewal Survey whether they have been charged or found guilty of offences in Canada or elsewhere, including *Criminal Code*, *Controlled Drugs and Substances Act*, *Food and Drugs Act*, *Health Insurance Act*, and/or related legislation in any jurisdiction, as well as any other offences related to or that might impact the practice of medicine. Normal practice is to follow up when this information is received, even if it is not posted.
- It is expected that member reporting will be the College's primary source of information on international criminal offences. Information may also be reported by some international medical bodies.
- January 1, 2019 was selected because the quality of information that occurred in the past is inconsistent.
- Three of five other AGRE Colleges include other jurisdictions in their bylaws.

NEXT STEPS:

- If Council agrees with the recommendation above, proposed by-law changes to reflect this decision is are attached as Appendix A.

DECISION FOR COUNCIL:

1. Should 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 *Controlled Drugs and Substances Act (Canada)* that occur on or after January 1, 2019 be posted on the public register, if known to the College?

Contact: Maureen Boon, ext. 276
Lisa Brownstone, ext. 472
Lauren Nagler, ext. 338

Date: May 10, 2019

Attachments: Appendix A: Council Motion for By-Law No. 125

Appendix A:
Council Motion for By-Law No. 125

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Register By-law Amendments**

Date of Meeting: **May 31, 2019**

It is moved by_____,

and seconded by_____, 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)*, ~~made~~ 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.

Explanatory Note: This proposed by-law needs to be circulated to the profession.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Approval of Financial Statements for 2018

Date of Meeting: May 31, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Appointment of the Auditors for 2019

Date of Meeting: May 31, 2019

It is moved by_____,

and seconded by_____, that:

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Fees By-law Amendment – Criminal Record Check Fee and Fairness Commissioner Fee**

Date of Meeting: **May 31, 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. 127:

By-law No. 127

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Pension Resolution**

Date of Meeting: **May 31, 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 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

WHEREAS 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. 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.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: 2018 AUDITED FINANCIAL STATEMENT & APPOINTMENT OF THE AUDITOR FOR 2019

FOR DECISION

ISSUE:

- Annual audit and audited financial statements for 2018
- Appointment of the Auditor for the 2019 fiscal year

BACKGROUND:

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

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

At the April 2, 2019 meeting of the Finance and Audit Committee, Mr. Rooke reported that the financial statements are represented fairly and in accordance with Canadian accounting standards for not-for-profit organizations. The reports states:

> "In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2018, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations."

In keeping with the direction of Council, the surplus was transferred to the Building Reserve.

The Finance and Audit Committee made the following motions:

> The Finance and Audit Committee recommends to Council that the Audited Financial Statements for the year ended December 31, 2018, as presented by Tinkham LLP Chartered Professional Accountants be accepted as amended.

The Finance and Audit Committee recommends to Council that the firm of Tinkham LLP Chartered Professional Accountants be appointed as the College's auditors or the fiscal year 2019.

The auditor also stated that the College has excellent internal controls and they did not have any recommendations to improve internal controls or accounting procedures as a result of the application of their audit procedures.

DECISION FOR COUNCIL:

1. Does Council approve the audited financial statements for the year ended December 31, 2018 as presented?

2. Does Council approve the recommendation that the firm of Tinkham LLP Chartered Professional Accountants be reappointed as the College's auditors for the year 2019?

Contact: Mr. Peter Pielsticker, Chair Finance and Audit Committee
Mr. Douglas Anderson, Corporate Services Officer, ext. 607
Ms. Leslee Frampton, Manager, Finance and Business Services, ext. 311

Date: May 2, 2019

Attachments:

Appendix A: Audited Financial Statements for the year ended December 31, 2018

Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2018

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

D C Tinkham FCPA FCA CMC LPA
P J Brocklesby CPA CA LPA
M Y Tkachenko CPA CA
M W G Rooke CPA CA LPA
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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of the College of Physicians and Surgeons of Ontario ("College"), which comprise the statement of financial position as at December 31, 2018 and the statements of operations and changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2018, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our opinion.

Information Other than the Financial Statements and Auditor's Report thereon

Management is responsible for the other information. The other information comprises the information included in the Annual Report of the College but does not include the financial statements and our auditor's report thereon. The Annual Report is expected to be made available to us after the date of this auditor's report.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information, and in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

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

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College’s financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

TORONTO, Ontario
DATE

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Financial Position

As at December 31	2018	2017
Assets		
Current		
Cash (note 2(a))	**$ 40,373,089**	$ 30,587,647
Accounts receivable (note 3)	**402,932**	435,235
Prepaids	**965,631**	777,460
	41,741,652	31,800,342
Investments (note 4)	**51,021,465**	50,886,488
Capital assets (note 5)	**9,603,955**	10,131,121
	$102,367,072	$ 92,817,951
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 7,403,274**	$ 6,173,307
Administered programme (note 7)	**124,318**	58,589
Current portion of obligations under capital leases (note 9)	**473,926**	422,981
	8,001,518	6,654,877
Deferred revenue (note 6)	**31,281,172**	28,933,972
	39,282,690	35,588,849
Accrued pension cost (note 8)	**5,474,878**	5,687,665
Obligations under capital leases (note 9)	**504,542**	537,087
	45,262,110	41,813,601
Net assets (note 10)		
Invested in capital assets	**8,625,487**	9,171,053
Building fund	**48,479,475**	41,833,297
Unrestricted	**509,379**	617,362
Pension remeasurements (note 8)	**(509,379)**	(617,362)
	57,104,962	51,004,350
	$102,367,072	$ 92,817,951

Commitments and contingencies (notes 11 and 12, respectively)

Approved on behalf of the Council

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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Net Assets

Year ended December 31	**2018**	2017
Revenue		
Membership fees		
General and educational (note 6)	**$ 62,520,587**	$ 58,374,991
Penalty fee	**336,705**	256,662
	62,857,292	58,631,653
Application fees	**8,407,339**	7,657,450
OHPIP annual and assessment fees (note 6)	**1,454,792**	1,460,514
IHF annual and assessment fees (note 6)	**1,033,582**	1,053,893
OHPIP, IHF application fees and penalties	**65,131**	64,469
Cost recoveries and other income	**2,342,916**	1,775,172
Investment income	**1,625,027**	1,165,492
	77,786,079	71,808,643
Expenses		
Committee costs (schedule I)	**14,528,149**	15,581,175
Staffing costs (schedule II)	**46,235,432**	43,891,826
Department costs (schedule III)	**7,554,364**	7,159,261
Depreciation of capital assets	**1,216,936**	1,236,585
Occupancy (schedule IV)	**2,258,569**	2,144,409
	71,793,450	70,013,256
Excess of revenue over expenses for the year	**5,992,629**	1,795,387
Net assets, beginning of year	**51,004,350**	49,514,166
Actuarial remeasurement for pension (note 8)	**107,983**	(305,203)
Net assets, end of year	**$ 57,104,962**	$ 51,004,350

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	**2018**	2017
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 5,992,629**	$ 1,795,387
Depreciation of capital assets	**1,216,936**	1,236,585
	7,209,565	3,031,972
Net change in non-cash working capital items:		
Accounts receivable	**32,303**	498,715
Prepaids	**(188,171)**	(340,813)
Accrued interest receivable	**(134,977)**	(342,575)
Accounts payable and accrued liabilities	**1,229,967**	(355,386)
Administered programme	**65,729**	(5,908)
Deferred revenue	**2,347,200**	1,405,460
Pension cost	**(104,804)**	(89,612)
Cash provided by operating activities	**10,456,812**	3,801,853
Cash flows used by investing activities:		
Purchase of capital assets	**(163,077)**	(57,501)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(508,293)**	(490,612)
Net increase in cash	**9,785,442**	3,253,740
Cash, beginning of year	**30,587,647**	27,333,907
Cash, end of year	**$ 40,373,089**	$ 30,587,647

See accompanying notes to the financial statements.

1 Organization

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

The College is exempt from income taxes.

2 Significant accounting policies

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

(a) Cash

Cash includes cash deposits held in an interest bearing account at a major financial institution.

(b) Investments

Guaranteed investment certificates are carried at amortized cost.

(c) Capital assets

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

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. As at December 31, 2018, no such impairment exists.

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

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

(d) Pension plan

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

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

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

2 Significant accounting policies continued

(e) Revenue recognition

(i) Members' fees and application fees

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

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

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

(iii) Investment income

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

(f) Financial instruments

(i) Measurement

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

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

(ii) Impairment

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

(g) Management estimates

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

(h) Net assets invested in capital assets

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

3 Cancer Care Ontario Quality Management Partnership

The College and Cancer Care Ontario (CCO), are jointly developing a provincial quality management program in three areas: mammography, colonoscopy and pathology. The program is fully funded by CCO. The program's expenses totaling $579,059 (2017 - $640,362) are excluded from the College's financial statements.

As at December 31, 2018, the College's account receivable arising from reimbursement of expenses incurred on behalf of CCO are $152,124 (2017 - $116,971). CCO has the right to audit the expenses charged to the program and adjustments, if any, to the accounts will be accounted for in the year of settlement.

4 Investments

As at December 31	**2018**	2017
Guaranteed Investment Certificates (GIC)		
National Bank, 2.01%, due December 22, 2020	**$ 10,000,000**	$ 10,000,000
Manulife Bank, 2.20%, due November 16, 2020	**10,000,000**	10,000,000
BMO, 3.17%, due November 16, 2020	**10,000,000**	-
CIBC, guaranteed growth, minimum 0.60% annual return, due November 13, 2020	**10,000,000**	10,000,000
CIBC, guaranteed growth, minimum 0.50% annual return, due November 13, 2019	**10,000,000**	10,000,000
Manulife Bank, 1.95%, due November 13, 2018	**-**	10,000,000
Accrued interest	**1,021,465**	886,488
	$ 51,021,465	$ 50,886,488

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

5 Capital assets

As at December 31	**2018**		2017	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**20,834,320**	**15,140,020**	20,779,959	14,637,816
Furniture and fixtures	**4,483,078**	**3,702,872**	4,380,871	3,540,453
Computer and other equipment	**1,274,589**	**1,266,510**	1,268,078	1,262,123
Computer equipment under capital lease	**2,591,536**	**1,613,069**	2,200,964	1,240,896
Leasehold improvements	**-**	**-**	396,339	356,705
	$ 31,326,426	**$ 21,722,471**	$ 31,169,114	$ 21,037,993
Net book value		**$ 9,603,955**		$ 10,131,121

6 Deferred revenue

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

	Membership Fees	IHF	OHPIP	2018 Total	2017 Total
Balance, beginning of year	**$ 25,585,183**	**$ 2,328,594**	**$ 1,020,195**	**$ 28,933,972**	$ 27,528,513
Amounts billed during the year	**64,677,739**	**1,431,319**	**1,247,103**	**67,356,161**	62,294,857
Less: Recognized as revenue	**(62,520,587)**	**(1,033,582)**	**(1,454,792)**	**(65,008,961)**	(60,889,398)
Balance, end of year	**$ 27,742,335**	**$ 2,726,331**	**$ 812,506**	**$ 31,281,172**	$ 28,933,972

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

7 Administered programme

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

	2018	2017
Balance, opening	**$ 58,589**	$ 64,497
MOHLTC	**446,743**	513,744
Expenditures	**(381,014)**	(519,652)
Balance, closing	**$ 124,318**	$ 58,589

8 Pension plans

(i) Plan description

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

In addition, the College maintains a closed (1998) defined benefit pension plan for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2018 Total	2017 Total
Plan assets at fair value	**$ 2,417,973**	**$ -**	**$ 2,417,973**	$ 2,742,860
Accrued pension obligations	**(3,724,765)**	**(4,168,086)**	**(7,892,851)**	(8,430,525)
Funded status - deficit	**$ (1,306,792)**	**$ (4,168,086)**	**$ (5,474,878)**	$ (5,687,665)

8 Pension plans continued

(iii) Plan assets

Defined Benefit Plan	Funded Plan	Unfunded Plan	2018 Total	2017 Total
Fair value, beginning of year	**$ 2,742,860**	**$ -**	**$ 2,742,860**	$ 2,929,387
Interest income	**90,514**	**-**	**90,514**	107,216
Return on plan assets (excluding interest)	**(90,707)**	**-**	**(90,707)**	48,797
Employer contributions	**-**	**292,498**	**292,498**	289,889
Benefits paid	**(324,694)**	**(292,498)**	**(617,192)**	(632,429)
Fair value, end of year	**$ 2,417,973**	**$ -**	**$ 2,417,973**	$ 2,742,860

