The College of Physicians and Surgeons of Ontario

Meeting of Council

Friday, September 8th, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Friday September 8, 2017 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

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

Rocco Gerace, MD
Registrar

August 14, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
September 8, 2017
Council Chamber, 3rd Floor, 80 College Street, Toronto
AGENDA

CALL TO ORDER

9:00 President's Announcements

9:05 Council Meeting Minutes of May 25/26, 2017……..1

Executive Committee's Report to Council, April to July, 2017 ……10

9:10 Physician Services During Disasters and Public Health Emergencies Policy – Draft for Consultation ……13

- ***For Decision***

The College's *Physicians and Health Emergencies* policy is currently under review. After considering the public health and emergency management literature, the information gathered through a jurisdictional review, and the feedback received during a preliminary consultation, a draft policy titled *Physician Services During Disasters and Public Health Emergencies* has been developed. Council is asked whether the draft *Physician Services During Disasters and Public Health Emergencies* policy can be released for external consultation.

9:25 Opioids Strategy – Status Update……23

- ***For Discussion***

Members of Council will be provided with a status update on the elements of the Opioids Strategy.

9:45 The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain – Proposed Updates to the Prescribing Drugs Policy ……..32

- ***For Decision***

Minor changes are being proposed to the Prescribing Drugs policy to reflect commitments made by the College following the 2016 Opioid Summit and Conference. These commitments included updating relevant policy to reflect the release of the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. Council is asked for its feedback on the draft policy, and whether the draft policy can be approved as a final policy of the College.

10:15 ***Break***

PRESENTATION

10:30 Vision 2020 – Modernizing the College of Nurses of Ontario's Governance……60

Guest Speaker: Anne L. Coghlan, RN, MScN, Executive Director & CEO
College of Nurses of Ontario

At its December 2016 meeting, the College of Nurses of Ontario's Council approved a vision for governance for 2020. The vision will ensure the College's board remains an effective leader in building the public's trust that the board is focused on the public's needs and interests. This presentation will describe CNO Council's journey, guided by evidence, leading practices in regulatory governance and the recommendations of an expert Task Force.

COUNCIL AWARD PRESENTATION

11:30 Council Award Winner: Dr. Michael Colin Stephenson, Kitchener Ontario……**91**

12:00 – 1:00 ***Lunch***

1:00 Motion to go In-Camera

IN CAMERA

2:00 Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice Policy – Draft for Consultation ……92

- ***For Decision***

The College's *Changing Scope of Practice and Re-entering Practice* policies are currently under review and a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* has been developed, which addresses

both topics. Council is provided with an overview of the policy review process undertaken to date, and is asked whether it recommends that the draft policy be released for external consultation.

2:30 ***Break***

MEMBER TOPICS

2:50 **123**

REGISTRAR'S REPORT
Corporate Report and Dashboard – 2017 Q2

3:15 **New Member Orientation……131**

- ***For Decision***

Council is being asked to approve that new applicants, as a condition of being granted their first certificate of practice in Ontario, be required to engage in education related to professionalism and self-regulation including boundary violations and sexual abuse prevention.

3:45 **Governance Committee Report**

Items for Decision

- Facilitating Public Member Presidents
- Election of 2017/2018 Academic Representatives on Council
- 2018 Chair Appointments

Items for Information

- Committee Appointment - Rescinded
- Public Member Reappointment
- 2017 District 5 and 10 Election Update
- Completion of 2017 Council Performance Assessment (Form)

INFORMATION ITEMS

4:00 ADJOURNMENT

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
May 25, 2017

Attendees:

Dr. David Rouselle (President)
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Mr. Roy Marra
Ms. Judy Mintz
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Ms. Joan Powell
Dr. John Rapin
Dr. Jerry Rosenblum
Ms. Gerry Sparrow
Mr. Emile Therien
Dr. James Watters
Dr. Scott Wooder

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

Regrets: Dr. Richard (Rick) Mackenzie, Dr. Peeter Poldre, Mr. Arthur Ronald, Dr. Andrew Turner

CALL TO ORDER

President's Announcements

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

Council Meeting Minutes of December 1 and 2, 2016

01-C-05-2017

It is moved by Mr. Sudershen Beri and seconded by Dr. Deborah Hellyer that:
The Council accepts the minutes of the meeting of the Council held on February 24, 2017 with the following corrections:

Dr. Deborah Hellyer, Ms. Gerry Sparrow and Dr. Scott Wooder were present.

CARRIED

Executive Committee's Report to Council – January to March 2017

Received.

FOR DECISION

2016 Audited Financial Statements

Mr. Pierre Giroux, Chair, Finance Committee, presented the Report of the Finance Committee.

02-C-05-2017

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

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

CARRIED

Appointment of Auditors

03-C-05-2017

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

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

CARRIED

PRESENTATION

Data and Analytics

Karey Iron, Director of Research and Evaluation, provided Council with an update on the development of the CPSO Data and Analytics Strategic Framework that outlined planned activities from 2017 to 2020.

Education Strategic Initiative – College Long-Term Vision for Education

Dr. Bill McCauley, Medical Advisor, provided Council with an update of the activities of the Visioning Group of the Education Strategic Initiative.

REGISTRAR'S REPORT

Corporate Reporting and Dashboard Update.

COUNCIL AWARD WINNER

Dr. Joel Kirsh presented the Council Award to Dr. William Gary Smith of Orillia, Ontario.

Motion to Go In Camera

04-C-05-2017

It is moved by Ms. Lynne Cram and seconded by Ms. Judy Mintz that:

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

CARRIED

IN CAMERA

Council entered into an in-camera session at 11:45 a.m. and returned to open session at 12:15 p.m.

PRESENTATIONS

Peer Assessment Redesign – Update on Implementation

William Tays, Research and Evaluation Department, provided Council with an update on the Peer Assessment Redesign.

CPSO Evaluation of Multi-Source Feedback (MSF)

Wendy Yen, Research and Evaluation Department, provided Council with an update on the MSF evaluation and several ongoing CPSO and national initiatives.

FOR DECISION

Governance Committee Report - 2018 Executive Committee Vote

05-C-05-2017

It is moved by Mr. Sudershen Beri and seconded by Major A. Khalifa that:

Council appoints Dr. Steven Bodley (as President), Dr. Peeter Poldre (as Vice President), Dr. Brenda Copps (as physician member), Ms. Lynne Cram and Mr. Pierre Giroux (2 public members) and Dr. David Rouselle (Past President) to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2017.

CARRIED

MEMBER TOPICS

Council members provided commentary for the following:

- Physician wellness and work-life balance as part of the Physician Health Program
- Paperless Initiative and online shared portal to access CPSO related information
- Cost recovery process through the Finance Committee

ADJOURNMENT

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

_____
Dr. David Rouselle, President

_____
Franca Mancini, Recording Secretary

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
May 26, 2017

Attendees:

Dr. David Rouselle (President)
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Mr. Roy Marra
Ms. Judy Mintz
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Ms. Joan Powell
Dr. John Rapin
Dr. Jerry Rosenblum
Ms. Gerry Sparrow
Dr. James Watters
Dr. Scott Wooder

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

Regrets: Dr. Richard (Rick) Mackenzie, Dr. Peeter Poldre, Mr. Arthur Ronald, Dr. Robert (Bob) Smith, Mr. Emile Therien and Dr. Andrew Turner

CALL TO ORDER

President's Announcements

Dr. David Rouselle called the meeting to order at 9:00 a.m.

FOR DECISION

Accepting New Patients – Consultation Report and Revised Draft Policy

06-C-05-2017

It is moved by Ms. Lynne Cram and and seconded by Ms. Diane Giampietri that:

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

CARRIED

Ending the Physician Patient Relationship – Consultation Report and Revised Draft Policy

07-C-05-2017

It is moved by Dr. Carol Leet seconded by Mr. Sudershen Beri that:

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

By-Law Amendments Re Compensation Committee

08-C-05-2017

It is moved by Dr. Marc Gabel seconded by Mr. Pierre Giroux that:

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

By-law No. 115

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

Executive Committee

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

(a) consult with Council in respect of the performance of the registrar and with respect to setting performance objectives in accordance with a process approved from time to time by Council;
(b) ensure that the appointment and re-appointment of the registrar are approved by Council; and
(c) approve a written agreement setting out the terms of employment of the registrar.

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

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

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

Expenses

5. (8) Despite sections 4(2) and 4(6), an agreement for employment of the Registrar shall be signed on behalf of the College by one of the President or the Vice-President.

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

CARRIED

Approval of Procedure for Administration of Registrar Employment, Compensation and Performance Reviews

09-C-05-2017

It is moved by Ms. Joan Powell seconded by Mr. Pierre Giroux that:

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

CARRIED

PRESENTATION

Dr. David Juurlink, Division of Clinical Pharmacology and Toxicology at Sunnybrook Health Sciences Centre, Medical Toxicologist at the Ontario Poison Centre at The Hospital for Sick Children and Senior Scientist at ICES, provided Council with an update on the research program in drug safety including the consequences of drug interactions and harms associated with opioids.

Opioids

Maureen Boon, Director Strategy, provided council with an update outlining the CPSO role and roles of others, planned changes to the methadone committee including a strategy framework.

10-C-05-2017

It is moved by Dr. Marc Gabel seconded by Dr. Joel Kirsh that:

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

CARRIED

11-C-05-2017

It is moved by Dr. Marc Gabel seconded by Dr. Jerry Rosenblum that:

Council approves the Opioid Strategy Framework, as set out in the briefing note (a copy of which forms **Appendix "E"** to the minutes of this meeting).

CARRIED

ANNUAL FIRE DRILL AND EVACUATION PROCEDURES

The College is required to complete annual testing of fire drill procedures. Krista Waaler provided a brief presentation on safety procedures and Council members successfully participated in the evacuation process.

TOPICS FOR INFORMATION

Government Relations Report, including Bill 87

Policy Report

Fertility Services: Finalized Companion Document "Applying the Out-of-Hospital Premises Inspection Program Standards in Fertility Services Premises"

Discipline Committee – Report of Completed Cases, May 2017

OMA Request for Member Self Reporting of CPD Compliance to the CPSO

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 1:45 p.m.

_____
Dr. David Rouselle, President

_____
Franca Mancini, Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

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

FOR INFORMATION

April 25, 2017 Executive Committee Meeting

1. Bill 87 (teleconferenced for Council participation)

Bill 87, the *Protecting Patients Act, 2017* grants the Minister very broad new governance-related regulatory powers, perhaps the most significant of which is the new Ministerial regulation-making authority that allows the Minister to establish the "structure" of the seven statutory committees.