(iv) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2018 Total	2017 Total
Balance, beginning of year	**$ 3,980,411**	**$ 4,450,114**	**$ 8,430,525**	$ 8,401,461
Interest cost on accrued pension obligations	**131,354**	**146,854**	**278,208**	307,493
Benefits paid	**(324,694)**	**(292,498)**	**(617,192)**	(632,429)
Actuarial (gains) losses	**(62,306)**	**(136,384)**	**(198,690)**	354,000
	$ 3,724,765	**$ 4,168,086**	**$ 7,892,851**	$ 8,430,525

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

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

	2018	2017
Funded defined benefit plan	**$ 40,840**	$ 38,712
Unfunded supplementary defined benefit plan	**146,854**	161,565
Defined contribution plan	**3,224,756**	2,849,219
Supplementary defined contribution plan	**-**	229,047
	$ 3,412,450	$ 3,278,543

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2018 Total	2017 Total
Interest cost on accrued pension obligations	**$ 131,354**	**$ 146,854**	**$ 278,208**	$ 307,493
Interest income on pension assets	**(90,514)**	**-**	**(90,514)**	(107,216)
Pension expense recognized	**$ 40,840**	**$ 146,854**	**$ 187,694**	$ 200,277

8 Pension plans continued

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2018 Total**	2017 Total
Actuarial (gain) losses	**$ (62,306)**	**$ (136,384)**	**$ (198,690)**	$ 354,000
Return on plan assets (excluding interest)	**90,707**	**-**	**90,707**	(48,797)
Charge (credit) to net assets	**$ 28,401**	**$ (136,384)**	**$ (107,983)**	$ 305,203

(viii) Actuarial assumptions

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

	2018	2017
Discount rate	**3.75 %**	3.30 %
Rate of compensation increase	**N/A**	N/A

9 Obligations under capital leases

The College has entered into several capital leases for computer equipment. The following is a schedule of the future minimum lease payments of the obligations under these leases expiring on various dates to December 2022:

2019	$ 473,926
2020	293,389
2021	165,803
2022	45,350
	978,468
Less: current portion	473,926
	$ 504,542

10 Net assets

2018	Invested in Capital Assets	Building Fund	Unrestricted	Pension Re-measurement	Total
Balance, January 1	**$ 9,171,053**	**$ 41,833,297**	**$ 617,362**	**$ (617,362)**	**$ 51,004,350**
Excess (deficiency) of revenue over expenses for the year	**(545,566)**	**-**	**6,538,195**	**-**	**5,992,629**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**107,983**	**107,983**
Transfers	**-**	**6,646,178**	**(6,646,178)**	**-**	**-**
Balance, December 31	**$ 8,625,487**	**$ 48,479,475**	**$ 509,379**	**$ (509,379)**	**$ 57,104,962**

2017	Invested in Capital Assets	Building Fund	Unrestricted Net Assets	Pension Re-measurement	Total
Balance, January 1	$ 9,859,526	$ 39,654,640	$ 312,159	$ (312,159)	$ 49,514,166
Excess of revenue over expenses for the year	(688,473)	-	2,483,860	-	1,795,387
Actuarial remeasurement for pensions	-	-	-	(305,203)	(305,203)
Transfers	-	2,178,657	(2,178,657)	-	-
Balance, December 31	$ 9,171,053	$ 41,833,297	$ 617,362	$ (617,362)	$ 51,004,350

The College has transferred $6,646,178 (2017 - $2,178,657) to the building fund from unrestricted net assets.

Net assets invested in capital assets is calculated as follows:

As at December 31	2018	2017
Net book value of capital assets	**$ 9,603,955**	$ 10,131,121
Less: obligations under capital leases	**(978,468)**	(960,068)
	$ 8,625,487	$ 9,171,053

11 Commitments

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

2019	$ 729,311
2020	737,650
2021	746,155
Total	$ 2,213,116

12 Contingencies

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

The College has accrued an estimate of funding to patients who have been approved by the Patient Relations Committee through the Survivors' Fund.

13 Financial instruments

General objectives, policies and processes

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

Credit risk

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

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

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

Liquidity risk

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

Market risk

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

(i) Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College is not exposed to foreign exchange risk.

(ii) Interest rate risk

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

(iii) Equity risk

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

Changes in risk

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

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule I
Committee Costs

Year ended December 31	2018	2017
Attendance	**$ 3,659,301**	$ 3,683,250
Preparation time	**2,916,341**	3,164,413
Decision writing	**1,049,257**	901,074
Expert opinions	**1,293,652**	1,838,289
Assessors	**481,861**	330,793
Travel time	**1,717,261**	1,616,670
HST on per diems	**663,676**	650,946
Legal costs	**1,083,157**	1,956,780
Audit fees	**55,597**	44,526
Sustenance	**368,398**	236,991
Meals and accommodations	**439,965**	366,523
Travel expenses	**774,788**	750,491
Witness expenses	**24,895**	40,429
	$ 14,528,149	$ 15,581,175

Schedule II
Staffing Costs

Year ended December 31	2018	2017
Salaries	**$ 36,796,000**	$ 34,895,857
Employee benefits	**4,909,647**	4,486,376
Pension (note 8)	**3,412,450**	3,278,543
Training, conferences and employee engagement	**760,356**	691,195
Personnel, placement and pension consultants	**356,979**	539,855
	$ 46,235,432	$ 43,891,826

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule III
Department Costs

Year ended December 31	2018	2017
Consultant fees	**$ 1,166,055**	$ 1,691,887
Credit card service charges	**1,513,182**	1,335,698
Software	**366,598**	367,590
Equipment leasing	**28,664**	10,796
Equipment maintenance	**36,431**	55,711
Miscellaneous	**439,768**	277,216
Photocopying	**362,798**	352,211
Printing	**4,492**	22,828
Postage	**257,853**	280,095
Members dialogue	**340,363**	339,522
Courier	**41,293**	68,669
Telephone	**320,172**	325,511
Office supplies	**292,339**	315,636
Reporting and transcripts	**326,489**	453,629
Professional fees - staff	**107,170**	91,324
FMRAC membership fee	**433,900**	490,620
Publications and subscriptions	**181,367**	193,784
Travel	**328,594**	252,311
Survivors' Fund	**952,836**	140,223
Grants	**54,000**	94,000
	$ 7,554,364	$ 7,159,261

Schedule IV
Occupancy

Year ended December 31	2018	2017
Building maintenance and repairs	**$ 760,937**	$ 681,026
Insurance	**514,556**	500,276
Realty taxes	**94,302**	87,457
Utilities	**208,657**	248,325
Rent	**680,117**	627,325
	$ 2,258,569	$ 2,144,409

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: Criminal Record Check Fee and Fairness Commissioner Fee

FOR DECISION

ISSUE:

Removing the Criminal Record Check and Fairness Commissioner Fees from the Fees By-laws.

BACKGROUND:

The Fees By-law contemplates charging applicants a fee of $15 to offset the cost of a criminal record check for registration applications not accompanied by a criminal record check. The College previously obtained criminal record checks for applicants who did not obtain their own, at a cost of $15. The College discontinued this practice a number of years ago and has required applicants to obtain their own criminal record check for a number of years.

The Fees By-law provides for a fee of $5 per registration applicant to offset the costs of audits, reports and reviews of registration practices required by provincial legislation. This fee was originally implemented at $11 in 2009, and was changed to $5 in 2011 to reflect then anticipated actual recovery costs. When it was instituted, the College anticipated being required to undertake an audit of its fairness and equitable registration practices every three years (as well as reporting and other related activities and obligations to the Ontario Fairness Commissioner). The fee was implemented on each application to recover the College's costs in this regard. Further analysis has determined that this fee is no longer necessary as these costs have been worked into our regular processes and do not create additional costs. Accordingly, the College wishes to cease charging this additional fee on applications.

In March, Council approved the proposal to remove these two fees from the fees by-laws. The proposed by-law revisions were circulated to the profession as required by law. No comments were received.

DECISION FOR COUNCIL:

1. To remove the $15 Criminal Record Check Fee from the Fees By-Law, as contemplated in Appendix A?
2. To remove the $5 fee for the Fairness Commissioner Fee from the Fees By-law, as contemplated in Appendix A?

Contact: Leslee Frampton, ext. 311
Douglas Anderson, ext. 607

Date: May 7, 2019

Attachments:

Appendix A: Fees and Remuneration By-Law.

Appendix A

Proposed By-law Amendments

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

APPLICATION FEES

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

…

(e) ~~An additional fee of:~~

~~(i) $5 to offset costs of audits, reports and reviews of registration practices required by provincial legislation will be applied to every application for a certificate of registration; and~~

~~(ii) $15 to offset the cost of a criminal record check will be applied to every application for a certificate of registration that is not accompanied by the results of a criminal record check from an acceptable source.~~

Council Briefing Note

May 2019

TOPIC: Pension Plan Resolution

FOR DECISION

ISSUE:

- Termination of the current Defined Contribution Pension Plan and the establishment of a new Defined Contribution Pension Plan.

BACKGROUND:

- At the February Council meeting, Council agreed with the proposal to offer staff the option to join the Healthcare of Ontario Pension Plan or to remain in a Defined Contribution Pension Plan arrangement.

- In order to facilitate this, there are several steps that need to happen. One of those steps is a Resolution of Council to fully terminate the current Defined Contribution Pension Plan and the establishment of a new Defined Contribution Pension Plan for those who wish to remain in a Defined Contribution Pension Plan.

- The current plan needs to be terminated in order for plan members to be able to use the assets in the plan; to purchase past services credits with HOOPP, transfer to the new Defined Contribution Pension Plan, transfer the assets to a personal locked in fund or purchase an annuity.

DECISION FOR COUNCIL:

1. Does Council approve the resolution as presented?

Contact: Mr. Douglas Anderson, CSO ext. 607

Ms. Leslee Frampton, Manager, Finance and Business Services ext. 311

Date: May 3, 2019

Attachments:

Appendix A: Resolution of the Council

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Stem Cell Therapies
2. Policy Consultation Update:
    I. Complementary/Alternative Medicine
    II. Delegation of Controlled Acts
3. Policy Status Table

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1. Stem Cell Therapies

- At the February 2019 Council meeting the issue of unproven and potentially risky stem cell therapies was raised during Members' Topics.

- Currently, cell therapies, including stem cells, are regulated by Health Canada and are considered a drug under the *Food and Drug Act*. Beyond a small set of long-standing therapies, stem cell therapies have not yet been approved for human use outside of clinical trials.

- However, there is a gap in Health Canada's regulatory framework that has permitted some stem cell therapies to proliferate across Canada. More specifically, minimally manipulated autologous cell therapies for homologous use (i.e., instances where stem cells are extracted from a patient [usually from fat tissue], not significantly altered, and then injected into another area of the same patient).

- Critics of these procedures point to the lack of evidence regarding efficacy and both the known and unknown risks associated with them. In contrast, proponents point to widespread anecdotal evidence and emerging research that purports to demonstrate their efficacy.

- In this way, stem cell therapies are not unlike many complementary, alternative, or 'cutting edge' therapies which are not yet supported by professional consensus or established clinical evidence. As a result, stem cell therapies that are not captured by the federal regulatory framework would be captured by the College's *Complementary/Alternative Medicine* policy.

    - Among other things, this policy requires physicians to only offer non-conventional treatments where there is a logical connection between the patient's diagnosis and the treatment being proposed, and where there is a favourable risk/benefit ratio.

    - The policy purposely does not prohibit physicians from providing specific treatments, but instead articulates principles against which physician conduct can be evaluated.

- The College also periodically encounters stem cell therapies that fall outside the federal regulatory framework in the context of the Out-of-Hospital Premises Inspection Program. Consistent with the policy position, the College has not proactively prohibited physicians from providing these therapies, but rather addresses them on a case-by-case basis.

- Unfortunately, there is continued uncertainty regarding the role of Health Canada in regulating this space and key critics continue to point out that Health Canada has not closed this gap.

- As the *Complementary/Alternative Medicine* policy is currently under review, staff will continue to monitor issues relating to stem cell therapies as part of a broader examination of the alternative medicine environment. Additionally, an article providing information and guidance to patients on navigating the complementary/alternative medicine space was recently published in the College's *Patient Compass* newsletter.

2. Policy Consultation Update

I. Complementary/Alternative Medicine

- A preliminary consultation on the current *Complementary/ Alternative Medicine* policy was held between March and May 2019. We received a total of 891 responses[1]: 97 pieces of written feedback and 794 via online survey.

[1] Organizational responses included the Ontario Medical Association, the Ontario Medical Association Complementary and Integrated Medicine Medical Interest Group, the Ontario Association of Naturopathic Doctors, the College of Naturopaths of Ontario, and the College of Homeopaths of Ontario.

- Notably, a majority respondents to the online consultation survey agreed that the current policy strikes the right balance between respecting the rights of patients and physicians to utilize CAM treatment options, and sets appropriate boundaries to ensure safe and effective care.

- Through the written feedback, many physicians indicated that patients need to be protected from "pseudoscience". In contrast, members of the public expressed a desire to access treatments that they find helpful. Among those physicians who did voice support for complementary/alternative medicine (CAM), a number identified themselves as CAM practitioners.

- A range of opinions were similarly expressed relating to the idea that only treatments which are "evidence based" should be offered to patients. For example, some respondents noted that there is evidence for CAM treatments while others noted that even conventional medicine is not always evidence based.

- A number of respondents also specifically sought to refute the idea that CAM practitioners are "taking advantage" of patients. Their feedback sought to reject the perception that CAM practitioners are "less ethical" than physicians who provide only conventional treatments.

- All feedback is currently being reviewed in detail and will help inform revisions to the policy.

II. Delegation of Controlled Acts

- A preliminary consultation on the current *Delegation of Controlled Acts* policy was held between March and May 2019. We received a total of 872 responses[2]: 83 pieces of written feedback and 789 via online survey.

- Unfortunately, much of the participation appears to have been driven by a perception that this consultation is the result of lobbying by plastic surgeons and dermatologists, and is intended to limit nurses' ability to provide aesthetic medical treatments.

- This appears to be in response to a Joint Society Position Statement on Medical Aesthetic Treatments and Procedures from 5 representative organizations in the aesthetic medicine field, released in 2016. As a result, the majority of the feedback received on the discussion page centres on the idea that nurses are capable of performing such injections and should be allowed to continue to do so.

[2] Organizational responses included the Ontario Medical Association, the Coalition of Aesthetic Medical Practitioners, Skin Vitality Medical Clinic and a joint response from the Canadian Dermatology Association, the Canadian Academy of Facial Plastic Surgery, and the Canadian Society of Aesthetic Plastic Surgery.

- Additional feedback included:

    - Suggestions that the policy prohibit the delegation of controlled acts to unregulated professionals.
    - Statements that telemedicine is a legitimate mechanism for forming a physician-patient relationship, and that this should continue to be a tool that can help to facilitate delegation.
    - Comments that the policy works well and should not be made more complicated.

- Additionally, a majority of survey respondents agreed with the principles in the current policy: that delegation is only appropriate where patient care is not compromised, where there is no additional risk to the patient and where monetary or convenience reasons are not the sole reasons for delegating.

- All feedback is currently being reviewed in detail and will help inform revisions to the policy.

3. 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: May 10, 2019

Appendices:

AppendixA: Policy Status Table

Appendix A

Policy Status Report – May 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		
Complementary/ Alternative Medicine	Mar-19	✓					2020	
Delegation of Controlled Acts	Mar-19	✓					2020	
Disclosure of Harm	Sept-18			✓			2019	
Prescribing Drugs	Dec-17			✓			2019	
Confidentiality of Personal Health Information	May-17		✓				2020	
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	Sept-17			✓			2019	
Medical Records	Sept-17		✓				2020	
Continuity of Care and Test Results Management	May-16				✓		2019	The current Test Results Management policy is being reviewed alongside the development of new Continuity of Care policies.
Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	May-16				✓		2019	The timeline for this policy has been adjusted to align with the new Continuity of Care draft policies given points of intersection.

Policy Status Report – May 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		

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2019

TOPIC: **GOVERNMENT RELATIONS REPORT**

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Issues of Interest
3. Interactions with Government

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1. ONTARIO'S POLITICAL ENVIRONMENT:

- Government policy announcements continue to impact the health care sector, including changes to the Ontario Autism Program, the termination of OHIP coverage for out-of-country travelers and, as announced in the 2019 Budget, a planned reduction in the number of public health units from 35 to 10 (along with a $200M reduction in annual public health funding).
- The Budget also signaled the planned consolidation of local ambulance services, from 59 to 10, and changes to the scope of practice for certain regulated health professionals to reduce the need for multiple patient visits for diagnostic tests and routine care. Further details of these announcements have not yet been announced.
- The government's Expenditure Estimates for fiscal year 2019-20 have also been released. They include an overall $1.74B increase for the Ministry of Health and Long-Term Care and a $1.2B increase for OHIP spending.
- However, operating funding in some individual program areas will be reduced, including:
    - the Health Policy and Research Program, by $51M (this program supports Ministry-wide priorities such as health workforce planning and regulatory oversight);
    - drug programs, by $96M; and
    - eHealth, by $70M (this reduction is related to eHealth's merger into the Ontario Health super agency).

- The Ontario Telemedicine Network has also announced that it has reduced its workforce by 15% (44 jobs) because of reduced provincial funding, and it is anticipated that other health agencies will experience similar spending reductions.
- The current session of the Legislature is scheduled to end on June 6.

2. ISSUES OF INTEREST:

Public Appointments Update

- At the beginning of May, the government appointed a new public member of Council, Shahid Chaudhry, for a 12-month term and reappointed Peter Pielsticker for a 3-year term.
- The College now in a very good position with a full complement of 15 public members.

Red Tape Reduction, Governance Modernization, and Legislative Submissions

- In January 2019 the College sent a submission to the Minister of Health and Long-Term Care (included in the March Council materials) that detailed the legislative changes required to achieve the College's governance modernization recommendations.
- In March 2019 the College followed up with a second submission to the Minister (attached as **Appendix A**) that recommended a series of legislative changes to simplify the College's regulatory processes.
- These recommendations, many of which flow from previous legislative change requests, align with this government's focus on reducing red tape and promoting process efficiencies.
- This submission also includes the College's governance modernization recommendations, which fit well within the red tape reduction narrative.
- In addition to working with government to achieve these changes, it is anticipated that College will continue to work to identify additional recommendations that would modernize our regulatory legislation and achieve increased efficiency in organizational processes.

Legislation Update

- The health system transformation legislation – Bill 74, the *People's Health Care Act, 2019* – received Royal Assent in mid-April, although the Bill's central provisions are not yet in force.
    - Susan Fitzpatrick, former CEO of the Toronto Central LHIN and Associate Deputy Minister at the Ministry of Health, is acting as Interim CEO of Ontario Health while a permanent CEO is recruited.
- Implementation and regulatory development under Bill 87 (*Protecting Patients Act, 2017*) and Bill 160 (Community Health Facilities) remains on hold. In the meantime, regulatory changes are moving forward to bring fertility services within the scope of the College's Out-of-Hospital Premises Inspection Program.

3. INTERACTIONS WITH GOVERNMENT:

- Public appointment related issues and red tape reduction recommendations are currently major areas of focus in discussions with government.
- We continue to facilitate meetings with key staff in the Minister's office, the Ministry, and other elected officials including new MPPs. We anticipate regular contact between the College and MPPs/staff as we maintain our relationships with government.

Contact: Maureen Boon, ext. 276
Heather Webb, ext. 753

Date: May 10, 2019

Attachment:

Appendix A: Letter to Minister Elliott re: Recommendations to reduce red tape, March 19, 2019

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

March 19, 2019

The Honourable Christine Elliott, MPP
Deputy Premier and Minister of Health and Long-Term Care
5th Floor, College Park
777 Bay Street,
Toronto, ON M7A 2J3

Dear Minister,

RE: Recommendations to reduce red tape

We write to provide you with our recommendations to reduce red tape and achieve a more efficient and effective regulatory structure.

We share your government's commitment to regulatory modernization and red tape reduction, and are actively transforming our approach to regulation to better serve the public interest and implement the principles of Right Touch Regulation. We are working hard to improve the timeliness and effectiveness of core regulatory functions including investigations, registration and physician assessments.

However, in order to achieve the best possible results, we need the government's help to modernize the *Medicine and Regulated Health Professions Acts*.

The following changes would have a significant impact:

1. Red Tape Reduction in Regulatory Processes:
    - Provide CPSO with the power to make rules, rather than by regulation, on issues within its core mandate (registration, advertising, standards of practice, and quality assurance) allowing us to nimbly respond to changing practice environments.
    - Provide CPSO with greater discretion to triage complaints to allow us to focus regulatory activity on the complaints that most impact public safety.
    - Provide CPSO with authority to share information about investigations with a doctor's privileging hospital(s) to streamline the process and keep patients safe.
    - Clarify the application of the *Mental Health Act* to avoid delays, duplication and to support College hearings.

2. Red Tape Reduction in Governance:
    - Reduce the size of the board from 34 to between 12-16 members while increasing public member representation to comprise half the board.
    - Eliminate overlap between board and statutory committee membership.
    - Implement a competency-based board selection process.
    - Permit equal compensation for physician and public members of the board (CPSO to compensate all board members).

The accompanying attachment provides the detailed rationale and the legislative change(s) required to achieve each recommendation.

Our recommendations to reduce red tape and modernize Ontario's health regulatory structure will help to better serve patients and bolster the integrity of Ontario's health regulatory system. Louise Verity, lverity@cpso.on.ca is available to work with your team in support of legislative changes.

Yours truly,

Peeter Poldre, MD, EdD, FRCPC
President

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

Encl. CPSO Red Tape Reduction Recommendations, Rationale, and Required Legislative Changes

c. Honourable Todd Smith, MPP, Minister of Economic Development, Job Creation and Trade
Helen Angus, Deputy Minister of Health and Long-Term Care
Heather Watt, Chief of Staff, Minister of Health and Long-Term Care
Patrick Dicerni, Assistant Deputy Minister, Strategic Policy and Planning Division
Giles Gherson, Deputy Minister, Red Tape and Regulatory Burden Reduction, Cabinet Office

Appendix A

Recommendation		Rationale	Legislative Changes[1]
1.	**Regulatory Process Improvements**		
1.1	**Simplify the College's power to make rules relating to areas and functions within its core mandate.**	Updating and maintaining regulations under the RHPA/Code is onerous on government and health Colleges. Approval of dozens of regulations from health Colleges requires government approval and it unnecessarily involves multiple branches of government in matters falling within the College's core regulatory mandate. The process is duplicative, time-consuming and inefficient. As a first step, we recommend that the following regulation-making powers under the Code regarding registration, promotion and advertising, standards of practices and quality assurance be moved to either College by-law authority or another instrument at the discretion of Council. They are all overseen by College Councils and are central to the core work of health regulators: i. Governing certificates of registration and registration requirements (s. 95(1)(a)-(f)) ii. Governing professional promotion and advertising (s. 95(1)(l)) iii. Prescribing standards of practice (s.95(1)(n)) iv. Prescribing the quality assurance program (s. 95(1)(r)-(r.1)) This would avoid the inefficient regulation-approval process, and enable both government and the College to be more agile and responsive in serving the public interest.	**Code, s. 95(1)** sets out Council's regulation making authority which requires approval of the LGIC (review and approval from gov't). Move s. 95(1)(a)-(f), (l), (n), (r), and (r.1) to s. 94(1). Move s. 95(1.1) and (1.2) to become s. 94(1.1) and (1.2).
1.2	**Expand the CPSO's discretion to investigate complaints.**	CPSO requires greater discretion to manage complaints that are frivolous and unrelated to patient care and professional conduct in order to focus our regulatory actions on the most serious patient safety concerns. Currently CPSO is required to investigate all complaints, regardless of their seriousness, unless they are deemed to be frivolous or vexatious. Even the "frivolous or vexatious" complaints must undergo a bureaucratic process that takes time (at least 6 weeks). As a result, CPSO can be and is drawn into conflicts that are unrelated to the duty to serve the public interest on issues of clinical care or professional behaviour – for example, a recent campaign by firearm advocates has encouraged individuals to file complaints with CPSO about physicians advocating for system-level change on gun control. The College has received more than 70 complaints about this physician's advocacy work.	Amend **s. 25 of the Code** by adding the following provision: ***25(4.1)*** *Despite subsection (1). A panel shall not be selected to investigate a complaint if, in the opinion of the Registrar, the complaint does not relate to the member's professional conduct, competence or capacity.*

[1] NB: The list of proposed legislate changes is not comprehensive – other incidental changes may also be required.