Given the speed in which the Bill is proceeding through the legislative process, Council members were invited to participate in the Executive Committee meeting via teleconference to discuss a proposal to achieve greater independence of the Discipline Committee. The CPSO will present recommendations to the Standing Committee on April 26, 2017.

The Executive Committee supported recommendations to the Standing Committee that there be no overlap in membership between Council and the Discipline Committee, and that both physicians and members of the public participate on Discipline Committee panels.

2. Governance Committee Report

Appointments

The Executive Committee appointed

- Mr. Roy Marra to the Discipline and Premises Inspection Committees;

- Dr. Steven Bodley and Dr. Meredith MacKenzie as Co-chairs of the Methadone Committee; and
- Dr. Janet van Vlymen to complete the four year term as the CPSO representative to the Medical Council of Canada.

3. Recommendation from Education Committee on the OMA Request for Member Self Reporting of CPD Compliance to the CPSO

The Executive Committee supported the Education Committee's recommendation to deny a request from the Ontario Medical Association to permit physicians who are not members of the Royal College of Physicians and Surgeons or the College of Family Physicians of Canada to self-report Continuing Professional Development (CPD) compliance to the CPSO.

4. "Expectations of Physicians Not Certified in Emergency Medicine Intending to Include Emergency Medicine Work in their Practice – Changing Scope of Practice"

The College has developed a draft document to serve as a guide for physicians without certification in Emergency Medicine (EM) who wish to include EM as part of their practice. It is increasingly common for urban Emergency Departments to require certification in EM. As such, this document will most often serve as a guide for family physicians and general practitioners intending to work in a rural setting. This framework is an extension of the CPSO's "Changing Scope of Practice" policy, which requires that physicians report to the College when they have changed their scope of practice or intend to change their scope of practice. The CPSO is undertaking a limited targeted consultation on this draft document with medical organizations and certifying bodies.

5. Attendance of a Physician Council Member and a Public Member of Council at the 2017 FMRAC Annual Meeting and Conference

Dr. Carol Leet and Major Abdul Khalifa were selected to attend the 2017 FMRAC Annual Meeting and Conference.

6. Fertility Services: Finalized Companion Document "Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises"

This document was developed in response to a request by the Ministry of Health for the CPSO to develop and implement a quality and inspections framework for the delivery of fertility services across the province.

June 20, 2017 Executive Committee Meeting

1. The Use of Clean versus Sterile Technique in the Performance of Neuraxial Blocks

In response to the College's position that sterile technique was the standard for neuraxial blocks, members of the OMA Chronic Pain section and the College's Assessor Network Group for chronic pain management sought clarification about whether this was the standard in community pain management settings.

The College, based on additional information from experts, affirmed the position that sterile technique is the required standard of practice, given the risk of infection and complications with neuraxial nerve blocks. Trigger point injections can be performed with clean technique.

In response to ongoing communications on this issue, the Executive Committee directed that a letter be sent to all CPSO assessors in this area of practice, stating the College's expectations.

Contact: David Rouselle, President
Lisa Brownstone, ext. 472

Date: August 21, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: Physician Services During Disasters and Public Health Emergencies Policy – Draft for Consultation

FOR DECISION

ISSUE:

- The College's *Physicians and Health Emergencies* policy is currently under review. After considering the public health and emergency management literature, the information gathered through a jurisdictional review, and the feedback received during a preliminary consultation, a draft policy titled *Physician Services During Disasters and Public Health Emergencies* has been developed.

- Council is provided with information regarding the policy review and development process along with an overview of the draft policy. Council is asked whether the draft *Physician Services During Disasters and Public Health Emergencies* policy can be released for external consultation.

BACKGROUND:

- The College's Physicians and Health Emergencies policy was developed in preparation for an anticipated H1N1 pandemic, and was approved by Council in 2009. This policy sets out expectations of physicians during health emergencies, such as pandemics.

- In accordance with the College's regular policy review cycle, a review of the policy commenced in the spring of 2016.

- An Advisory Group is assisting with this policy review, and is comprised of Council members and College Staff. Dr. Janet Van Vlymen (physician member of Council), Mr. Harry Erlichman (public member of Council), Dr. Bill McCauley (College staff – Medical Advisor) and Lindsay Cader (College staff – Legal Counsel) are members of this Advisory Group.

- As part of the policy review process a literature review was undertaken and a preliminary consultation on the current policy was conducted.

Research

- The development of the draft policy has been informed by extensive research which included the following:

    1. A comprehensive literature review was conducted of Canadian and international scholarly articles, research papers, and newspaper publications. The topics explored include, among others:
        - Emergency Preparedness and Emergency Management planning;
        - Public Health interventions and insights from recent disasters and/or public health emergencies;
        - Ethical approaches in crisis situations, including rationing resources and triaging care;
        - Roles for governments, health authorities and health professionals in planning and providing care; and,
        - Challenges experienced balancing professional duties with personal/familial responsibilities.

    2. An extensive jurisdictional review was undertaken to evaluate the policy positions of Canadian medical regulators, Canadian health authorities' emergency management plans, and select international public health and emergency management organizations.

Preliminary Consultation

- A preliminary consultation[1] was held on the current policy between September 25th and November 25th, 2016.

- In total, 57 submissions were received in response to the consultation. This included 13 written comments and 44 online surveys.

- Approximately 82% of the respondents identified themselves as physicians, 9% as members of the public, 2% as other health professionals, 2% as medical students, 3% as organizations[2], and 2% who preferred not to say.

[1] Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the College's entire membership. In addition, a general notice was posted on the College's website, Facebook page, and announced via Twitter. It was also published in Dialogue and Patient Compass (the College's public e-newsletter). Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to an online discussion page.
[2] The organizational respondents included the Professional Association of Residents of Ontario (PARO) and the Emergency Management Branch of the Ministry of Health and Long-Term Care (EMB-MOHLTC).

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

- Broadly speaking, stakeholder feedback covered a range of issues pertaining to providing services during health emergency situations. A summary of the major substantive comments advanced in the feedback is set out below:

    - **Use of the term "health emergency":** Although a majority of respondents indicated they thought it was clear which situations would be considered health emergencies for the purposes of this policy, analysis of the open-ended feedback and examples provided by respondents made it apparent that respondents were unable to distinguish between individual health emergencies and emergency situations that affect a large population of people. Respondents indicated that having examples would provide clarity on the types of health emergencies to which this policy would apply.

    - **Physicians should provide care:** An overwhelming majority of respondents indicated that they expected physicians to provide care to people in need during a health emergency. A few respondents with experience providing care in past health emergencies felt that in those situations, the profession as a whole was not as engaged in supporting front-line physicians as it could have been. Respondents suggested the new draft policy highlight options for physicians who might not be able to provide direct care to patients but who have the capacity to provide physician services in other ways.

    - **Impact on physician and family:** Many physician respondents acknowledged that the decision to provide care had to be balanced with the needs of the physician's family and that this was an ongoing struggle. Several felt that a lack of liability and disability insurance coverage affected their willingness to provide care in a future health emergency situation.

    - **Reciprocal duties to support physicians:** Several physicians noted that governments, agencies who coordinate emergency management plans and organizations who provide health care services have a reciprocal duty to ensure top-down communication to physicians and other health professionals. This included the need for assurances that health professionals would have the equipment and supplies they need to provide health care services in a health emergency situation.

    - **Access to information:** Of the twenty respondents to the online survey who indicated they had provided care to people in need during a health emergency,

fifteen respondents indicated that they had accessed sources of information which helped them decide to provide care during that health emergency. Sources of information included federal, provincial and/or municipal pandemic or emergency management plans, hospital or organizational pandemic or emergency management plans, public health literature, and peer-reviewed literature. Several respondents indicated that they were unsure where to access relevant information prior to and during health emergencies. One respondent suggested that CPSO could be a resource for physicians in this regard.

- **Practicing outside scope and typical practice setting:** A strong majority of respondents indicated that the current policy's position regarding scope of practice during a health emergency was reasonable and acceptable. One organizational respondent pointed out that there may be cause for a physician to work within their scope of practice but outside their typical practice setting (e.g. in a temporary clinic versus a hospital), and that the next iteration of the policy may wish to acknowledge this possibility.

CURRENT STATUS:

- In response to the research and feedback gathered to date, a revised policy has been drafted with the title 'Physician Services During Disasters and Public Health Emergencies'. (**Appendix A**)

- Overall, the draft policy retains the key content and central principles of the current policy. Changes have been made to enhance clarity, comprehension, and flow, as well as to address issues not currently addressed by the policy, and to ensure alignment and consistency with other College polices.

- Importantly, the draft policy now clarifies that physicians must provide services if they are able to do so, physician services provided need not be limited to direct care to people in need, that there are resources to assist physicians, and that the nature of the situation may require physicians to temporarily practice outside one's scope of practice but that this does not remove the requirement to follow College policy if they elect to change their scope of practice following the health emergency.

- The key revisions and additions reflected in the draft policy are set out below:

<u>Key revisions and additions</u>

1. **Updated title:**

- The proposed title in the draft policy seeks to provide clarity for when this policy would apply. The title has been updated to reflect that:
    a. the policy applies to physician services more broadly; and,
    b. the terms "disaster" and "public health emergency" are widely used and broadly understood in the public health and emergency planning/emergency management fields.

2. New principles have been added:

- The principles section has been updated to ensure consistency with departmental drafting convention, and reflects the format of recently reviewed policies.
- These principles highlight the need to provide care, collaborate with others, maintain knowledge, balance competing duties and responsibilities, and participate in the regulatory process in line with the values of medical professionalism as set out in the *Practice Guide*.

3. The scope of the policy has been further defined:

- The draft policy has been updated to explicitly clarify that the expectations contained in the policy apply to all physicians, regardless of specialty or practice setting (Lines 25-26).

4. Adding a terminology section:

- Feedback received from stakeholders suggested that additional clarity of the terms used in the policy would be useful. A terminology section has been added. The definitions acknowledge that disasters may result in human consequences and have the potential to lead to public health emergencies.
- The development of an FAQ document to accompany the policy is being considered to, among other things, provide examples of disasters and public health emergencies in order to provide additional clarity.

5. Adding information on the resources available to physicians:

- The "Staying Informed" section includes references to various forms of information that physicians can consult while preparing for, and responding to, disaster and public health emergency situations (Lines 46-49).

6. Expanding the idea of support beyond direct care:

- The "Providing Physician Services" section now acknowledges that physicians have options when considering how they can provide support during a health emergency.

This may include direct care to people in need, taking on administrative support roles or temporarily expanding the capacity of one's practice to offset the increased strain on physician resources.

NEXT STEPS:

- In keeping with College policy processes, the next stage in the review process is to solicit feedback on the draft policy externally, through a consultation with the profession, the public, and other interested stakeholders.