Appendix A

Recommendation		Rationale	Legislative Changes[1]
1.3	**Enable the CPSO to share information with hospitals.**	While hospitals are required by law to share certain kinds of information with the CPSO related to concerns about doctors, the RHPA *does not permit* the CPSO (in most circumstances) to share information regarding investigations with a doctor's privileging hospital(s). This unnecessary barrier to information-sharing has caused a number of problems and, in some cases, poses a threat to patient safety: • The CPSO is quite limited in its ability to share information with a hospital about investigations involving one of its physicians and the subject physician may be credentialed at more than one hospital. • The hospital and CPSO may each conduct parallel investigations about a physician, which duplicates efforts, wastes resources, and may affect the quality of each investigation. • Where the College receives complaints about possible systems issues, the College is limited in the amount and timing of information that it can share, such that issues may continue unabated for an unnecessary period oftime.	Amend **RHPA, s. 36(1)(d)**, to add the *Public Hospitals Act* to the list of statutory exceptions in the confidentiality section, which will enable the CPSO to share information with hospitals. Strike **RHPA, s. 36(1)(d.1)** to eliminate need for regulation that would set out prescribed purpose when information could be shared.
1.4	**Clarify the application of the Mental Health Act to avoid delay and duplication of College hearings**	Section 35(9) of the MHA has been interpreted as requiring notice to be given to every patient who received care in a facility whose health information is involved in a proceeding, prior to being able to use that information in a Discipline hearing. The patients can then each consent (if they are capable) or the College asks the Court to allow the documents to be used. In a case in which the College is concerned about eth quality of care a physician provided in a mental health facility, this could involve dozens of patients - the patient charts may be several years old and contact information out of date. Even if every patient could be located, the College would have to consider how to effect notification in light of each individual patient's particular mental health or vulnerability. The application itself would require an evidentiary record. In short, applying section 35(9) bifurcates the proceedings, requiring the College to run a lengthy and cumbersome hearing in the Divisional Court before the Discipline hearing can proceed. The purpose of this section of the MHA is to protect the confidentiality interests of patients, which CPSO already does in its proceedings. This includes invoking publication bans to ensure patient identities are not revealed. The provision was not, surely, intended to shield physicians working in mental health facilities from having their quality of care and conduct reviewed in the same way as any other physician's care and conduct would be reviewed.	Add a new provision, **RHPA s. 36(4)** to clarify that s. 35(9) of the *Mental Health Act* does not apply to any proceeding under the RHPA or a health profession Act.

Appendix A

Recommendation		Rationale	Legislative Changes[1]
2. Governance Modernization			
2.1	**Increase public member representation so there are equal numbers of physicians and public members on the board.**	Public members occupy less than half or 44% of board positions (when gov't appoints the full complement of 15 members). Equal public/professional board membership is increasingly accepted as a best practice internationally. This change will ensure a balance between public and physician expertise and competencies in regulation and help strengthen public confidence in the regulatory system.	**Medicine Act, s. 6(1)**, which currently requires 15-16 professional members and 13-15 public members, plus 3 academic representatives.
2.2	**Reduce the size of the board from 34 to between 12-16 members.**	A 34 member board is too large. Literature supports smaller boards as being more effective and efficient in decision making. The range is intended to provide flexibility to achieve the right combination of competencies.	**Medicine Act, s. 6(1)**, which currently requires 15-16 professional members and 13-15 public members, plus 3 academic representatives.
2.3	**Eliminate overlap between board and statutory committee membership.**	Existing quorum requirements require board member participation on some statutory committees. These requirements are particularly onerous for public board members who must provide between 100 and 120 days of work as board and committee members each year. Quorum requirements for board member participation on statutory committees (discipline, complaints screening) cause hearing delays and lengthen timelines. Separation between the Board and statutory committees is considered a best practice. Board and statutory committees have very different roles (oversight/strategic for the board vs. adjudicative for statutory committees). Separation in membership from the board will enhance the integrity and independence of the board and statutory committees and, help strengthen public confidence in the regulatory system.	Section 10(3) of the Code currently requires the composition of committees to be set by by-law, although a number of sections in the Code set composition and quorum requirements for the following statutory committee panels: • s. 17(2): Registration Committee panels • s. 25(2) and (3): ICRC panels • s. 38(2-5): Discipline Committee panels • s. 64(2-3): Fitness to Practice Committee panels Once Bill 87 amendments to the RHPA and the Code are proclaimed, composition and quorum requirements for these committees will be set by regulation. **New regulations** therefore need to be developed pursuant to the **RHPA, s. 43(1)(p) to (s)** and the **Code, s. 94(1)(h.1)- (h.4)**.

Recommendation		Rationale	Legislative Changes[1]
2.4	**Implement a competency- based board selection process.**	Competency-based board selection for physician and public members support the right mix of knowledge, skills and experience amongst board members to ensure the Board is able to effectively discharge its functions. A competency based selection process is considered a best practice.	For professional members: the **Medicine Act, s. 6(1)** currently requires members to be "elected in accordance with the by- laws." This would need to be amended to permit members to be "selected" in accordance with the by-laws. Supporting by-law changes could then be made to facilitate this change. Other consequential legislative changes may also be required (for example, s. 5 of the Code which provides for the term of elected Council members). For public members: there are different options available to accomplish this change. **Medicine Act, s. 6(1)** requires the appointment of 13-15 public members by LGIC, so an amendment to this section could import language around competency-based appointments. There is language in s. 14(1) of the *Governance and Appointments Act, 2009* that might be helpful ("The selection process for the appointment of members to an adjudicative tribunal shall be a competitive, merit-based process and the criteria to be applied in assessing candidates shall include the following: …")
2.5	**Implement a hybrid selection model for physician members** (some elected members, some competency-based appointments).	Currently 16 physician members of the board are elected by the profession and 3 are appointed. The election process at times causes confusion and promotes a perception that physician board members represent the profession rather than the public interest. A hybrid approach of elected and appointed professional members will help ensure that the board collectively possesses necessary competencies and facilitate ongoing physician engagement in the board selection process.	**Medicine Act, s. 6(1)** currently requires physician members to be "elected in accordance with the by-laws." This would need to be amended to permit members to be "selected" in accordance with the by-laws. Supporting by-law changes could then be made to facilitate this change.

Appendix A

Recommendation		Rationale	Legislative Changes[1]
2.6	**Provide equal compensation for professional and public members of the board.**	Public members of Council are compensated by government at a much lower rate than physician members. The College is prohibited from compensating public members of Council for their work. Compensation for public members is inadequate and unfair. The College should have the ability to compensate all board and committee members directly and equitably.	**Code, s. 8** currently requires that Council members appointed by the LGIC be paid, by the Minister, the expenses and remuneration the LGIC determines. An accompanying amendment to the **Code, s. 94(1)(h)** would also be required. This provision currently allows Council to make by-laws providing for the remuneration of the members of the Council and committees other than persons appointed by the LGIC.
2.7	**Retain the option of appointing an Executive Committee.**	Smaller boards may not require an Executive Committee. In the interest of maintaining flexibility, CPSO recommends retaining the option of an Executive Committee, which is largely dependent on board size. A board with 16 members may require an Executive Committee.	**Code, s. 10(1)** currently requires colleges to have an Executive Committee. Other consequential amendments to the Code may also be required to reflect a discretionary Executive Committee.

Discipline Committee
Report of Completed Cases – May 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 February 9, 2019 and May 14, 2019. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse – 2 cases

1. Dr. J. C. Gilbert

Name:	Dr. Jane Catherine Gilbert
Practice:	Psychiatry
Practice Location:	Oakville
Hearing:	Uncontested Facts Penalty – Not Opposed
Finding/Penalty Decision Date:	January 9, 2019
Written Decision Date:	March 5, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Gilbert is a psychiatrist who received her certificate of registration authorizing independent practice in 1990.

From 2009 to October 2011, Dr. Gilbert practised at the Urgent Care Clinic ("UCC") in the Hospital. Dr. Gilbert provided interim psychiatric care to patients who were awaiting outpatient psychiatry appointments. In October 2011, Dr. Gilbert resigned from the UCC and opened her own psychiatric care clinic.

In 2009, Patient A attended for a psychiatric consultation at the Hospital. He was suffering from depression. He had, the month prior, been hospitalized for anxiety. Patient A had been diagnosed with cancer. He underwent multiple treatments. Patient A developed severe anxiety and depression following his cancer treatments. Patient A had a history of psychiatric difficulties, including suicidal ideation, anxiety and panic attacks.

Following the initial intake, Patient A was referred to Dr. Gilbert for an additional psychiatric consultation. Dr. Gilbert first provided psychiatric treatment to Patient A at the Hospital in November 2009. She continued to provide psychiatric treatment to Patient A at the Hospital until December 2009, and then from March 2010 to November 2010. Her last appointment with Patient A at the Hospital was in December 2010.

In September 2010, during an appointment with Patient A, Dr. Gilbert started to cry. She disclosed to Patient A details about her marital problems, and told him her husband was leaving her. Patient A did not know what to do. He gave Dr. Gilbert a hug to console her. He invited Dr. Gilbert to his house to have dinner with him and his wife. Dr. Gilbert accepted the invitation and attended Patient A's house that evening.

While treating Patient A at OTMH, Dr. Gilbert became friends with Patient A and his wife and started to attend at their home regularly. Dr. Gilbert would go to Patient A's home in the mornings around 7:30 a.m. and would stay for hours while Patient A's wife was at work. She would also go to Patient A's home regularly on Friday evenings where she would drink alcohol with Patient A.

In the fall of 2010, while still treating Patient A at the Hospital, Dr. Gilbert initiated a sexual relationship with him. This occurred one afternoon while Dr. Gilbert and Patient A were alone at his home drinking together. Patient A's wife was at work. Dr. Gilbert told Patient A she was attracted to him and wanted to cultivate "that kind of friendship." He told Dr. Gilbert he had undergone a prostatectomy and it took him a long time to get sexually aroused and get an erection. Dr. Gilbert asked Patient A if he wanted help with getting an erection. He said no and Dr. Gilbert then asked, "Wouldn't you like to get back on track and take that back to [your wife]?" Dr. Gilbert asked Patient A to see his penis. Patient A took out his penis and could not get an erection. Dr. Gilbert asked Patient A, "Should I help you with my mouth?" Patient A said no. Dr. Gilbert then commenced masturbating Patient A by fondling his penis with her hands. Patient A touched Dr. Gilbert's breasts and vagina with his hands.

His sexual encounter with Dr. Gilbert was very emotionally significant for him. A few days after this sexual encounter, Patient A told Dr. Gilbert he loved her and would leave his wife for her. Dr. Gilbert responded that she loved him and wanted to be with him.

Dr. Gilbert continued to engage in a sexual relationship with Patient A until April 2014. Patient A's wife did not know about the relationship. Dr. Gilbert continued to spend time with Patient A at his house and Patient A spent time at Dr. Gilbert's house. Patient A met Dr. Gilbert's two children.

Pharmacy records were obtained from three different pharmacies. These records demonstrate that between 2009 and 2014, Dr. Gilbert prescribed to Patient A numerous medications including anti-depressants, sedatives, narcotics, and medications for erectile dysfunction.

Dr. Gilbert also provided Patient A non-prescription pills to treat Patient A's erectile dysfunction. She told Patient A that she ordered these pills from a "third world country."

During their physician-patient relationship, Dr. Gilbert and Patient A engaged in sexual acts including kissing, performing oral sex on each other, Patient A kissing and fondling Dr. Gilbert's breasts, Dr. Gilbert masturbating Patient A, and sexual intercourse. Dr. Gilbert and Patient A engaged in these sexual acts at her house, in her office at the hospital, at Patient A's rural property, and at a hotel. Patient A would sleep at Dr. Gilbert's house. Dr. Gilbert took Patient A to a sex store. He had never been to a sex store in the past. He tried on a penis ring to maintain an erection.

In July of 2013, Dr. Gilbert attempted to end the sexual relationship with Patient A. Dr. Gilbert and Patient A, however, continued the sexual relationship until April of 2014.

Dr. Gilbert made statements, which were untrue, about the timing of the commencement of her sexual relationship with Patient A.

Disposition

On January 9, 2019, the Discipline Committee ordered that:
- The Registrar revoke Dr. Gilbert's certificate of registration effective immediately.
- Dr. Gilbert 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 sixty (60) days from the date of this Order in the amount of $16, 060.00.
- Dr. Gilbert appear before the panel to be reprimanded.
- Dr. Gilbert pay to the College its costs of this proceeding in the amount of $6000.00 within sixty (60) days from the date of this Order.

2. Dr. T. Sundaralingam

Name:	Dr. Theepa Sundaralingam
Practice:	Oncology
Practice Location:	Toronto
Hearing:	Uncontested Facts Penalty - Uncontested
Finding/Penalty Decision Date:	January 23, 2019
Written Decision Date:	March 14, 2019

Allegations and Findings

- sexual abuse of a patient - **proven**
- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Sexual Abuse and Disgraceful, Dishonourable and Unprofessional Conduct re Patient A

In January 2015, Patient A, a man, was referred to Dr. Sundaralingam from the emergency room where he had attended. Dr. Sundaralingam ordered bone marrow testing. At a follow-up appointment in February 2015, Dr. Sundaralingam diagnosed Patient A with cancer. Dr. Sundaralingam continued to treat Patient A regularly. She treated him 23 times between January 2015 and July 2015 and one time in March 2016.