- Subject to Council's approval, the consultation will be held following the September 2017 Council Meeting and stakeholder feedback will be shared with both the Executive Committee and Council in 2018.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft Physician Services During Disasters and Public Health Emergencies policy?

2. Does Council recommend that the draft policy be released for external consultation?

Contact: Delia Sinclair Frigault, ext. 216

Date: August 18, 2017

Attachments:

Appendix A: *Physician Services During Disasters and Public Health Emergencies* draft policy

APPENDIX A

Physician Services During Disasters and Public Health Emergencies

Introduction

In the event of a disaster or public health emergency, the public relies on physicians to provide medical services. Federal, provincial and local responses to disasters and public health emergencies require extensive involvement of physicians. Physicians who provide care in these situations often put themselves at risk in order to assist others. This policy articulates the College's expectations of physicians and reinforces the profession's commitment to the public during these times of need.

Principles

The key values of professionalism articulated in the College's *Practice Guide* – compassion, service, altruism and trustworthiness – form the basis of the expectations set out in this policy.

Physicians embody the values of the profession and uphold the profession's reputation by:

1. Providing care for those in need.
2. Collaborating with and supporting colleagues, other health professionals, law enforcement, emergency response personnel and others when disasters or public health emergencies occur.
3. Maintaining current knowledge of relevant information available prior to and during disasters or public health emergencies.
4. Balancing competing professional and personal obligations in accordance with the values, principles and duties of medical professionalism.
5. Participating in the regulation of the medical profession by complying with the expectations set out in this policy.

Scope

This policy applies to all physicians during disasters and/or public health emergencies, regardless of practice setting or specialty.

Terminology

A **disaster** is a sudden, calamitous event that seriously disrupts the functioning of a community or society and results in human, material, economic or environmental losses that exceed a

community's or society's ability to cope. [1] A disaster may require medical response for the treatment of injured persons, and can lead to the occurrence of a public health emergency.

A **public health emergency** is an occurrence or imminent threat of an illness or health condition caused by biological and/or chemical terrorism, endemic/pandemic disease, or a novel and highly fatal infectious agent or biological toxin that poses a substantial risk to human life.[2]

Policy

This policy articulates the College's expectations of physicians during disasters and public health emergencies. This includes expectations regarding physician responsibilities to stay informed, to provide physician services, and to practise outside one's scope when necessary during disasters and public health emergencies. These expectations exist for the duration of the disaster and/or public health emergency.

Staying Informed

Physicians are advised to be proactive and inform themselves of the information available which will assist them in being prepared for a disaster or public health emergency. Once a disaster or public health emergency arises, however, physicians must make reasonable efforts to access relevant information and to stay informed for the duration.

Relevant information can include federal legislation[3], provincial legislation[4], emergency management plans developed by federal[5], provincial[6] and municipal governments[7], and advice provided by the CMPA[8]. A physician's practice setting may afford access to additional sources of information. This may include, but are not limited to, hospital protocols, directives from

---

[1] Adapted from the International Federation of Red Cross & Red Crescent Societies http://www.ifrc.org/en/what-we-do/disaster-management/about-disasters/what-is-a-disaster/

[2] Adapted from the World Health Organization http://www.who.int/hac/about/definitions/en/

[3] *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

[4] *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

[5] Public Safety Canada: Emergency Management https://www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/index-en.aspx

[6] Ministry of Community Safety & Correctional Services: Emergency Response Plans https://www.emergencymanagementontario.ca/english/emcommunity/response_resources/plans/plans.html

[7] Ministry of Municipal Affairs: List of Ontario Municipalities http://www.mah.gov.on.ca/page1591.aspx

[8] 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

community settings where medical services are provided, or organizational plans and/or policies.

Providing Physician Services

In fulfilling their individual commitment to patients, professional commitment to colleagues and collective commitment to the public, physicians must provide physician services during disasters and public health emergencies.

Physicians providing medical care directly to people in need must do so in accordance with relevant legislation and emergency management plans. Physicians must document these patient encounters to the best of their ability given the circumstances. Resources may become scarce during disasters or public health emergencies, so documentation of the facts and circumstances of the patient encounter as well as the rationale for the medical decisions made is recommended.

There may be reasons related to the physicians' own health, that of family members or others close to them[9] which may place limits on the physicians' ability to provide direct medical care to people in need during a disaster or public health emergency. In those instances, physicians who have a personal health and/or ability limitation must lend support during disasters and public health emergencies. This support can include performing administrative or other support roles, as well as increasing capacity in one's practice to offset the increased strain placed on physician resources during disasters and public health emergencies.

When deciding what role to undertake in a disaster or public health emergency, physicians must balance their competing obligations to the public, their patients, themselves and their families in accordance with the values, principles and duties of medical professionalism.

Practising Outside of Scope of Practice

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.[10] If a physician wishes to change their scope of practice the physician must do so in accordance with College policy[11].

During disasters and public health emergencies, it may be necessary for physicians to temporarily practise outside of their scope. In order to ensure competence while temporarily practising outside of one's scope of practice during disasters and public health emergencies,

[9] As defined in the College's *Physician Treatment of Self, Family Members and Others Close to Them* policy
[10] Subsection 2 (5) of Ontario Regulation 865/93 under the *Medicine Act, 1991*.
[11] *Changing Scope of Practice* policy (NOTE: currently under review – to be updated once review complete)

physicians are expected to exercise their professional judgement, and collaborate with their colleagues in health care, in determining what appropriate medical care they can provide to persons in need of care, in accordance with relevant legislation and emergency management plans.

Physicians must only practice outside of their scope of practice during disasters and/or public health emergencies if:

- the medical care needed is urgent;
- a more skilled physician is not available; and,
- not providing medical care may result in greater risk or harm to the patient or public than providing it.

Once the disaster or 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[12].

[12] *Changing Scope of Practice* policy (NOTE: currently under review – to be updated once review complete)

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: Opioid Strategy Update

FOR DISCUSSION

ISSUE:

- The Opioid Strategy, attached as Appendix A, was approved by Council at its May meeting.
- This briefing note provides a status update on the elements of the strategy.

CURRENT STATUS:

	Elements	Status
1 Guide	Review Prescribing Drugs policy to include updated guidelines and new expectations, as required	Interim revisions to the Prescribing Drugs policy have been made to incorporate the 2017 Canadian Guidelines and include a requirement for physicians to review available information prior to prescribing opioids. These will be considered at the September Council meeting and will be supported by an opioid position statement consistent with the strategy. A full review of the policy will be conducted in 2018.
	Facilitate review of MMT guidelines	This work is currently on hold, pending resolution of the possible s56 methadone exemption changes and development of the HQO standards.

	Elements	Status
2 Assess	Continue focused methadone assessments via methadone program	Methadone assessments are continuing.
	Expand focus on assessments to opioid prescribing via QAC	Work is underway to incorporate an opioid prescribing review into the existing random assessments.
	Identify & assess moderate risk opioid prescribing, avoiding need for investigations	Planning is underway to explore an alternate approach to responding to **moderate** risk prescribing, within the context of work already being done by other partners like ICES and HQO.

	Elements	Status
3 Investigate	Identify, investigate and monitor high risk (problem) opioid prescribing	Initial investigations are anticipated to be complete in fall 2017, at which time an evaluation will be conducted relating to the effectiveness of the algorithm and the investigative approach. Work is underway to identify **high** risk prescribing, within the context of work already being done by other partners like ICES and HQO.

	Elements	Status
4 Facilitate Education	Work with partners to: Ensure multiple educational offerings, targeted at multiple stages of practice: general education, awareness and remediation	Existing offerings have been identified. Regular communication with education providers, medical schools, and CPD programs is occurring to maintain an up-to-date list of resources. Opioids resources are available on the website: *http://www.cpso.on.ca/CPSO-Members/Continuing-Professional-Development/CPD-Practice-Improvement-Resources/Medical-Expert-Role-Resources*
	Work with partners to: Develop an Opioid Prescriber's Education Series, focused on the fundamentals of appropriate prescribing as well as particular areas of focus to be determined	Planning is underway for sessions in 2018 in collaboration with CPD-COFM. Multiple educational sessions and modules are being planned by multiple organizations, both provincially and nationally, so coordination will be important to avoid duplication.

ENABLING ACTIVITIES

	Elements	Status
A Communicate	Continue Dialogue coverage from multiple perspectives, including patients and families	**Issue 1 (Feb 2017)** • A Picture of Opioid Prescribing in Ontario – Infographic • Gaining Control - a family physician who inherited an opioid intense practice describes the techniques used to safely taper high-dose patients **Issue 2 (Jun 2017)** • Message from the Registrar – a description of approved Opioids Strategy • The Canadian Guideline Recommendations • Dr. David Juurlink's presentation to Council • Opioid Strategy Infographic • A case study of an elderly patient who died after being given a high opioid dose. **Issue 3 (Planned)** • Patient Perspective – a mother who lost her son to an overdose and a young mother who describes her own struggle to get off opioids. • Physician perspective about how to get patient buy-in for tapering **Issue 4 (Planned)** • Prescribing opioids for the elderly • Looking at other treatment modalities for Pain Relief and Functional Improvement • College Update on Progress Made • CPSO work with ICES
	Compile all Dialogue articles into a resource for other educational initiatives	This will be incorporated into the planning related to the Opioid Prescriber's Education Series.
	Communicate directly with patients and the public	Work is underway to develop communications with patients/the public as part of the Communications Strategy described below.
	Develop an Opioids Statement that clearly sets out the role of the College, physicians and system partners.	Work is underway to develop an Opioids Position Statement (consistent with the Strategy) as part of the Communications Strategy described below.

	Elements	Status
B Use Data and Analytics	Accessing, analyzing and acting on prescribing data are key enablers of the strategy framework	Current work includes: • Work with ICES to define levels of prescribing and physician factors associated with those levels. • Work with HQO and ICES to use consistent definitions for levels of prescribing. • Using the defined levels to determine what information should routinely come to the CPSO.
	Physicians need information to prescribe appropriately	CPSO has advocated for physician access to NMS data. Access is starting to become available with a goal of access to most physicians by the end of the year. Not entirely clear how solo physicians or physicians without EMRs will obtain access.
	The CPSO needs data to fulfill its regulatory responsibilities and to identify factors that support appropriate prescribing.	CPSO is working with ICES to receive de-identified information for analytics purposes in order to determine what kinds of identified information it should request from government.

	Elements	Status
C Collaborate	For activities that are not the CPSO's primary responsibility, collaborate with key stakeholders – Health Quality Ontario, the MOH, eHealth Ontario, and others – to promote safe prescribing and access to information for physicians	Ongoing work with HQO and education providers to identify the supports that will be offered to physicians at various levels of prescribing. Ongoing work with the MOH re the Prescription Monitoring Leadership Roundtable to establish algorithms and data transfer processes.