In February 2015, the day after Dr. Sundaralingam diagnosed Patient A with cancer, she provided Patient A with her personal contact information and Instagram ID. Dr. Sundaralingam breached appropriate boundaries with her patient, as the two immediately commenced texting in a highly personal manner.

In the next several weeks, Dr. Sundaralingam continued to breach appropriate boundaries with Patient A including by:

(a) Frequently texting Patient A, communicating in a highly personal and flirtatious manner;

(b) Meeting outside her clinic, including meeting at a coffee shop a few days after she communicated his cancer diagnosis;

(c) Holding hands with Patient A, hugging Patient A for long periods of time and kissing Patient A.

In or around March 2015, Patient A was admitted to Hospital for chemotherapy. While cancer treatments were provided, Dr. Sundaralingam continued to monitor Patient A regularly and treated him by administering regular blood transfusions.

While a patient in Hospital, Dr. Sundaralingam visited Patient A, at times staying for 5-7 hours at a time. His entire family got to know her. During these visits, the discussions between Dr. Sundaralingam and Patient A became more sexually explicit, including discussions about the pornography they enjoy.

One evening, Dr. Sundaralingam visited Patient A after hours, when she had been drinking. Dr. Sundaralingam lay with Patient A in his bed, and the two engaged in mutual sexual touching. Patient A touched Dr. Sundaralingam's breasts. Dr. Sundaralingam touched Patient A's penis. They kissed. In March 2015, Dr. Sundaralingam and Patient A engaged in texting during which they described sexual activities with each other while masturbating.

Dr. Sundaralingam continued to treat Patient A throughout this period, including after his inpatient treatment. He saw Dr. Sundaralingam regularly at her clinic in Hospital, where she examined him, administered tests and administered blood transfusions.

During their medical appointments, Dr. Sundaralingam behaved in a physical, flirty and sexual manner toward Patient A. In addition to examining him, Dr. Sundaralingam asked Patient A to examine her. During these appointments, Patient A touched Dr. Sundaralingam's breasts.

While examining a birthmark on his inner thigh during a medical appointment, Dr. Sundaralingam removed Patient A's pants and underwear and touched his penis sexually. She recorded in the medical record "On examination, he does have a mole in the inner-left thigh. This will be monitored. I have instructed Patient A to keep an eye on the skin lesion".

On a number of occasions, Dr. Sundaralingam visited Patient A in his home, where he lived with his family. They spent hours together in his bedroom where they continued to engage in sexual activities, including mutual masturbation. They regularly engaged in phone sex.

In July 2015, Patient A returned to Hospital for a bone marrow transplant. At that time, Dr. Sundaralingam visited him frequently. While Patient A was in the Hospital, she masturbated him, but on one occasion ceased abruptly when a friend walked in.

Towards the end of his inpatient stay, she slept overnight with him in his bed in his hospital room. They had sexual intercourse on two occasions while he was an inpatient.

Dr. Sundaralingam repeatedly asked Patient A to delete their texts and keep their relationship a secret, as she was concerned the College would become aware of their sexual and inappropriate relationship.

By the end of September 2015, their sexual relationship came to an end. After having sexual intercourse with Patient A at his home, Dr. Sundaralingam told Patient A that she was in love with a colleague with whom she was having an affair. Their friendship continued, but it was non-sexual. From November 2015 onward, Dr. Sundaralingam, refused to see him. She refused to meet him when he reached out to her in February 2016. He found this very difficult to deal with.

In March 2016, Patient A developed an infection. Dr. Sundaralingam treated him. This was their last formal clinical interaction. He was subsequently admitted to Hospital. Dr. Sundaralingam did not visit him there. She did not treat him again or engage in any further sexual encounters with Patient A.

Dr. Sundaralingam engaged in sexual abuse and disgraceful, dishonourable and unprofessional conduct in respect of Patient A.

Disgraceful, Dishonourable and Unprofessional Conduct re Hospital Records

When Dr. Sundaralingam visited Patient A in the bone marrow transplant unit in July 2015, Dr. Sundaralingam was required to sign her name and signature on the log to identify herself and who she was visiting.

Dr. Sundaralingam engaged in disgraceful, dishonourable and unprofessional conduct by asking Patient A to alter the hospital records by scratching out her name after she left so that there would be no evidence that she was there. Patient A did as she instructed.

Dr. Sundaralingam does not contest these facts, nor does she contest that she engaged in sexual abuse of patient A and an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Disposition

The Discipline Committee Ordered that:

- The Registrar revoke Dr. Sundaralingam's certificate of registration effective immediately.
- Dr. Sundaralingam appear before the panel to be reprimanded.
- Dr. Sundaralingam 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 days of this order in the amount of $16,060.00.
- Dr. Sundaralingam pay costs to the College in the amount of $6000.00 within 30 days of the date of this order.

Failed to Maintain the Standard of Practice of the Profession – 1 case

1. Dr. M. J. Sager

Name:	Dr. Mark Jerome Sager
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Uncontested Facts Penalty – Joint Submission
Finding/Penalty Decision Date:	March 4, 2019
Written Decision Date:	April 23, 2019

Allegations and Findings

- failed to maintain standard of practice of the profession - **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Mark J. Sager is a 74-year-old general physician practising in Toronto. Dr. Sager received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on July 6, 1972. He has practiced general medicine since that time.

Communication and Conduct with Patient A

Patient A was a patient of Dr. Sager’s for over 30 years. During this period she was treated for two occurrences of breast cancer.

During gynecological examinations, Patient A would often cover herself with her hand or her gown out of shyness. On these occasions, in order to perform the examinations, Dr. Sager would move Patient A’s hand or gown out of the way. He did so without asking Patient A to move her hand or gown herself, and without asking if he could move her hand or providing her with an adequate explanation. This left Patient A feeling humiliated.

The gynecological examinations were otherwise not inappropriate.

In early 2017, Patient A was scheduled for s gynecological surgery. Given her cancer history, she was anxious about the procedure. Her specialist instructed her to insert misoprostol vaginally prior to the surgery.

Patient A had an appointment with Dr. Sager in January 2017, prior to the surgery. At this appointment, Patient A asked Dr. Sager to explain medical terms in a lab report. Dr. Sager shouted at Patient A to “come over here, just come over here”.

At the same appointment, Patient A asked Dr. Sager to clarify the instructions she had received regarding the insertion of misoprostol. Patient A was unfamiliar with the drug and had questions about the prescription, as the literature accompanying the prescription indicated it was used for stomach ulcers and did not mention gynecological uses.

When Patient A asked for clarification regarding the use of misoprostol vaginally, Dr. Sager flew into a rage and said, “fucking take the pills when a doctor told you”, “fucking do what you’re told” and that she was “fucking annoying” him. He told her to take the pills and “stick those up your pussy”.

Patient A told Dr. Sager she had a right to ask questions and that she was intelligent enough to understand. Dr. Sager responded by saying, “You’re not that intelligent.” Patient A repeated that she had a right to ask questions and get clarification, to which Dr. Sager responded, “Ask your goddamn questions.”

Communication with College Investigators

Patient A complained to the College in July 2017 regarding Dr. Sager’s conduct.

On August 11, 2017, College investigators attended unannounced at Dr. Sager’s office to deliver the complaint notification letter. Dr. Sager was informed of the complaint and given the opportunity to read the letter and comment. He was encouraged to contact the Canadian Medical Protective Association (CMPA) and was informed he was not obliged to speak with the investigators.

After briefly reviewing the complaint letter, Dr. Sager said the following to the investigators:

- He had treated Patient A for 25 years and she was a “nut case”. Dr. Sager stated several times that Patient A was mentally unwell and had depression and cancer;
- This was a “fairy tale”; it was “made up”; he didn’t “diddle” her; “diddling people” is not his gig;
- Asked if the incidents in the letter were before or after Patient A had her “breasts mutilated”; and
- Asked that investigators speak with Patient A to “trip her up” and find inconsistency in her story.

Dr. Sager has advised the College that when he made these statements to the College investigators, he believed he was being accused of having touched Patient A inappropriately, which he did not do.

Telephone Call to Patient A

In September 2017, Dr. Sager telephoned Patient A while she was at work and asked her to discuss her complaint to the College. Patient A said she could speak, but only for a moment as she was working on an urgent task.

During this telephone conversation, Dr. Sager asked what Patient A hoped to get out of the complaint. He told Patient A: he had not slept in a month; complained about his health problems; and told Patient A her complaint was causing him misery. During the call, Dr. Sager asked Patient A more than once to drop the complaint. He reminded Patient A that it was before Rosh Hashanah (the time for God's forgiveness of sins) and suggested she should contact the College before Rosh Hashanah to withdraw her complaint.

Patient A told Dr. Sager several times during the call that she was at work and could not take a long, personal phone call, but Dr. Sager did not end the call and repeated his request that she drop her complaint. The phone call was difficult, awkward and emotional for Patient A. She felt manipulated by his reference to her religious faith. After the call she was shaken and embarrassed. Her employer was angry at the distraction of a long, personal call during work hours. At the end of the day, Patient A was fired from her job, which was her sole source of income.

Failure to Maintain the Standard of Practice of the Profession re: Record Keeping

During the investigation, the College obtained Dr. Sager's chart for Patient A. In providing the chart, Dr. Sager acknowledged that his notes were not legible and provided a transcription of the chart entries.

The College retained Dr. Marcus Law to review Dr. Sager's record keeping. Dr. Law noted that of the 11 patient encounters he reviewed, there was not a single encounter note which was legible. Further, all encounter notes were missing pertinent information that other health professionals would need in order to understand the patient's health issues. He concluded that Dr. Sager's medical record keeping did not meet the standard of practice of the profession.

Relevant College History

In June 2013, the Inquiries, Complaints and Reports Committee of the College ("ICRC") issued a decision requiring Dr. Mark Jerome Sager ("Dr. Sager") to be cautioned and to complete a specified continuing education or remediation program in relation to his record keeping. Dr. Sager completed the University of Toronto Medical Record Keeping Course in October 2013.

Undertaking to the College

Dr. Mark Jerome Sager entered into an undertaking to the College on January 16, 2019, by which he agreed to resign his certificate of registration effective February 26, 2019. He also undertook not to apply or re-apply for registration as a physician in Ontario or any other jurisdiction.

Disposition

The Discipline Committee ordered that:

- Dr. Sager appear before the panel to be reprimanded.
- Dr. Sager pay costs to the College in the amount of $6,000. 00 within thirty (30) days of the date of this Order.

Found Guilty of Offence Relevant to Suitability to Practise – 2 cases

1. Dr. H.C. Hyson

Name:	Dr. Harvey Christopher Hyson
Practice:	Neurology
Practice Location:	London
Hearing:	Uncontested Facts Penalty - Uncontested
Finding/Penalty Decision Date:	January 23, 2019
Written Decision Date:	March 14, 2019

Allegations and Findings

- found guilty of offence relevant to suitability to practise - **proven**
- conduct unbecoming a physician – **proven**
- disgraceful, dishonourable or unprofessional conduct – **withdrawn**
- failed to maintain the standard of practice of the profession - **withdrawn**

Summary

Dr. Harvey Christopher Hyson ("Dr. Hyson") is a neurologist practising at various office locations in southwestern Ontario. He received his certificate of registration authorizing independent practice in January 2002. At all relevant times, Dr. Hyson practised at the London Health Sciences Centre as a neurologist in London, Ontario, and held a position as an assistant professor in neurology at the University of Western Ontario.

In 2012, working in an undercover capacity, Detective Howe ("Det. Howe"), a member of the London Police Service Cyber Crime Unit, commenced an investigation using a free online classifieds website called "Craigslist". Craigslist is a website that facilitates contact between people including through e-mail. Once an advertisement is posted on the website, e-mail responses are forwarded directly to the person who posted the advertisement.

On April 3rd 2012, Det. Howe, posing as a young girl, posted an advertisement stating, "$weet and Petite girl for you" on the Craigslist website. The advertisement was linked to a fictitious e-mail address used by Det. Howe in his communications in an undercover capacity. On the same date, April 3rd, 2012, Det. Howe, received a response from an e-mail address belonging to Dr. Hyson stating, "Interested in hearing more!" The e-mail signed off using the name "Rob".

On April 3rd, 2012, Det. Howe, posing as a young girl named Janice, told Dr. Hyson that *she* was sixteen years old. Dr. Hyson arranged to meet with Det. Howe, whom Dr. Hyson believed to be a sixteen year old girl, to receive sexual services in exchange for three hundred dollars.

Between April 3rd, 2012, and April 12th, 2012, numerous e-mails were exchanged between Dr. Hyson and Det. Howe, continuing to pose as a young girl, discussing arrangements to meet for sexual services. On April 11th, 2012, Det. Howe, for the second time, told Dr. Hyson that *she* was sixteen years old. Dr. Hyson responded with "Ok". On more than one occasion, Dr. Hyson asked Det. Howe to send him a photograph of *herself*. On April 11th, 2011, Det. Howe sent Dr. Hyson a photograph of a young female.