METHADONE TRANSITION

Preparations are underway for the appointment of the panel at the December Council meeting:

- Planning training for January to be ready for first QAC meeting in February.
- Confirming Methadone Committee ability to meet QAC expectations, increased time commitment for meeting attendance, etc.
- Leveraging knowledge of addictions and opioid prescribing that exists on the Methadone Committee in QAC.

COMMUNICATIONS STRATEGY

A comprehensive Opioids Communication Strategy has been developed with the following objectives:

- Communicate the CPSO's role/response/position on physician prescribing to internal and external stakeholders.
- Communicate the College's initiative and strategy to the public and media as well as the outcomes of investigations.
- Demonstrate CPSO's high level of engagement and partnership on the issue.

A number of products are being developed in support of the CPSO opioids strategy, which include the following:

- Refinement of key messages.
- A dedicated opioid hub webpage that will contain useful and relevant information for the public and physicians where information can be easily accessed. It will include dialogue articles, pieces from newsletters, media announcements, links to resources and focused information for patients.
- An opioids position statement (modeled after the eHealth position statement) that clearly sets out the role of the College, approach to opioids and strategy, the role of the CPSO and system partners.
- Development of fact sheets containing clear information about the College approach and strategy.
- Continuing Dialogue coverage from multiple perspectives, including patients and families.
- Development of public and physician focused Q and A.

OTHER UPDATES

PROVINCIAL

Minister/Ministry of Health

- The Ministry is working on the next phase of the opioids strategy but details and timing are not known.
- The MOH is currently consulting on a proposal to require physicians and health care organizations to disclose any support they have received from drug or other health care companies. This is partially related to concerns expressed about possible conflicts on the panel that developed the 2017 Canadian guidelines.

Prescription Monitoring Leadership Roundtable (PMLR)

- The PMLR's purpose is to ensure that NMS data is used by the MOHLTC in a consistent and evidence-based manner to ensure that potentially inappropriate prescribing and dispensing practices are identified and handled appropriately.
- The group is intended to deal with the development of algorithms to identify areas of highest risk and appropriate intervention methods when questionable prescribing and dispensing behaviour is identified.

Health Quality Ontario (HQO)

1. **Quality standards** relating to Opioid Use Disorder, Opioid Prescribing for Chronic Pain and Opioid Prescribing for Acute Pain have been drafted and will be released for consultation in the fall. They are expected to be finalized in March of 2018. These will be taken into consideration during the more comprehensive review of the Prescribing Drugs policy in 2018.

2. **Primary care practice reports** for physicians relating to opioids are scheduled to be released in November. Decisions have not yet been made about how these reports will be sent to physicians or what information will be included.

3. **Prescriber Supports for Primary Care**: HQO has continued its work to develop a collaborative and coordinated approach to supporting prescribers in their efforts to provide appropriate pain management. It has brought together groups that provide education and support for physicians: Medical Mentoring for Addictions and Pain (MMAP), Centre for Effective Practice (Academic Detailing) and OMD. The objective is to connect physicians with appropriate supports and concrete suggestions for improvement depending on their level of prescribing. For example, a high prescriber would be identified as a good candidate for a more intense program such as academic detailing.

Institute of Clinical and Evaluative Sciences

- The CPSO is working with ICES to identify the characteristics of particular kinds of prescribers using NMS data. This information will inform next steps.

Federal

Joint Statement of Action

- The CPSO is one of many organizations that made commitments as part of the Joint Statement of Action. The CPSO commitment is set out at Appendix B. A status report has been provided and we are progressing on all items.

2017 Canadian Guideline for Opioid Therapy and Chronic Non-Cancer Pain

- The guidelines were released in May 2017. Due to the issue of conflict, the Federal Minister has announced a review of the process leading to the guidelines. No further information has been received about the status of this review.

NEXT STEPS:

Work will continue on all elements of the strategy with a particular focus on clearly articulating the College's role regarding the review of NMS data, in the context of work ongoing at HQO, ICES and the MOH.

DECISION FOR COUNCIL:

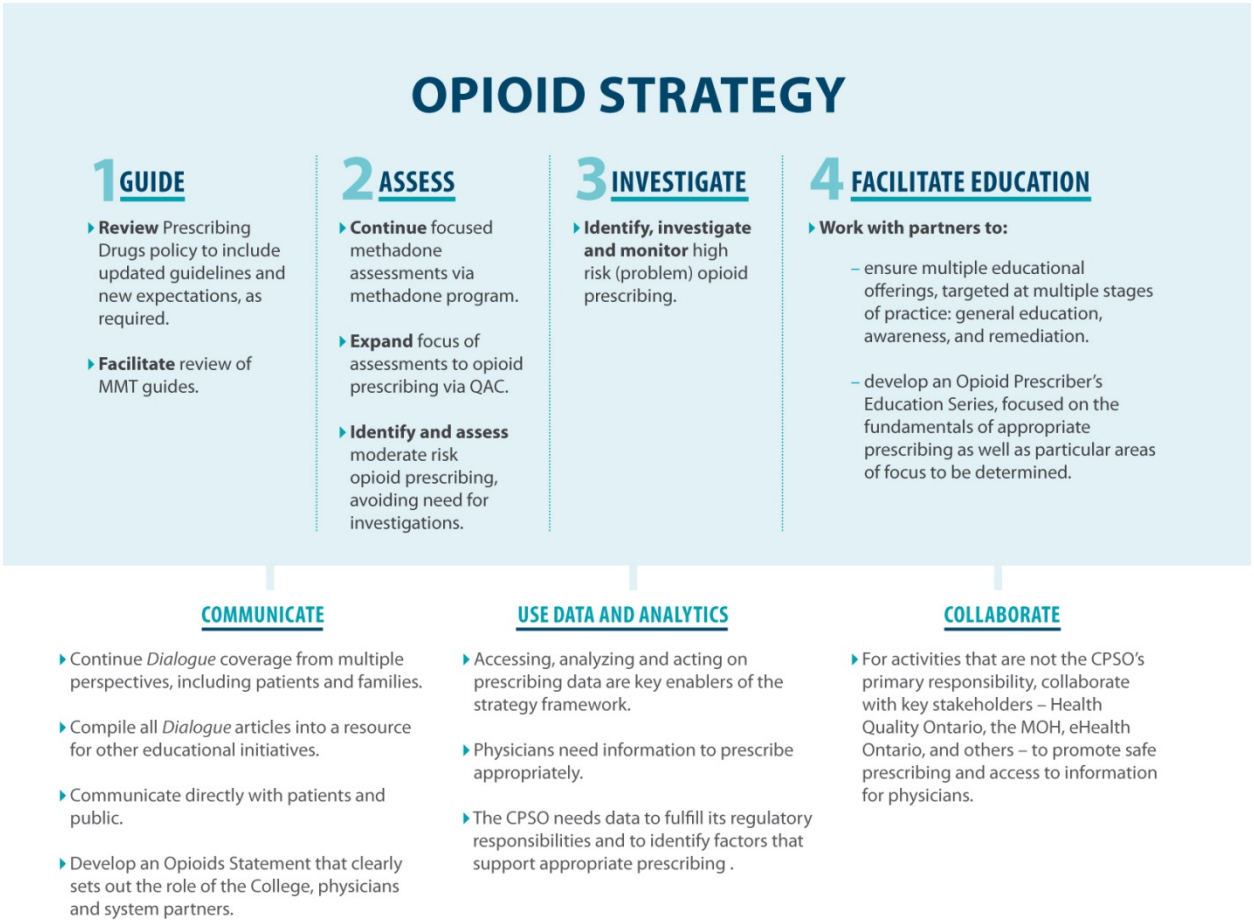
For Discussion

Contact: Maureen Boon, extension 276
Louise Verity, extension 466

Date: August 18, 2017

Attachments:
Appendix A: Opioid Strategy
Appendix B: Joint Statement of Action - CPSO

Appendix A: Opioid Strategy



Appendix B

Joint Statement of Action to Address the Opioid Crisis
November 19, 2016

The College of Physicians and Surgeons of Ontario commits to:

- **By June 2017**: Collaborating with the Ontario Ministry of Health and Long-Term Care on the recently released strategy and development of a plan to use Narcotics Monitoring System data held by the Ministry to promote patient safety. This includes:
  - identifying possible high risk prescribing and referring to regulatory bodies for follow up; and
  - developing a plan to identify low risk prescribing and providing a variety of educational interventions, including tools, that are tailored to individual needs of prescribers.
- **By December 2017**: Publicly reporting, as permitted by legislation, on the outcomes of the current approach.
- **By December 2017:** Updating existing policy to reflect revised Canadian Guidelines and Health Quality Ontario Quality Standards (if available).
- Once all physicians have access to narcotics profiles, inclusion of expectation in policy for physicians to check the medication profile prior to prescribing narcotics.
- Using prescribing information (comparative prescribing reports or prescribing data), when available, to inform educational approaches in conjunction with assessment of physician practice.
- Supporting and contributing to a broader strategy to ensure necessary supports are available to patients and other health professionals.

Rocco Gerace, Registrar

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: **The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain – Proposed Updates to the Prescribing Drugs Policy**

FOR DECISION

ISSUE:

- As part of a coordinated, multi-stakeholder response to the ongoing opioid epidemic, the CPSO has committed to undertake a number of specific actions, including to update the Prescribing Drugs policy to reflect the new 2017 Canadian National Guideline for Opioids for Chronic Pain.

- In keeping with these commitments, a number of minor changes are being proposed to the Narcotics and Controlled Drugs section of the Prescribing Drugs policy.

- Council is provided with a copy of the proposed revisions to the policy (**Appendix A**), and asked whether the draft policy can be approved as a final policy of the College.

BACKGROUND:

- Canada is in the midst of an opioid epidemic, with the second highest rate of opioid prescribing/use per capita in the world, and an escalating number of overdose deaths in multiple provinces.

2016 Opioid Conference and Summit

- As part of developing a coordinated, multi-stakeholder response to the opioid epidemic, the Federal Minister of Health and Ontario Minister of Health co-hosted an Opioid Conference and Summit in November, 2016.

- This Summit brought together medical regulators and other key stakeholders for a national discussion on actions to address the harms related to opioid misuse and abuse, and to identify concrete actions for moving forward.

- Summit participants were asked to commit to undertake specific actions to help combat the epidemic. These commitments are captured in the Joint Statement of Action to Address the Opioid Epidemic.

- Among other commitments made by the CPSO, the College committed to update existing policy to reflect the revised Canadian opioid prescribing guideline, which had not yet been released at that time.