On April 12th, 2012, the following e-mail exchange occurred between Det. Howe and Dr. Hyson:

> Dr. Hyson [e-mail address] sent at 9:56 a.m.:
>
> > Still for meeting today? How recent is that pic?
>
> Det. Howe [e-mail address] sent at 10:18 a.m.:
>
> > Hi i am ok for this afternoon, what is it u want to do then I want to make sure the $ is ok
>
> Dr. Hyson [e-mail address] sent at 10:24 a.m.:
>
> > Just some oral and straight up sex. Nothing too exotic. Anything in particular that you like? Have you done this before?
>
> Det. Howe [e-mail address] sent at 10:32 a.m.:
>
> > Ok oral and straight sex is good, don't forget to bring your money. Is 2 or 3 good. I will give u the number to text me soon. I am going to be at the Knights Inn on Dundas.

Dr. Hyson then arranged to meet Det. Howe, whom he believed to be a sixteen year old girl, at 3:00 p.m. at the corner of Manitoba Street and Whitney Street in London, Ontario. Det. Howe provided a (police) cell phone number for Dr. Hyson to contact. Dr. Hyson texted the police cell phone number when he was approaching the agreed-upon location saying that he was "Just 10 minutes behind."

On April 12th, 2012, shortly after 3:00 p.m., police observed Dr. Hyson approach the agreed-upon location in his vehicle. Police initiated a stop and Dr. Hyson was arrested. On arrest, three hundred dollars in cash was seized from Dr. Hyson's front pocket and a cell phone from his car. Three hundred dollars was the price agreed on by Dr. Hyson and Det. Howe, posing as the sixteen year old girl, for the anticipated sexual services that Dr. Hyson would receive.

Police conducted an investigation into the Internet Protocol Addresses ("IP address") associated with the e-mails exchanged between Dr. Hyson and Det. Howe. Dr. Hyson sent the emails from his personal IP addresses and also from an IP address belonging to the University of Western Ontario, and other IP addresses associated to London Health Sciences Centre.

On December 20th, 2016, Dr. Hyson pleaded guilty before Justice Gorman in the Superior Court of Justice in London Ontario, to one count of attempting to stop a motor vehicle for the purposes of obtaining the sexual services of a prostitute, contrary to section 213(1)(a) of the *Criminal Code of Canada* (as it stood on April 12th 2012).

The Crown Attorney and Dr. Hyson's counsel made a joint submission on sentence for a suspended sentence and an order of six months' probation. The joint submission was accepted by Justice Gorman.

Voluntary Undertaking – January 2018

On January 14, 2018, Dr. Hyson entered into a voluntary undertaking in lieu of an Order under section 25.4 of the *Health Professions Procedural Code,* Schedule 2 to the *Regulated Health Professions Act,* S.O. 1991, C-18. This superseded an earlier undertaking dated March 12, 2015 that Dr. Hyson had voluntarily entered into as a result of the investigation into the subject matter of these proceedings.

The January 2018 Undertaking provides that Dr. Hyson was to notify staff at his Practice Locations (a nursing home) of his practice restriction by providing a copy of the Undertaking to management. Further, the undertaking provides that Dr. Hyson was to ensure that the manager or other person in charge during each of his shifts at his Practice Locations was aware of his practice restriction.

Breach of Undertaking

McCormick Home is a long-term care home in London, Ontario. Dr. Hyson provides care to one resident at McCormick Home. In 2018, Dr. Hyson attended at McCormick Home to provide care to the resident and also provided consultations through the Ontario Telemedicine Network ("OTN").

On January 11, 2019, the College received information that Dr. Hyson had not notified the Administrator or any nursing leader of his practice restrictions. While providing care at McCormick Home, Dr. Hyson did not, at any time, notify any member of the staff of McCormick home of his practice restrictions or provide a copy of the Undertaking to the management as required by the terms of his undertaking.

Dr. Hyson breached his January 14, 2018 undertaking with the College.

Relevant College History

Apart from the matter at hand, Dr. Hyson has no prior history with the Discipline Committee.

Disposition

The Discipline Committee ordered that:

- The Registrar revoke Dr. Hyson's certificate of registration effective immediately.

- Dr. Hyson appear before the panel to be reprimanded.
- Dr. Hyson pay costs to the College in the amount of $6000.00 within 30 days of the date of this order.

2. Dr. S. Mukherjee

Name:	Dr. Siddhartha Mukherjee
Practice:	Obstetrics and Gynaecology
Practice Location:	Pembroke
Hearing:	Agreed Facts Penalty - Joint Submission
Finding/Penalty Decision Date:	March 4, 2019
Written Decision Date:	April 23, 2019

Allegations and Findings

- found guilty of offence relevant to suitability to practise- **proven**
- disgraceful, dishonourable or unprofessional conduct – **proven**
- conduct unbecoming a physician – **withdrawn**

Summary

Dr. Siddhartha Mukherjee ("Dr. Mukherjee") is a 57 year-old obstetrician/gynecologist. Dr. Mukherjee treated Ms. B as a patient in May and June 2009, when Ms. B attended at the Emergency Department at the Hospital and for a subsequent consultation. Ms. B was referred again to Dr. Mukherjee for a consultation concerning a different matter in June 2010. He did not see her as a patient after June 2010.

Dr. Mukherjee next encountered Ms. B when she was completing a nursing placement in the labour and delivery ward at the Hospital where Ms. B subsequently worked as a part-time RN. Ms. B also worked as an RN in Dr. Mukherjee's office.

Dr. Mukherjee was involved in an extra-marital sexual relationship with Ms B. During their relationship, Dr. Mukherjee prescribed a common antibiotic for Ms. B's two children and Lorazepam for Ms. B for five days. Both Ms. B and her children had their own family doctor for the duration of the relationship.

Dr. Mukherjee's wife learned of the affair. Dr. Mukherjee's relationship with Ms. B deteriorated. Ms. B told Dr. Mukherjee on several occasions that she wanted to end the relationship, but Dr. Mukherjee pleaded for it to continue. During the relationship, Ms. B became financially dependent on Dr. Mukherjee. Dr. Mukherjee threatened to end Ms. B's employment at his office, and take gifts back or demand to be repaid for cash gifts he had previously made to her. Ultimately, Ms. B went to the police.

Dr. Mukherjee was found guilty by Justice Selkirk of the Ontario Court of Justice of the following offences under the *Criminal Code of Canada*, committed against Ms. B:

a) mischief (two counts) pursuant to section 430(4); and

b) uttering threats to cause death or bodily harm pursuant to section 264.1 (1)(a).

The first mischief offence occurred when Dr. Mukherjee broke into the door of Ms. B's house leading from the garage when she was not home, damaging the door. Dr. Mukherjee was enraged and wanted to confront Ms. B.

The second mischief occurred when Dr. Mukherjee deliberately drove his car into Ms. B's car, thereby damaging it. After driving into her car once, Dr. Mukherjee reversed his car and drove into Ms. B's car again. Ms. B backed up her car and drove to the police station but did not go in.

Dr. Mukherjee uttered threats to Ms. B by text messages on three occasions. On one occasion, Dr. Mukherjee texted Ms. B, "[Ms. B's name] someday I will slit Ur throat - I m slick surgeon u should know that" [sic]. On another occasion, Dr. Mukherjee texted Ms B, "U have got me mad I m fuckjng killing u" [sic] and "I will kill u someday" [sic]. Dr. Mukherjee's threats were intended to intimidate Ms. B.

Dr. Mukherjee was sentenced to a conditional discharge and 12 months' probation.

Dr. Siddhartha Mukherjee ("Dr. Mukherjee") was sentenced to a conditional discharge and 12 months' probation. Dr. Mukherjee fulfilled all the terms of the conditional discharge, which included: complying with a safety plan as set out by the Hospital; making a $1,000 charitable donation to the Bernadette McCann House; and completing a 12-session counseling and rehabilitation program for resolving conflict in non-abusive ways ("*Living Without Violence*").

Dr. Mukherjee's privileges at the Hospital have never been limited or restricted. Dr. Mukherjee voluntarily entered into an agreement with the Hospital to ensure that he did not encounter Ms. B in the workplace ("safety plan"). Dr. Mukherjee was required to comply with the safety plan as part of his bail conditions and subsequently as part of his probation. The agreement also required him to reflect on what had occurred by engaging in psychotherapy sessions (including cognitive behavioural therapy) for a period of time to be determined by the therapist, and to work with a workplace mentor. Dr. Mukherjee has complied with all of these obligations to the full satisfaction of the hospital. Ms. B no longer works at the hospital.

Dr. Mukherjee has undergone therapy and remediation, including:

- Successful completion of the Partner Assault Response Program aka *Living Without Violence*.
- Successful completion of the *Understanding Boundaries* course, at his own expense, at the Schulich School of Medicine & Dentistry in London, Ontario.
- Assessment by forensic psychiatrist as required by the hospital, as well as completion of psychotherapy sessions (twelve hours, including cognitive behavioural therapy), at his own expense, with psychotherapist Michele Riopelle. Ms. Riopelle's opinion included that Dr. Mukherjee was fully engaged in receiving psychotherapy and gained understanding, insight and self-awareness throughout the therapeutic

process. According to Ms. Riopelle:

- "…I believe Dr. Mukherjee, found himself in a position, based on vulnerability in his home life, that escalated beyond what he could have foreseen given his experience, knowledge, information, and vulnerabilities at that time."
- Working with a workplace mentor at the Hospital on a monthly basis to discuss and review his conduct and interpersonal performance in the workplace, as required by his agreement with the hospital.

Dr. Mukherjee's probation ended on February 23, 2016. Since then, Dr. Mukherjee has had no further criminal charges and/or convictions.

Dr. Mukherjee cooperated with the College's investigation. He has had no previous findings before the Discipline Committee.

Disposition

The Discipline Committee ordered that:

- Dr. Mukherjee attend before the panel to be reprimanded.
- The Registrar suspend Dr. Mukherjee's certificate of registration for a period of six (6) months, commencing immediately, and that Dr. Mukherjee comply with 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".
- The Registrar place the following terms, conditions and limitations on Dr. Mukherjee's certificate of registration:
    - Dr. Mukherjee will, at his own expense, participate in and successfully complete comprehensive and intensive instruction in anger management approved by the College, no later than twelve (12) months from the date of this Order.
- Dr. Mukherjee pay costs to the College in the amount of $6,000.00 within 30 days of the date of the order.

Disgraceful, Dishonourable or Unprofessional Conduct – 6 Cases

1. Dr. V.I. Arora

Name:	Dr. Vineet Iqbal Arora
Practice:	Ophthalmology
Practice Location:	Hamilton
Hearing:	Agreed Facts Penalty - Joint Submission
Finding/Penalty Decision Date:	January 9, 2019
Written Decision Date:	March 5, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct - **proven**

Summary

Dr. Arora is a 53-year-old ophthalmologist who received his certificate of registration authorizing independent practice in 1989. Dr. Arora practices in Hamilton, Ontario.

On June 21, 2015, Dr. Arora entered into an Undertaking with the College whereby he agreed to, among other things:

- restrict his number of daily patient encounters to a maximum of eighty (80) patient encounters per day except on days when he is on-call for the Ophthalmology Service at Hamilton Health Science and St. Joseph's Health Centre; and
- maintain a call log verifying all patients seen above the ordinary 80 patient maximum.

In September 2016, the College received correspondence from the Ministry of Health and Long-Term Care, indicating that on various dates between June 21, 2015 and August 22, 2016, Dr. Arora had claimed for more than 80 fee codes which require a direct encounter with the patient. Dr. Arora was on-call on one of these dates. Dr. Arora did not maintain a call log verifying all patients seen above the ordinary 80 patient maximum on the dates when he was on-call.

Dr. Arora admits that, based on these facts, he engaged in acts or omissions relevant to the practice of medicine that would be regarded by members as disgraceful, dishonourable or unprofessional by breaching the terms of his June 2015 Undertaking to the College.

Complaints resolved by the June 2015 Undertaking and a caution-in-person

The June 2015 Undertaking was directed by the Inquiries, Complaints and Reports Committee of the College (the "ICRC") in resolution of 2 separate patient complaints.

Each of these complaints involved an allegation that Dr. Arora communicated in a rude and unprofessional manner.

The ICRC noted that Dr. Arora had a history of complaints regarding communications and expressed its view that Dr. Arora's high-volume, high-stress practice contributed to his communication difficulties. In addition to accepting Dr. Arora's June 2015 Undertaking in resolution of each complaint, the ICRC also directed that Dr. Arora attend at the College to be cautioned in respect to patient communications.