- The CPSO also committed to update existing policy to reflect any Health Quality Ontario Standards (when available), and require physicians to consult medication profiles (when available) prior to prescribing opioids.

- The CPSO committed to complete this policy update by December, 2017.

The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

- In May, 2017, the Michael G. Degroote National Pain Centre at McMaster University released the new 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain.[1]

- The 2017 guideline aims to assist health care providers in making practice decisions about the safe and effective use of opioids for chronic non-cancer pain management, and is an update of the former national guideline which was released in 2010.

- The new guideline is comprised of 10 recommendations, which are each classified as either "weak" or "strong".

- Among the more significant updates to the guideline is a reduction of the maximum "recommended" dose", which was an expected response to evolving best practices and the ongoing opioid epidemic:

    - While the 2010 guideline recommended a "watchful dose" of 200 mg morphine equivalents (MME)/daily, the 2017 guideline recommends restricting the prescribed dose to less than 90 MME/daily (and preferably less than 50).

- In response to the new guideline, the CPSO released a statement which welcomed it, and which acknowledged it as an important part of a long-term strategy to deal with an opioid crisis.

[1] For an overview of the new Canadian recommendations, please see the *2017 Canadian Opioid Prescribing Guideline Poster*, which is a product of the Pan-Canadian Collaborative for Improved Opioid Prescribing

CURRENT STATUS:

- In keeping with the CPSO's commitments made at the 2016 Opioid Conference and Summit, minor changes have been made to the Prescribing Drugs policy for Council's consideration.

- Consistent with the College's general position on clinical practice guidelines, it is not proposed that the updated policy formally endorse the guideline or incorporate the guideline's recommendations.

- Instead, the proposed updates are intended to:

    1. Update and emphasize the key principles of good practice, consistent with the 2017 Canadian Guideline, existing practice standards, and policy;
    2. Emphasize for physicians that they are expected to be aware of relevant practice standards, quality standards, and clinical practice guidelines, and incorporate them into practice where it is appropriate to do so. With respect to the prescribing of opioids for chronic non-cancer pain, the 2017 Canadian Guideline, the Centers for Disease Control and Prevention (CDC) Guideline, and Health Quality Ontario Quality Standards will be referenced; and
    3. In limited cases, highlight key recommendations of the 2017 Canadian Guideline where those recommendations relate to issues of significant importance to patient safety.

<u>Proposed amendments to the policy</u>

- The revised draft of the policy is attached as **Appendix A**.

    Note: The full Prescribing Drugs policy has been attached, so Council can view the proposed changes in context. Given that the proposed changes are substantial, a track-changes version of the policy has not been provided. Instead, the revised content will appear as regular text, with the remainder of the policy shaded grey. All updates have been made to the Narcotics and Controlled Substances section of the policy, which begins on page 11.

- The following proposed updates have been undertaken with the assistance and feedback of the CPSO Internal Opioid Steering Group, Dr. Michael Szul, Dr. Keith Hay, and Dr. Angela Carol.

    1. Updates have been made to the section of the policy related to the prescribing of Narcotics and Controlled substances (this section of the policy does not solely pertain to the prescribing of opioids for chronic non-cancer pain).

2. Updated references: References throughout the policy have been updated to reflect the new 2017 Canadian Guideline as well as the CDC Guideline.

3. Revised introductory section: A revised introductory section (lines 422 - 437) has been added to frame the new content within the policy. In particular, it is emphasized that the policy does not seek to curb the appropriate prescribing of narcotics and controlled substances, but does acknowledge the risks they pose.

4. Expectations prior to prescribing: A new section has been added to the policy which articulates a set of expectations for physicians *prior* to prescribing a narcotic or controlled substance (lines 439 – 481). This section incorporates existing expectations from the policy and articulates new ones (key expectations are set out below):

    i. Physicians must consider and apply relevant practice standards, quality standards, and clinical practice guidelines when deciding whether to prescribe. The policy specifically references the 2017 Canadian National Guideline for Opioids for Chronic Pain, the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and any relevant Quality Standards developed by Health Quality Ontario (when available) (lines 446 – 460);
    ii. Consistent with the 2017 Canadian Guideline, the policy requires physicians to consider alternative treatment options, particularly non-opioid treatment options, prior to initiating a prescription for a narcotic or controlled substance (lines 462 - 471); and
    iii. Consistent with the CPSO's commitment at the 2016 Opioid Summit and Conference, physicians are now required to review relevant prescribing data when available, including patient narcotic prescribing profiles (lines 473 – 483).

5. Expectations when prescribing: A new section has been added to the policy which articulates a set of expectations for physicians *when* prescribing a narcotic or controlled substance (lines 485 – 523). This section incorporates existing expectations from the policy and articulates new ones (key expectations are set out below):

    i. Physicians must communicate with patients about risks, including any risk of addiction and overdose (lines 492 – 493);
    ii. Physicians must consider and apply relevant practice standards, quality standards, and clinical practice guidelines to determine a safe and effective dose. In particular, it is highlighted that with respect to opioids, both the 2017 Canadian Guideline and the CDC Guideline recommend against

prescribing doses above 90 morphine milligram equivalents (MME)/day (lines 495 – 502); and

iii. Physicians must recognize patients who are receiving an unusually high dose of narcotics or controlled substances, and slowly taper those patients when appropriate, and consistent with relevant clinical practice guidelines. Physicians are reminded that rapid cessation and/or tapering is usually inappropriate and dangerous (lines 504 - 505).

6. Ending the physician-patient relationship: New content has also been added which articulates the College's expectations with respect to ending the physician-patient relationship with patients who are receiving a prescription for a narcotic or controlled substance (lines 629 – 639). The key expectation is that physicians must not end the physician-patient relationship solely because a patient is addicted or dependent on a drug, or because the patient is on a high dose of opioids.

CONSIDERATIONS:

Scope of the proposed revisions

- The proposed updates to the Prescribing Drugs policy are intended to reflect the scope of the new 2017 Canadian Guideline and fulfill the CPSO's commitment under the Joint Statement of Action to Address the Opioid Epidemic. As a result, they do not comprehensively address every identified/relevant issue related to the current opioid crisis.

- The Prescribing Drugs policy is scheduled for a full review beginning in the fall/winter of 2017, in accordance with the College's regular policy review cycle. Over the course of that review there will be an opportunity to consider any additional relevant issues that are not addressed in these minor, interim revisions.

Anticipated availability of Health Quality Ontario Quality Standards and other relevant prescribing data (e.g. narcotic profiles)

- While the CPSO committed to update the policy to reflect any relevant Quality Standards developed by Health Quality Ontario, and to require physicians to review any available prescribing data (such as narcotic profiles), neither are currently available to physicians.

- Both are expected in the near future (i.e. late 2017 or early 2018), so they have been included in the updates proposed above, with the caveat that physicians are not required to consult either resource until such time as they are available. This avoided the need to revisit the policy again prior to completion of the full policy review.

- Staff will continue to monitor the development of these external resources to ensure that the final policy remains accurate and up-to-date, and Council will receive updates as new developments occur.

NEXT STEPS:

- Should Council support the updated policy, it will be published in *Dialogue* and will replace the current version of the Prescribing Drugs policy on the CPSO website.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft Prescribing Drugs policy?

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

Contact: Cameron Thompson, Ext. 246

Date: August 17, 2017

Attachments:

Appendix A: Draft Policy: Prescribing Drugs

Note: New content can be found on pages 11 – 13 and 16.

Prescribing Drugs

Policy Number:5-16
Policy Category: Drug/Prescribing
Under Review: No
Approved by Council: December 2012
College Contact: Physician Advisory Service

Introduction

Prescribing drugs is a standard component of most physicians' practices. It is an important area of practice that requires appropriate knowledge, skill and professional judgment. To improve patient safety when prescribing, this policy sets out expectations for physicians who prescribe drugs.

Prescribing is also governed by a complex legislative framework. In addition to the expectations set out in this policy, physicians must be aware of, and comply with, relevant requirements for drugs and prescribing set out in law. This includes, but is not limited to, requirements contained in the Food and Drugs Act, 1 Controlled Drugs and Substances Act, 2 Narcotics Safety and Awareness Act, 2010, 3 and Drug and Pharmacies Regulation Act. 4

The first section of this policy contains general expectations for prescribing that always apply when physicians prescribe a drug. The second section highlights issues and expectations for specific prescribing circumstances that apply when such circumstances exist. The last section of the policy contains guidelines for physicians who prescribe drugs.

Principles

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

1. Acting in patients' best interests;
2. Demonstrating professional competence, which includes maintaining the medical knowledge and clinical skills necessary to prescribe appropriately. This involves keeping abreast of current developments in:
    a. applicable legislation;
    b. CPSO expectations and guidelines regarding prescribing;

c. prescribing practices, including technology related to medication management, electronic prescribing and associated information systems;
d. relevant practice guidelines and tools; and
e. implementing these expectations and best practices, as appropriate.

3. Maintaining patients' confidentiality and privacy when collecting, using or disclosing (e.g., transmitting) prescription information;
4. Collaborating effectively with patients, physicians and other health-care providers;
5. Communicating with patients and other health-care providers with civility and professionalism; and
6. Not pursuing personal advantage, whether financial or otherwise, at the expense of the patient, when prescribing drugs, so as not to compromise their duty to their patients. 5

Purpose and Scope

This policy sets out the College's expectations for all physicians who prescribe drugs or provide drug samples to patients.5a

Definitions

Drug: As defined in the Drug and Pharmacies Regulation Act (DPRA). 6 Drugs are also known as 'medications'.

Prescribing Drugs: Is a controlled act as set out in the Regulated Health Professions Act, 1991. 7 The controlled act of prescribing is comprised of the generation and authorization of prescriptions.

A drug is prescribed when a prescriber provides a direction that authorizes the dispensing of a drug or mixture of drugs. 8 The direction may be communicated verbally, in writing or electronically.

Electronic Prescribing (ePrescribing): Electronic prescribing encompasses the electronic generation, authorization and transmission of dispensing directions for a drug or mixture of drugs.

Electronic prescriptions are generated electronically (using a system or tool) in a format that can be understood by a computer, authorized electronically (with an electronic signature or other process), and transmitted electronically to another system or repository that can only be accessed by an authorized dispenser. All three stages must be electronic before a prescription is a true 'electronic prescription'.

Drug Sample: A package of medication distributed by pharmaceutical companies to physicians or others free of charge. Drug samples are also known as 'clinical evaluation packages'.

Narcotics and Controlled Substances: As defined in the Controlled Drugs and Substances Act (CDSA), 9 and the Narcotic Control Regulations. 10 The term 'narcotics' includes opioids.

Policy

Physicians must comply with the expectations set out in this policy when prescribing drugs or providing drug samples.

1. General Expectations

Before Prescribing

Physician-Patient Relationship

Physicians typically prescribe drugs within the context of a physician-patient relationship. 11 In most cases, this means that an appropriate clinical assessment of the patient has been conducted, the physician has made a diagnosis or differential diagnosis and/or has a clinical indication based on the clinical assessment and other relevant information, informed consent has been obtained, and the physician prescribes a drug.

Assessment

Before prescribing a drug, physicians must have current knowledge of the patient's clinical status. This can only be accomplished through an appropriate clinical assessment of the patient. An assessment must include:

a) An appropriate patient history, including the most complete and accurate list possible of drugs the patient is taking and any previous adverse reactions to drugs. A physician may obtain and/or verify this information by checking previous records and databases, when available, to obtain prescription and/or other relevant medical information; 12 and if necessary.
b) An appropriate physical examination and/or any other examinations or investigations.

In many cases, physicians conduct all or part of the assessment themselves; however, the College recognizes that this may not always be in the best interests of the patient. Physicians are permitted to rely on an assessment conducted by someone else if:

a) they have reasonable grounds to believe that the person conducting the assessment has the appropriate knowledge, skill and judgment to do so. 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 (e.g., hospital or long-term care home), 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 to do so; and

b) they obtain the assessment information from the person conducting the assessment and make an evaluation that it is appropriate.

If these conditions cannot be met, the physician must conduct his or her own clinical assessment. The prescribing physician is ultimately responsible for how they use the assessment information, regardless of who conducted the assessment.

Exceptions

The circumstances in which physicians are permitted to prescribe without a prior assessment of the patient can include:

a) Prescribing for the sexual partner of a patient with a sexually transmitted infection (STI) who, in the physician's determination, would not otherwise receive treatment and where there is a risk of further transmission of the STI;
b) Prescribing prophylaxis (e.g., oseltamivir) as part of public health programs operated under the authority of a Medical Officer of Health; and
c) Prescribing post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne pathogen.

Diagnosis

If physicians intend to prescribe a drug, they are required to make a diagnosis or differential diagnosis and/or have a clinical indication based on the clinical assessment and other relevant information. 13 There must be a logical connection between the drug prescribed and the diagnosis or differential diagnosis and/or clinical indication.

Physicians must consider the risk/benefit ratio for prescribing that particular drug for that patient. In addition, physicians must consider the combined risk/benefit ratio when prescribing multiple drugs. If using technology to prescribe (e.g., Electronic Medical Record), clinical decision support tools may be helpful in assisting physicians determine whether the drug(s) are appropriate for the patient.

Physicians are also required to consider the risk/benefit ratio when providing long-term prescriptions. The duration of the prescription must be balanced with the need to re-assess the patient and the potential harm that may result if the patient runs out of the medication. 14

Informed Consent

As with the usual requirements for informed consent when considering any treatment, 15 physicians are required to advise the patient about the material risks 16 and benefits of the

drug being prescribed, including the drug's effects and interactions, material side effects, contraindications, precautions, and any other information pertinent to the use of the drug.

When Prescribing

Content of Prescriptions

Physicians must include the following information on a prescription:

- Name of patient;
- Name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for use of the drug;
- Full date (day, month and year);
- Refill instructions, if any;
- Printed name and signature of prescriber (if outside of an institution, include address and telephone number of location where medical records are kept);
- CPSO registration number; 17 and
- Any additional information required by law.

If the prescription is for a monitored drug, 18 physicians must also include an identifying number for the patient (e.g., health card number) 19 and indicate the type of identifying number it is (e.g., health card), unless certain conditions set out in regulation are met. 20

If the prescription is for a fentanyl patch, physicians must include the following additional information on the prescription:

- The name and address of the pharmacy where the prescription will be filled;
- A notation that it is the patient's first prescription for fentanyl patches when:
  i. The physician has not previously prescribed fentanyl patches to that patient; and
  ii. The physician is reasonably satisfied that the patient has not previously obtained a prescription for a fentanyl patch from another prescriber.

It is recommended that physicians consider, on a case-by-case basis, whether it is appropriate to include the following information on the prescription:

- Address and/or date of birth of patient
- Indication for use, if prescribed p.r.n.
- "No substitutions", if applicable and clinically appropriate 22, 23
- "Do not adapt", "do not extend" or "do not refill", when prudent or advisable24
- The patient's weight and/or age (e.g., where the patient is a child and this information would affect dosage)

Clarity of Prescriptions

Physicians must ensure that all prescriptions are clearly understandable and that written prescriptions are legible. It is recommended that physicians use the generic name of the drug to ensure prescriptions are clear.

a. *Verbal Prescriptions*

Medication safety literature highlights that the use of verbal prescriptions is error-prone. Physicians must have protocols in place to ensure verbal prescriptions are communicated in a clear manner. 25

b. *Handwritten or Electronic Prescriptions*

To improve legibility, among other things, the College recommends that physicians take advantage of technology, for example, by generating prescriptions via their Electronic Medical Record (EMR) system.

When generating prescriptions, physicians must pay particular attention to the use of abbreviations, symbols and dose designations, and must avoid using the abbreviations, symbols, and dose designations that have been associated with serious, even fatal, medication errors. 26 It is recommended that physicians use TALLman lettering 27 for drug names that may look-alike and/or sound-alike. 28

When generating prescriptions electronically, physicians must ensure the proper drug, dose and dosage form are chosen when selecting from a list of drugs and doses.

Authorization

Every prescription must be authorized by a prescriber before it can be filled and dispensed. A prescriber can authorize a prescription verbally, with a signature, or electronically. Regardless of the method of authorization, each prescription must only be authorized once. 29

a. Verbal

A prescription can be authorized by a physician verbally; however, there are some limitations on the use of verbal prescriptions. 30 For example, Section 40(3) of General, O. Reg., 58/11, enacted under the DPRA states that a drug shall not be dispensed in a pharmacy pursuant to a prescription given verbally unless several conditions have been met, including that the drug is not a narcotic drug. 31

b. Signature

A prescription can be authorized by a physician's signature. The signature must be authentic and unaltered. 32 Electronic signatures may be acceptable if they meet the College of Pharmacists (OCP) Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files. For example, the electronic signature must be a unique, clearly identifiable, life-size

image. 33Before physicians begin signing prescriptions electronically, it is recommended that they communicate with the pharmacist regarding the process they are using to sign the prescriptions, to ensure the pharmacists' requirements are being met.

c. Electronic

Electronic prescriptions can only be authorized by an authorized prescriber. 34There must be a mechanism that prevents duplicate prescription authorization and the prescription authorization mechanism 35 must be:

- Secure; 36 and
- Acceptable for the purposes of authentication to pharmacists. 37

After Prescribing

Transmitting a Prescription

In an ePrescribing context, authorization and transmission of a prescription are often combined. However, regardless of the method of transmission (e.g., paper, verbal, fax, 38 digitized image files 39 or electronic), physicians must comply with the following requirements:

1. All prescriptions transmitted must originate with the prescriber; 40
2. The process of transmitting prescriptions must maintain patient confidentiality;
3. Transmission of the prescription must employ reasonable security measures (e.g., password protection, encryption, etc.). 41 This includes transmission to or from the EMR (i.e., from a stand-alone application to the EMR or from the EMR to the dispenser); and
4. Patient choice must be protected; that is, the patient must have a choice of pharmacy where the prescription is to be filled. 42

Physicians must respond in a timely and professional manner when contacted by a pharmacist 43 or other health-care provider to verify a prescription or respond to a request for information about the drug prescribed.

Notifying pharmacies of a fentanyl prescription

Where a physician prescribes fentanyl patches, physicians must notify the pharmacy that will fill each prescription directly, either by telephone or by faxing a copy of the prescription

Documentation

In addition to complying with the general requirements for medical records, 44physicians must specifically document the following information regarding the drugs they prescribe in a patient's medical record:

- The date the drug is prescribed;
- The type of prescription (verbal, handwritten, electronic);
- The name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for use of the drug;
- The fact that the drug's material risks, including material side effects, contraindications or precautions were discussed with the patient; 45
- Refill information; and
- Other relevant information (e.g., drug cannot be substituted; prescription cannot be adapted, extended or refilled, as applicable).

The College recommends that entries be recorded as soon as possible after the encounter. This is important to ensure safe delivery of care, especially in a shared care environment. 46

The documentation requirements set out above apply to physicians even if they are verbally prescribing, refilling prescriptions, or providing a patient with a drug sample.

a. Audit

Physicians who have an EMR with ePrescribing capabilities must ensure that their system is able to track all electronic prescriptions, who authorized them, whether they were printed or authorized and transmitted, where they were sent and whether/by whom they were modified and when. The system must also be able to identify what additions or edits were made to the prescription record over time. 47

Physicians must also ensure that their system is able to generate reports that contain the results of queried information (e.g., list of prescriptions issued to a particular patient, prescriptions issued by the prescriber, or prescriptions written for a particular drug, etc).

Monitoring

After prescribing, physicians must inform patients of the need for follow-up care to monitor whether any changes to the treatment plan (e.g., prescription) are required. It is recommended that patients are informed of their role in safe medication use and monitoring effectiveness. Patients must be monitored for any emerging risks or complications. Drug therapy must be stopped, following appropriate protocol, if it is not effective, or the risks outweigh the benefits.

Sharing Information

To ensure good patient care is provided, communication between physicians and health-care providers is recommended. If the patient has a primary care provider, it is important for that provider to have all relevant information about his or her patient. This includes information about drugs prescribed for the patient. Unless a patient has expressly withheld or withdrawn

consent, health information can be shared within the 'Circle of Care' 48 in accordance with thePersonal Health Information Protection Act, 2004 (PHIPA).

2. Specific Issues in Prescribing

Refills 49

Physicians may write a prescription with a certain number of refills, if permitted by law. 50 Prescribing with refills is often appropriate for patients with chronic conditions that are likely to remain stable for the duration of the dispensing period. Physicians must ensure procedures are in place to monitor the ongoing appropriateness of the drug when prescribing with refills. This includes conducting periodic re-assessments looking for any changes in the underlying chronic condition, as well as any new drug interactions or contraindications, and/or new side effects of the prescribed drug.

When physicians are contacted to authorize a refill on a prescription that has run out, they must consider whether the drug is still appropriate, and whether the patient's condition is stable enough to warrant the prescription refill without further assessment. It is recommended that physicians also consider whether requests for prescription refills received earlier or later than expected may indicate poor adherence, possibly leading to inadequate therapy or adverse events.

At times, the request to authorize a refill on a prescription may be communicated to the physician's office staff. Physicians must ensure that there are protocols in place when they use office staff to facilitate the authorization of refills. Physicians must review and authorize all requests, unless physicians are delegating this responsibility to staff 51 or their staff person is a regulated health professional who has the authority to prescribe. Physicians must ensure that all requests for refills and all refills that are authorized are documented in the patient's medical record.