Relevant College history

Apart from the matter at hand, Dr. Arora has no prior discipline history with the College. Prior to the complaints resolved by the June 2015 Undertaking, Dr. Arora had been the subject of a number of complaints to the College between 1996 and 2011 regarding rude and unprofessional communications with patients.

In February 2007, in resolution of several complaints, Dr. Arora entered into an undertaking to complete a course in Medical Record-Keeping for Surgical Specialties and a course in Physician-Patient Communications. The undertaking was fulfilled. The Complaints Committee also directed that Dr. Arora attend at the College to be cautioned in respect to patient communications.

On May 14, 2007, the Co-Chair of the Complaints Committee wrote a warning letter to Dr. Arora. In that letter, he noted Dr. Arora's history of patient complaints regarding communications and conveyed that he expected that the College would not have to deal with matters of a similar nature again.

In June 2011, in resolution of a patient complaint, the ICRC directed that Dr. Arora attend at the College to be cautioned about maintaining professional communications with patients at all times. On December 5, 2011, the Chair of the ICRC wrote a warning letter to Dr. Arora. In that letter, he noted Dr. Arora's caution-in-person regarding unprofessional communications and advised Dr. Arora that the matter of repeated complaints of a similar nature and his failure to respond to the Committee's first warning may be brought to the attention of the ICRC should such episodes happen again.

Additional information

The June 2015 Undertaking provides that Dr. Arora was to practice under the guidance of a preceptor for a minimum of two (2) years and to see a therapist who is a member of a regulated health profession for a minimum of one (1) year. Dr. Arora continues to meet regularly with his preceptor and see a therapist, although he is no longer required to do so pursuant to the terms of his June 2015 Undertaking. Dr. Arora's therapist, Ms Stephanie Swayne, has continued to provide reports on his progress to the College.

Since entering into the June 2015 Undertaking, Dr. Arora has not been the subject of any new patient complaints to the College regarding rude or unprofessional communications. Dr. Arora has advised the College that, since being notified of the

College's concerns regarding compliance with the June 2015 Undertaking, he has made a number of changes to his practice, including: implementing a new system to track appointments; instructing his staff to book fewer appointments per day; and making changes to his staff, including hiring new staff. There is no evidence that Dr. Arora has exceeded 80 patient encounters a day since he was informed of the breach of his June 2015 Undertaking by the College, on December 13, 2016.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Arora's certificate of registration for a period of one (1) month, commencing from February 25, 2019 at 12:01 a.m.
- The Registrar place the following terms, conditions and limitations on Dr. Arora's certificate of registration:
  - Dr. Arora 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. Arora's progress and compliance. Dr. Arora 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 and Boundaries program for which Dr. Arora is eligible.
- Dr. Arora attend before the panel to be reprimanded.
- Dr. Arora pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

2. Dr. P. P. Baranick

Name:	Dr. Peter Paul Baranick
Practice:	Family Medicine
Practice Location:	Ottawa
Hearing:	Agreed Facts Penalty - Joint Submission
Finding/Penalty Decision Date:	January 30, 2019
Written Decision Date:	March 25, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Peter Paul Baranick is a 73 year-old physician who received his certificate of registration authorizing independent practice on August 3, 1979. At the relevant time, Dr. Baranick practised in Ottawa, Ontario.

In May 2015, the Inquiries, Complaints and Reports Committee considered a report of a Registrar's Investigation into Dr. Baranick's practice relating to his prescribing. In September 2015, Dr. Baranick signed an undertaking stating, among other things, that he:

- Will not issue new prescriptions or renew existing prescriptions for narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and all other monitored drugs; and
- Shall post a sign in the waiting rooms of all of his practice locations advising of his prescribing restriction.

Dr. Baranick practises at various locations of the Appletree Medical Clinics in Ottawa. On October 2017, College staff attended Appletree Clinic A and noted that the signs were not posted. Clinic staff advised that Dr. Baranick was not working there currently and that the sign was posted whenever Dr. Baranick was working there. College staff were advised that he was currently working at Appletree Clinic B. College staff then proceeded to Appletree Clinic B and noted that signs were posted. Dr. Baranick was working at this location and spoke with College staff. He advised that signs were posted when he came into the office to work.

In December 2017, the College sent a letter to Dr. Baranick's counsel requesting that Dr. Baranick post his prescribing restriction signs in the waiting rooms of all practice locations. By letter dated December 2017, Dr. Baranick's counsel indicated that having the signs posted when Dr. Baranick is not working at a particular location "falls outside the spirit and intent of his undertaking" and that there is no value in posting the signs if he is not present as it would cause confusion amongst patients.

In December 2017, the College sent a letter to Dr. Baranick's counsel requesting that he comply with his undertaking and post the required signage at all locations regardless of whether he is working there that day or not.

In January 2018, Dr. Baranick's counsel advised that Dr. Baranick had posted his prescribing restrictions signs at all practice locations. In January 2018, Dr. Baranick's counsel was advised that no further action would be taken as the College was advised that the signs were posted at all locations.

In February 2018, College staff attended Appletree Clinic C. Clinic staff advised that Dr. Baranick did not work there and therefore the sign was not posted. College staff was told that Dr. Baranick was working at Appletree Clinic A. College staff attended Appletree Clinic A and did not see the required sign posted. Appletree Clinic A staff advised that Dr. Baranick would be working later that day and that the sign would be posted when he starts to work. College staff advised the clinic staff that the sign is

required to be posted at all times and the clinic staff person said she would post the sign.

In February 2018, College staff attended Appletree Clinic A and Appletree Clinic D. The required signs were posted at both these locations. College staff also attended Appletree Clinic B, where signs were not posted.

By letter dated March 2018, Dr. Baranick's counsel requested a variance of section 5(a) of his undertaking, stating that Dr. Baranick should only be required to post his sign where he is physically present on any given day.

In April 2018, the College sent a letter to Dr. Baranick's counsel advising that despite previous reassurances, recent compliance visits in February showed inconsistent practices at the various Appletree Clinics where the required signage was not posted. The College reiterated that the signs are expected to be up at all of Dr. Baranick's practice locations at all times. The College also advised that if the ICRC accepted the proposed wording, an amended undertaking would be provided for signature.

The variance to the undertaking requested by Dr. Baranick was not granted by the College.

In January 2018, the College received data from the Narcotics Monitoring System for the period of June 2016 to December 2017 related to Dr. Baranick's prescribing.

In January 2018, the College contacted the pharmacies identified in Dr. Baranick's Narcotics Monitoring System data. The College requested copies of four prescriptions from the pharmacies where the pharmacist advised that Dr. Baranick wrote the prescription after he had signed his undertaking.

The College received three prescriptions signed by Dr. Baranick and dated November 2015, January 2017, and December 2017. Each of the prescriptions was for a testosterone medication that Dr. Baranick was prohibited from prescribing pursuant to the September 2015 Undertaking.

In February 2018, Dr. Baranick's counsel advised that Dr. Baranick did not initiate the prescriptions, but did refill them. He wanted to reassure the College that this was an honest mistake and that he never intended to breach his undertaking. To prevent this from occurring again, he had reviewed his undertaking and the lists of drugs and substances he is restricted from prescribing.

Agreed Statement of Facts Relevant To Penalty

Dr. Baranick entered into the September 2015 Undertaking as a result of a College

investigation into his prescribing practices.

As a result of the investigation, the Inquiries, Complaints and Reports Committee of the College ("the ICRC") accepted Dr. Baranick's September 2015 Undertaking to give up his narcotics prescribing privileges and required Dr. Baranick to attend at the College to be cautioned in person.

Dr. Baranick's Discipline History

On June 12, 2017, the Discipline Committee found that Dr. Baranick had failed to meet the standard of practice of the profession. The discipline hearing arose out of a reassessment of Dr. Baranick's practice pursuant to an Undertaking with the College that Dr. Baranick signed on July 10, 2013 (the "July 2013 Undertaking"). The College's assessor opined that Dr. Baranick failed to meet the standard of practice of the profession with respect to his record-keeping, assessment and management of community acquired infections, infant care, and chronic illness such as arthritis, diabetes and hypercholesterolemia. Dr. Baranick admitted the allegations.

The Discipline Committee accepted a joint submission on penalty and ordered a reprimand, a 2-month suspension of Dr. Baranick's certificate of registration, and terms, conditions and limitations on Dr. Baranick's certificate of registration, including that he complete a comprehensive Continuing Medical Education program focusing on the areas of concern raised by the assessor, that he continue to limit his practice to no more than six patients per hour, and that he undergo a six-month period of clinical supervision followed by a re-assessment of his practice. The Discipline Committee also ordered that Dr. Baranick pay costs to the College at the tariff rate.

The reassessment of Dr. Baranick's practice took place in November and December 2018. The College's assessor reviewed twenty patient charts and conducted a telephone interview with Dr. Baranick. The College's assessor concluded that for all twenty patient charts reviewed, Dr. Baranick had met the standard of care of the profession and had displayed appropriate knowledge, skills and judgment.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Baranick's certificate of registration for a period of 1 month, commencing immediately.
- Dr. Baranick appear before the panel to be reprimanded.
- Dr. Baranick to pay costs to the College in the amount of $6,000.00 within 30 days of the date of this Order.

3. Dr. M. Horri

Name:	Dr. Mehdi Horri
Practice:	Family Phyisician
Practice Location:	Saskatchewan
Hearing:	Agreed Facts Penalty - Contested
Penalty Redetermination Decision Date:	March 29, 2019
Penalty Redetermination Reasons Date:	March 29, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Dr. Horri, a 51-year-old family physician who practises family medicine in Saskatchewan, graduated in 1998 from the University of Tehran in Iran. He obtained a certificate of Independent Practice in 2015.

Patient A was in her early 20's when she became a patient of a family doctor, Dr. X, who diagnosed her with depression with suicidal ideation. Dr. X prescribed antidepressants to Patient A. During her third and final visit, Dr. X diagnosed Patient A with insomnia second to depression and found that Patient A did not presently have suicidal or homicidal thought process, prescribing her a different anti-depressant and sleep medicine. Following this appointment, Dr. X began a maternity leave.

Patient A agreed to continue to attend for appointments with Dr. Horri, who was acting as a substitute during Dr. X's leave.

Doctor-Patient Relationship

Dr. Horri saw Patient A between January and June 2010, continuing the care plan commenced by Dr. X and providing Patient A with on-going support and medication management.

Patient A describes that, because Dr. Horri was a medical professional whom she would not have to see again, she disclosed personal information to Dr. Horri that she had not previously disclosed to anyone. Dr. Horri provided Patient A with support for ongoing personal challenges, depression, anxiety, and sleep difficulties. Dr. Horri renewed prescriptions to Patient A for anti-depressants and sleep medicine.

During their appointments, Patient A recollects that when she would share with Dr. Horri details of her familial challenges, Dr. Horri would tell her that he could relate to what she was experiencing given his own experiences with his family of origin.

Post-Termination Sexual Relationship

Patient A's final appointment with Dr. Horri was on a date in mid-June 2010, which was the date the doctor-patient relationship ended. Following that appointment, Patient A dropped off a thank you note for Dr. Horri at his office. Dr. Horri looked up Patient A's phone number in her medical. He called her to thank her for the card, to offer his ongoing friendship, and to suggest that Patient A call him if she needed a friend.

Patient A described that at his point in her life, she was fairly isolated from her support network.

Dr. Horri and Patient A developed a friendship over the subsequent weeks. They met on a few occasions for coffee or walks together.

Approximately two weeks after Patient A's last appointment with Dr. Horri, Dr. Horri visited Patient A's apartment. After watching a movie together, they had sexual intercourse. Patient A described that she was scared and upset because they did not use a condom and she was worried about pregnancy. Dr. Horri left $200 on Patient A's nightstand, which Patient A found highly insulting. Dr. Horri intended this as a supportive gesture.

On July 1, 2010, Dr. Horri left for Thunder Bay where he entered the Family Practice anaesthesia program at the Northern Ontario Medical School.

After his departure, Dr. Horri and Patient A continued an on-and-off long-distance intimate relationship for about three years. Patient A travelled to see Dr. Horri and Dr. Horri would sometimes travel to see Patient A. During and after the end of the sexual relationship, Dr. Horri provided Patient A with gifts, including two $2,000 e-transfers, a credit card in her name, and a laptop. Dr. Horri and Patient A remained in contact after the sexual relationship ended until the spring of 2014.

Disposition

On October 13, 2016, the Discipline Committee reserved its decision on penalty. On March 24, 2017, the Discipline Committee released its decision on penalty.