'No Refill' Policies

Some physicians have blanket 'no refill' policies, meaning they will not authorize refills for any patient, for any drug, in any circumstance. The College prohibits the use of blanket 'no refill' policies because they are not consistent with patient-centered care and have no clinical basis. If there are situations where refills may not be advisable, the College recommends open discussion between physicians and dispensers, so that those involved in the patient's care are best positioned to exercise judgment where necessary and appropriate.

Drug Samples

Many physicians receive drug samples from representatives of the pharmaceutical industry. Drug samples are one means of determining whether a drug is effective and useful for a particular patient. As well, drug samples can benefit patients with limited financial resources and who do not have other means to access the drug.

When physicians provide drug samples, some of the general requirements for prescribing a drug will apply. More specifically, physicians must:

- Conduct an appropriate clinical assessment, make a diagnosis or differential diagnosis and/or have a clinical indication, and obtain informed consent before providing drug samples;
- Document the drug samples given to patients, including the date provided, name of the drug, drug strength, quantity or duration of therapy, instructions for use, and the fact that the drug's material risks, including material side effects, contraindications or precautions were discussed with the patient; 52
- Communicate the need for follow-up to monitor whether any changes to the treatment plan are required; and
- Share information about drug samples provided with other health-care providers, as appropriate.

In addition, physicians who provide drug samples must meet or ensure that the following requirements are met:

- No form of material gain is obtained for the physician or for the practice with which he or she is associated.
- No trading, selling, or bartering of drug samples for cash or other goods or services occurs.
- Samples are securely and appropriately stored to prevent spoilage and theft/loss, and are given to patients with current expiry dates.
- Samples that are unfit to be provided to patients (expired or damaged) are safely and securely disposed of. 53

Redistributing Unused Drugs

The College has become aware of circumstances in which physicians want to redistribute, to patients with limited resources, expensive drugs that have been returned to them by patients who are no longer able to use them. Redistributing unused drugs is inappropriate and strongly discouraged because the integrity of the drugs cannot be ensured. Returned drugs must be disposed of in a safe and secure
manner. 54

Narcotics and Controlled Substances

Narcotics and controlled substances are important tools in the safe, effective, and compassionate treatment of acute or chronic pain, mental illness, and addiction. This policy does not attempt to curb the appropriate prescribing of these substances.

Special consideration is necessary, however, given that narcotics and controlled substances are highly susceptible to diversion, misuse, and/or abuse, and many present a risk of addiction and overdose. In particular, addiction and overdose resulting from both the legitimate and non-medical use of prescription opioids is a serious and growing public health problem.

The purpose of this section of the policy is to clarify for physicians their obligations when prescribing narcotics and controlled substances, to highlight resources that can assist in their clinical decision making, and to emphasize their role in preventing and addressing the risk of harm associated with these drugs, including the risk of abuse, diversion, addiction, and overdose.

Before prescribing

Prior to initiating a new prescription for a narcotic or controlled substance (or continuing a prescription initiated by another prescriber), physicians must carefully consider whether a narcotic or controlled substance is the most appropriate choice for the patient. In making this determination, physicians must:

1. Consider and apply relevant practice standards, quality standards, and clinical practice guidelines, as appropriate.

    i. In addition to complying with the general requirements set out for prescribing any drug and applicable legislation, physicians are expected to be aware of relevant practice standards, quality standards, and clinical practice guidelines, and incorporate them into practice as appropriate.
    ii. The application of any standard or clinical practice guideline must be informed by the physician's own professional and clinical judgment, with consideration for the specific circumstances of the individual patient before him/her.
    iii. 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*[1], the *Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain*, and any applicable Quality Standards developed by Health Quality Ontario.

[1] For an overview of the new Canadian recommendations, please see the *2017 Canadian Opioid Prescribing Guideline Poster*, which is a product of the Pan-Canadian Collaborative for Improved Opioid Prescribing, and the CPSO article "National Opioid Guideline puts Emphasis on Harm Reduction".

2. Consider whether an alternative treatment or drug is more clinically appropriate.

    i. If there are no appropriate or reasonably available alternatives to a narcotic or controlled substance, physicians are advised to record this fact in the patient's medical record.
    ii. When considering opioids for the treatment of chronic non-cancer pain, relevant guidelines recommend that physicians first attempt alternative treatment options whenever possible and clinically appropriate,[2] and only initiate a trial of opioids where those options have not adequately alleviated the patient's symptoms.[3]

3. Review relevant prescribing data when such data are available.

    i. Initiatives are currently underway which aim to provide physicians with more comprehensive information on which to base decisions regarding the prescribing of narcotics and controlled substances.
    ii. With respect to the prescribing of opioids for chronic non-cancer pain, relevant data sources are expected to include patient narcotic prescribing profiles and reports detailing practitioner prescribing trends, which will be available through the provincial Narcotics Monitoring System and Health Quality Ontario respectively. Physicians are expected to be aware of and seek access to these sources of information as they become available.

When prescribing

Physicians who elect to prescribe narcotics and controlled substances to a patient must be mindful of the potential risks they pose, and take reasonable steps to mitigate those risks, consistent with relevant practice standards, quality standards, and clinical practice guidelines. In particular, these steps must include the following:

1. Ensure that the patient understands the risks associated with the drug being prescribed, including any risk of addiction and overdose.

2. Consider and apply relevant practice standards, quality standards, and clinical practice guidelines to determine a safe and effective dose.[4]

[2] Such alternative treatment options could include nonopioid pharmacotherapy and nonpharmacologic therapy, such as physiotherapy and cognitive behaviour therapy.
[3] This is consistent with *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* and the *Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain*.
[4] Whenever prescribing a drug with the potential for misuse, abuse, and/or diversion, the College recommends adherence to the general principle that patients be maintained on the lowest dose necessary to achieve symptom improvement.

i. Physicians are reminded that with respect to the prescribing of opioids for chronic, non-cancer pain, both the *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* and the *Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain* strongly recommend against prescribing doses above 90 morphine milligram equivalents (MME)/day.[5]

3. Recognize patients who are receiving an unusually high dose, and slowly taper those patients when appropriate, consistent with relevant clinical practice guidelines.[6]

4. Recognize and respond to signs of abuse, misuse, and diversion when such signs are present.[7]

5. Share information with others in accordance with physicians' legal obligations, including those set out in the *Personal Health Information Protection Act, 2004 (PHIPA)*[8], and any applicable mandatory reporting obligations.[9]

6. Institute measures to prevent prescription pad theft or tampering; taking measures to prevent the theft of drugs from their offices.

As with any drug, physicians who prescribe narcotics and controlled substances must continue to monitor patients at an appropriate interval for any emerging risks or complications, and prescribing must be discontinued where, due to changing circumstances, the drug does not meet the physician's therapeutic goals, or the risks outweigh the benefits. Whenever prescribing is discontinued, physicians must ensure that the discontinuation is undertaken consistently with any relevant clinical practice guidelines, and with consideration for the safety of the patient.[10]

Office Policies and Practices: Setting and Managing Patient Expectations

a. General Policies and Practices

It is recommended that physicians who prescribe narcotics and controlled substances consider implementing office policies and practices regarding the prescribing of these drugs, for

[5] *2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain*; *Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain*.

[6] Physicians are reminded that the sudden cessation and/or rapid tapering of opioids can be highly dangerous to the patient and is usually inappropriate.

[7] Further guidance with respect to recognizing the signs of aberrant drug-related behaviour can be found in the Guidelines section of this policy.

[8] *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A (*PHIPA*).

[9] For more information about physicians' mandatory reporting obligations, see the College's *Mandatory and Permissive Reporting* policy.

[10] Physicians are reminded that the sudden cessation and/or rapid tapering of opioids can be highly dangerous to the patient and is usually inappropriate.

example, a policy on the use of treatment agreements. 59 Communicating these office policies and practices to patients can help manage patient expectations and help monitor whether the treatment is being used as prescribed.

b. 'No Narcotics' Prescribing Policy

When physicians are asked by patients to prescribe narcotics or controlled substances, 60 they may feel obligated or pressured to prescribe them. In fact, some physicians have a general 'no narcotics' policy in order to avoid such situations.

Having a blanket 'no narcotics' policy removes the physician's ability to exercise his or her clinical discretion when considering whether or not to prescribe narcotics and controlled substances to a particular patient. Instead of having such a policy, it is advised that physicians use their professional judgment to determine whether prescribing narcotics and controlled substances is appropriate for each patient. Physicians have no obligation to prescribe any drug, including narcotics and controlled substances, if they do not feel it is clinically appropriate.

As such, the College recommends that physicians do not adopt a blanket policy refusing to prescribe narcotics and controlled substances, unless physicians have restrictions preventing them from prescribing narcotics and controlled substances. Prescribing narcotics and controlled substances are part of good clinical care and refusing to prescribe these drugs altogether may lead to inadequate management of some clinical problems and may leave patients seeking treatment from other physicians, putting pressure on others to manage these cases, or otherwise leaving patients without appropriate treatment.

Monitoring Patients: Misuse, Abuse and Double-Doctoring

When prescribing narcotics and controlled substances, physicians must be alert for behaviour which suggests that patients are seeking drugs for diversion purposes, or are misusing or abusing prescription drugs. 61

One of the ways in which patients may access narcotics and controlled substances to misuse or abuse is by double-doctoring. Under the CDSA, a person who has received a prescription for a narcotic shall not seek or receive another prescription or narcotic from a different physician without telling that physician about every prescription or narcotic that he or she has obtained within the previous 30 days. 62

Sharing Information

If physicians suspect or discover that their patient is double-doctoring, or is otherwise misusing or abusing narcotics and controlled substances, they might be unsure as to what to do with that information. Physicians must keep patient health information confidential and private, unless they have consent to share the information or are permitted or required by law to do so.

The following sections outline the most relevant requirements in PHIPA regarding consent, along with the instances in which physicians are permitted by law to disclose information without consent. If physicians are uncertain of their obligations, or whether the sections set out below apply in the circumstances of specific cases, physicians are advised to seek legal advice.

a. Circle of Care

The majority of circumstances addressed in this policy contemplate that physicians will share a patient's personal health information, including prescriptions, with other members of the patient's health-care team for the purpose of providing or assisting in the provision of health care.

Generally speaking, in these situations, physicians can assume they have a patient's implied consent to share personal health information (including information regarding prescriptions) with other members of the patient's health-care team, 63 and they will not need to seek patient consent each time. Physicians cannot, however, assume patient consent if the patient has expressly stated that he or she does not want the information to be shared.

b. Permitted Disclosure

PHIPA contains a number of provisions which permit personal health information to be disclosed without patient consent. The decision to disclose information in these situations is at the physician's discretion. 64 Physicians must use their professional judgment to determine whether the circumstances of each case satisfy the requirements of the provision and disclosing the information is justified.