Appeal of Penalty Decision

On April 6, 2017, Dr. Horri appealed the penalty decision to the Superior Court of Justice (Divisional Court). Pursuant to s. 25(1) of the *Statutory Powers Procedure Act*, the appeal operated to stay the penalty decision pending the outcome of the appeal. On May 30, 2018, the Divisional Court allowed Dr. Horri's appeal and returned the matter of penalty to the Discipline Committee for redetermination. On June 19, 2018, the College filed a motion for leave to appeal the decision of the Divisional Court to the Court of Appeal. On September 17, 2018, the Court of Appeal denied the motion for leave to appeal.

Penalty-Redetermination Disposition

The penalty redetermination hearing took place on November 7, 2018. The Discipline Committee reserved its decision. On March 29, 2019, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Horri's certificate of registration for a period of twelve months, effective immediately;
- The Registrar impose the following terms, conditions and limitations on Dr. Horri's certificate of registration:
    - Dr. Horri shall complete an individualized course in medical ethics approved by the College to include professional responsibility, boundaries, and professional communication within 12 months of the date of this Order and will provide reports of successful completion to the College, at his own expense.
- Dr. Horri appear before the panel to be reprimanded;
- Dr. Horri pay to the College costs in the amount of $15,680.00 within 30 days of the date of this Order.

Appeal of Penalty Redetermination Decision

On April 26, 2019, Dr. Horri appealed the penalty decision to the Superior Court of Justice (Divisional Court). Pursuant to s. 25(1) of the *Statutory Powers Procedure Act*, the appeal operates to stay the penalty decision pending the outcome of the appeal.

4. Dr. A. F. Noza

Name:	Dr. Assefa Fersha Noza
Practice:	Family Medicine
Practice Location:	Etobicoke
Hearing:	Uncontested Facts Penalty - Joint Submission
Finding/Penalty Decision Date:	March 27, 2019
Written Decision Date:	May 10, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse of a patient – **withdrawn**

Summary

Dr. Assefa Fersha Noza ("Dr. Noza") is a sixty-two (62) year old physician, practising family medicine in Etobicoke, Ontario. Dr. Noza received his certificate of registration authorizing independent practice on December 6, 2001.

Dr. Noza is a member of the Humber River Family Health Team ("Humber River FHT"). At all relevant times, Dr. Noza practised at the Humber River FHT clinic site in Etobicoke.

Patient A was a patient of Dr. Noza between 2013 and 2016. In May 2016, Dr. Noza saw Patient A for a periodic health examination. At this appointment, Patient A underwent a blood test and a urine test.

Upon receiving Patient A's blood and urine test results, Dr. Noza's secretary called Patient A and told her that the doctor wanted to see her for a follow-up appointment.

Patient A saw Dr. Noza to discuss her results. Patient A's urine culture was positive for Group B Beta Hemolytic Streptococcus. Dr. Noza discussed this with Patient A and asked her whether she had been experiencing any symptoms related to a urinary tract infection. Patient A told Dr. Noza that she did not have any problems. Dr. Noza told Patient A that if she did experience any issues she could return to see him. Patient A then left the clinic.

A short time later on the same day, Patient A remembered that she had been experiencing heavy vaginal bleeding for the past few days but she had forgotten to mention this to Dr. Noza. Patient A returned to Dr. Noza's clinic and asked the secretary to see him again. The secretary placed Patient A into an examination room and Dr. Noza saw Patient A for a second time that day.

Patient A told Dr. Noza about her heavy vaginal bleeding. Dr. Noza told Patient A to lie down on the examination table.

Dr. Noza first palpated Patient A's abdomen and asked whether she had any pain. Without adequately explaining, Dr. Noza then told Patient A to pull down her underwear. She was not offered a drape or gown. Dr. Noza put on a glove and conducted a vaginal examination.

Patient A was not expecting Dr. Noza to conduct a vaginal examination. Dr. Noza had never conducted a vaginal examination of Patient A. In the past, only Dr. Noza's female staff had conducted Pap smears for Patient A.

Following the examination, Dr. Noza told Patient A to get dressed and return to see him if she had any continuing concerns.

Prior to conducting the vaginal examination, Dr. Noza failed to:

- Advise Patient A that he was going to conduct a vaginal exam;
- Explain to Patient A the reason for the exam and what the exam would involve;
- Obtain Patient A's informed consent before proceeding;

- In accordance with his usual practice, ascertain whether Patient A wanted a chaperone present in the room; and
- Provide Patient A with proper draping or a gown.

As a result, Patient A felt confused and upset.

Dr. Noza did not make any notes in Patient A's medical chart of her having returned to see him for a second time on the same day. He failed to document her concerns about vaginal bleeding and failed to document the physical and vaginal examination.

Undertaking in Lieu of the s. 25.4 Order

On April 30, 2018, Dr. Noza entered into an interim undertaking to the College in lieu of an Order under section 25.4 of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act*, S.O. 1991, C-18.

No concerns regarding Dr. Noza's compliance with the interim undertaking have been identified by the College's compliance monitor.

Dr. Noza's March 27, 2019 Undertaking

Dr. Noza has entered into an undertaking to the College, effective March 27, 2019, by which he has agreed, among other things, that he will not conduct any breast, pelvic or rectal examination of any patient, of any age, in any jurisdiction, unless the examination takes place in the continuous presence and under the continuous observation of a monitor who is a regulated health professional acceptable to the College.

Prior History

On May 14, 2015, the Inquiries, Complaints and Reports Committee (the "ICRC") issued a written caution to Dr. Noza with regard to professional communication. The ICRC also directed a Specified Continuing Education or Remediation Program (a "SCERP") which required Dr. Noza to complete one-on-one instruction on communication, and engage in self-directed learning by writing a report reflecting on how he has changed his communication technique.

Dr. Noza has no prior history with the Discipline Committee.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Noza's Certificate of Registration for a three (3) month period effective immediately.

- The Registrar impose the following terms, conditions and limitations on Dr. Noza's Certificate of Registration:
    - Dr. Noza shall comply with the College's Policy #2-07, "Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation";
    - Dr. Noza shall successfully complete the PROBE Ethics and Boundaries Course ("PROBE course"), at his own expense, within twelve (12) months of the date of this Order. Dr. Noza will agree to abide by the recommendations of the PROBE course and provide proof of completion to the College;
    - Dr. Noza shall inform the College of each and every location where he practices, in any jurisdiction ("Practice Location(s)") within five (5) days of commencing practice at that location;
    - Dr. Noza shall be responsible for any and all fees, costs, and expenses, associated with implementing and fulfilling the terms of this Order; and
    - Dr. Noza shall provide irrevocable consent to the College to make appropriate enquiries of OHIP and/or any person or institution that may have relevant information, in order for the College to monitor compliance with this Order.
- Dr. Noza appear before the panel to be reprimanded.
- Dr. Noza pay costs to the College in the in the amount of $6,000.00 within thirty (30) days.

5. Dr. J. Peirovy

Name:	Dr. Javad Peirovy
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Allegations - Contested Penalty - Contested
Finding Decision Date:	February 26, 2018
Penalty Decision Date	March 20, 2019
Written Decision Date:	March 20, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**

Summary

Patient A

Dr. Peirovy is a general practitioner, who was working in a walk-in clinic in 2009. Patient A, a single woman in her twenties, saw him for a minor ailment. She was assessed by Dr. Peirovy in a brief interview involving history and physical examination. During the examination, she partially lifted her shirt up while he palpated her abdomen but was otherwise fully clothed. Patient A and Dr. Peirovy shared a cultural background and language. At the end of the medical appointment, he gave her his cell phone number. When she left the appointment, Patient A expected that she and Dr. Peirovy would date.

Nothing was said about dating or ending the doctor-patient relationship during the appointment. Patient A did not consider Dr. Peirovy her doctor after the appointment.

Two days later Patient A called Dr. Peirovy, and over the ensuing two weeks, they telephoned each other often, before going on a date. They developed a one and a half year relationship that was characterized by mutual respect and consideration, though there were several breakups. The relationship included holding hands, hugging, kissing and physical sexual touching, but no intercourse. Patient A eventually broke off the relationship.

At one point, Dr. Peirovy mentioned to Patient A his concern regarding how they first met, that is that it occurred during a medical encounter. He suggested he wanted her to sign a document because of his worry that the way they met was not right, was unethical. He did not follow through with this.

Decision

The Committee found that Dr. Peirovy engaged in conduct relevant to practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, by using his medical office to initiate a social relationship with a young female patient by giving her his personal cell phone number at her medical appointment with him.

Disposition

On March 20, 2019 the Discipline Committee ordered and directed that that:
- The Registrar suspend Dr. Peirovy's certificate of registration for a period of two (2) months, to commence 30 days from the date of this Order;
- Dr. Peirovy appear before the panel to be reprimanded within 60 days of the date of this Order;
- Dr. Peirovy pay to the College costs in the amount of $28,610 within 45 days of the date of this Order.

6. Dr. T. J. P. Szozda

Name:	Dr. Timothy James Peter Szozda
Practice:	Family Medicine
Practice Location:	Kitchener
Hearing:	Uncontested Facts Penalty - Joint Submission
Finding/Penalty Decision Date:	January 30, 2019
Written Decision Date:	March 25, 2019

Allegations and Findings

- disgraceful, dishonourable or unprofessional conduct – **proven**
- sexual abuse of a patient - **withdrawn**
- failed to maintain the standard of practice of the profession – **withdrawn**

Summary

Dr. Szozda is 57 years old and practises family medicine in Kitchener, Ontario. He received his certificate of registration authorizing independent practice from the College, and his specialist designation in family medicine in 1988.

Patient A was a patient of Dr. Szozda's from 1992 to 2016. During appointments with Patient A, Dr. Szozda made inappropriate and unprofessional comments to her, and engaged in inappropriate and unprofessional conduct towards her as follows:

a) In May 2013, Patient A attended an appointment with Dr. Szozda for an assessment of her acne. As she was sitting in a chair facing him, Dr. Szozda leaned over and lowered the top of her shirt to expose the upper chest above the bra line to examine her chest for acne. Dr. Szozda then told her to stand up and turn around, and pulled up her shirt at the back to determine if she had any acne on her upper back as well. Dr. Szozda did not adequately explain his examination of Patient A's upper chest and back before performing it. The inadequate explanation caused Patient A to be alarmed;

b) During the appointment in May 2013, Dr. Szozda assessed Patient A's need for oral contraceptives, both as a matter of birth control, and to determine the combination of therapies to treat her acne. In doing so, Dr. Szozda inappropriately asked Patient A if she had a boyfriend. When Patient A replied that she did not have a boyfriend, Dr. Szozda replied "Oh really, a pretty girl like you?" It was inappropriate of Dr. Szozda to comment on Patient A's appearance;

c) In August 2014, Dr. Szozda performed a pelvic examination on Patient A. The examination required her to be undressed from the waist down. She was provided with a gown. During the pelvic examination, before inserting the speculum, Dr. Szozda made an unnecessary and inappropriate comment to Patient A regarding the number of fingers he was able to insert into her introital opening. Patient A was upset by his comment;

d) After the pelvic examination, Patient A was not given sufficient privacy to change back into her own clothes. Dr. Szozda remained in the examination room, with his back turned to the patient, looking at his computer screen and typing his chart notes into his electronic medical record;

e) After Patient A was fully clothed, Dr. Szozda briefly hugged Patient A. This was inappropriate in the circumstances and demonstrated poor judgment. The hug made

Patient A uncomfortable;

f) Between 2014 and 2015, Patient A had an ongoing problem with yeast infections. She had several vaginal examinations by Dr. Szozda in that period. Each time she was asked to undress from the waist down, Dr. Szozda failed to give her sufficient privacy when putting her clothes back on. Dr. Szozda remained in the room, looking at the computer, which did not adequately protect the patient's privacy.

In May 2017, Patient A submitted a complaint to the College regarding Dr. Szozda's inappropriate conduct and comments.

Dr. Szozda does not contest the above facts, and does not contest that, based on these facts, he engaged in acts or omissions relevant to the practice of medicine that would be regarded by members as disgraceful, dishonourable or unprofessional.

Disposition

The Discipline Committee ordered that:

- The Registrar suspend Dr. Szozda's certificate of registration for a period of 2 months, effective February 1, 2019.
- Dr. Szozda attend before the panel to be reprimanded.
- The Registrar impose the following terms, conditions and limitations on Dr. Szozda's certificate of registration:
  - Dr. Szozda will successfully complete the PROBE course in ethics and boundaries, at his own expense, by obtaining an unconditional pass, and will provide proof of completion to the College within 8 months from the date of this Order.
- Dr. Szozda pay costs to the College in the amount of $6,000 within 30 days from the date of this Order.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **May 31, 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)(e) of the Health Professions Procedural Code.