PHIPA contains a number of provisions which permit disclosure. These provisions that are most likely to be relevant to prescribing information are described below.

i. Disclosure for authorized investigations or inspections

- This provision enables information to be disclosed in the context of an investigation or inspection, for the purposes of facilitating that investigation.
- The investigation or inspection must be authorized by a warrant, or by an Act of Ontario or an Act of Canada.
- The disclosure must be made to the person who is authorized to do the investigation or inspection. 65 The Canadian Medical Protective Association (CMPA) has provided information regarding double-doctoring and responding to inquiries from law enforcement officials in its article Responding to Prescription Fraud. 66

ii. Disclosures related to risks

- This provision allows for information to be disclosed in order to prevent or reduce a risk of harm to others.

- To rely on this provision, health-care providers must believe on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. 67

Mandatory Reporting Obligation

Physicians are required to report the loss or theft of narcotics and controlled substances from their office to the Office of Controlled Drugs and Substances, Federal Minister of Health, within 10 days. 68

Ending the Physician-Patient Relationship

When prescribing narcotics and controlled substances, circumstances may sometimes arise which lead a physician to consider ending the physician-patient relationship. Expectations for physicians who may be considering ending the physician-patient relationship can be found in the College's *Ending the Physician-Patient Relationship* policy, as well as the accompanying *Frequently Asked Questions* document.

It should be noted, however, that it is inappropriate for a physician to end the physician-patient relationship solely because his/her patient suffers from drug addiction or dependence, or because the patient is on a high dose of prescribed narcotics or another controlled substance.

Drugs that have not been Approved for Use in Canada ('Unapproved Drugs')

Physicians must not prescribe drugs that have not been approved for use in Canada, that is, drugs for which Health Canada has not issued a Notice of Compliance (NOC). 69 However, 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. 70

If physicians consider obtaining access to drugs for patients under these circumstances, they must comply with Health Canada's requirements.

Guidelines

PREVENTING MEDICATION ERRORS

Medication errors can cause serious harm and even death. Often, medication errors are caused by underlying problems in the system. For example, problems such as look-alike labels and confusing equipment can lead to mistakes in health care.
Physicians can help reduce the occurrence of some medication errors by considering the following guidelines.

Verbal Prescriptions 71

The use of verbal prescriptions (spoken aloud in person or by telephone) introduces a number of variables that can increase the risk of error. These variables include:

- Potential for misinterpretation of orders because of accent or pronunciation;
- Sound-alike drug names;
- Background noise;
- Unfamiliar terminology;
- Patients having the same or similar names;
- Potential for errors in drug dosages (e.g., sound-alike numbers); and
- Misinterpretation of abbreviations.

In addition, the use of intermediaries (e.g., office staff) has been identified as a prominent source of medication error. Medication safety literature recognizes that the more direct the communication between a prescriber and dispenser, the lower the risk of error. As such, if physicians wish to use verbal prescriptions, it is recommended that physicians communicate the verbal prescription themselves. If this is not possible, it is recommended that physicians consider asking someone who has an understanding of the drug and indication to communicate the prescription information, unless the prescription is a refill.

When verbal prescriptions are used, it is recommended that the accuracy of the prescription be confirmed using strategies such as a 'read back' of the prescription and/or a review of the indication for the drug. It is recommended that the read back include:

- Spelling of the drug name;
- Spelling of the patient's name; and
- Dose confirmation expressed as a single digit (e.g., "one-six" rather than "sixteen").

In addition, to reduce the risk of error due to patients having the same (or similar) names, it is advisable to communicate at least one additional unique patient identifier to the dispenser.

Look-alike/Sound-alike Drug Names

Some drug names may look-alike and/or sound-alike. 72 In order to avoid the potential for confusion, physicians may want to consider: 73

- writing prescriptions clearly by printing the name of the product in block letters or using TALLman lettering, 74 by not using abbreviations, or by using electronic prescriptions;
- including more information about the drug (e.g., include both brand name and generic name, and the reason for prescribing the medication);

- ensuring that the strength, dosage and directions for use are clearly indicated on the prescription; and
- communicating to the patient (or a family member) the reason the medication has been prescribed and verifying that the patient can read the prescription.

High-alert Medications

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error can be more serious. Physicians are advised to consider consulting the high-alert medications list to determine which medications require special safeguards to reduce the risk of errors. 75

Vulnerable Populations/High-alert Environments

Paediatric, geriatric, and medically complex patients are particularly vulnerable to medication incidents. In addition, high-alert environments and situations, such as emergency procedures, may contribute to a greater risk of error. It is recommended that the potential for harm in these circumstances be considered in advance, and systems and procedures be reviewed to mitigate the potential for error.

Double-Checking

A common cause of drug name mix-ups is what experts call confirmation bias, where a practitioner reads a poorly written drug name and is most likely to see in that name that which is most familiar to him or her, overlooking any disconfirming evidence. Physicians are advised to double-check all prescriptions they write to ensure they are clearly written for the drug they intended to prescribe.

Patient Involvement

Medication safety literature recognizes that patients represent an untapped resource for reducing the incidence of medication errors. It is recommended that physicians encourage their patients to: question why they are receiving a drug; verify that it is the appropriate drug, dose and route; and, alert the health-care provider involved in prescribing, dispensing, or administering a drug to potential problems, such as allergies or past drug-drug interactions, any new physical symptoms/side effects that occur, or any changes in their clinical status. 76

Physicians are encouraged to be alert to the possibility of an error in the dispensing of a drug when a patient expresses concern that the drug dispensed is different from that previously provided.

If a prescription is generated, authorized and transmitted electronically, the physician may wish to generate a record/receipt of the prescription for the patient. This would accomplish several things:

- Ensure the patient knows what they have been prescribed;
- Give the patient an opportunity to go home and look up the drug; and
- Avoid errors of dosing, etc.

Reporting Adverse Drug Reactions or Medication Incidents

It is recommended that physicians report any adverse drug reactions 77 to the relevant organizations. It is advisable to report all suspected adverse drug reactions, especially those that are:

- Unexpected, regardless of their severity, i.e., not consistent with product information or labelling;
- Serious, 78 whether expected or not; or
- Due to recently marketed health products (on the market for less than five years), regardless of their nature or severity.

Voluntary reporting by health-care providers and consumers of suspected reactions is the most common way to monitor the safety and effectiveness of marketed health products. These individual reports may be the only source of information concerning previously undetected adverse reactions or changes in product safety and effectiveness profiles to marketed health products. Adverse drug reactions can be reported to Health Canada's Vigilance Program at:http://www.hc-sc.gc.ca/dhp-mps/medeff/vigilance-eng.php.

It is recommended that physicians also report medication incidents to assist in identifying new or undetected safety issues. 79 This can be done through the Institute for Safe Medication Practices (ISMP) Canada at:
https://www.ismp-canada.org/err_report.htm.

It is recommended that physicians encourage their patients to report any medication incidents or near misses at: http://www.safemedicationuse.ca.

In addition to reporting any adverse drug reactions or medication incidents physicians are advised to refer to the CPSO's Disclosure of Harm policy for additional requirements that may apply.

Narcotics and Controlled Substances

RESPONDING TO REQUESTS FOR NARCOTICS AND CONTROLLED SUBSTSANCES

Physicians can implement a number of practical steps to help prevent diversion, misuse and abuse:

- If the patient is not well known to you, ensure the patient's identity has been verified; for example, by requesting two or three pieces of identification (e.g.,
- driver's licence, health card, social insurance number).
- Verify the presenting complaint and observe for aberrant drug-related behaviour. 80
- Screen for current and past alcohol, drugs (prescription and non-prescription) and illicit drug use.
    - Consider using screening tools from the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.
- Consider whether patients may be diverting, misusing or abusing narcotics and controlled substances when they:
    - Request a specific drug by name and/or state that alternatives are not effective, or they are "allergic" to them.
    - Refuse appropriate confirmatory tests (e.g., blood tests, x-rays, etc.).
- Ask the patient if they have received any narcotics or controlled substances in the last 30 days from another practitioner, and look for any signs of evasiveness.
- Talk to the patient's primary care provider, specialist and/or pharmacist.

Identifying Aberrant Drug-Related Behaviour 81

It may be difficult to determine whether patients are seeking prescription drugs for diversion purposes, or are misusing or abusing these drugs. Common aberrant drug-related behaviours can be divided into three groups:

- Escalating the dose (e.g., requesting higher doses, running out early);
- Altering the route of delivery (e.g., biting, crushing controlled-release tablets, snorting or injecting oral tablets); and
- Engaging in illegal activities (e.g., double-doctoring, prescription fraud, buying, selling and stealing drugs).

Office Practices and Policies: Setting and Managing Patient Expectations

When physicians prescribe narcotics and controlled substances, it is recommended that they clarify to patients under what conditions they will prescribe. It is advisable to outline the circumstances for prescribing and not prescribing in the policy. This can include information regarding the preconditions for prescribing generally, and more specific office policies such as:

- Aberrant drug-related behaviour will be monitored (e.g., urine drug screening); and
- Treatment agreements will be used.

Treatment Agreements

A treatment agreement 82 is often an effective tool for ensuring proper utilization of the narcotic or controlled substance. They may especially be helpful for patients not well known to the physician, or at higher risk for prescription drug misuse or abuse.

Treatment agreements are formal and explicit written agreements between physicians and patients that delineate key aspects regarding adherence to the therapy. An agreement could state that:

- the physician will only prescribe if the patient agrees to stop all other narcotics and controlled substances;
- the patient will use the drug only as directed;
- the patient acknowledges that all risks of taking the drug have been fully explained to him or her; and
- the patient will use a single pharmacy of their choice to obtain the drug.

Having an agreement ensures patients are told what is expected of them when they receive a prescription and the circumstances in which prescribing will stop. The consequence for not meeting the terms of the agreement would also be clear: the physician may decide not to continue prescribing narcotics and controlled substances. 83

Monitoring Patients

Physicians may wish to keep a narcotics and controlled substances log 84 for each patient. This would help physicians keep track of what was prescribed for each patient, to ensure patients are not over-prescribed narcotics and controlled substances. 85 The use of technology could help in this regard (e.g., EMR).

Preventing Prescription Fraud 86

In issuing prescriptions for narcotics and controlled substances physicians may want to consider taking the following precautions:

- If using a paper prescription pad:
  - Use carbon copies or numbered prescription pads;
  - Write the prescription in words and numbers;
  - Draw lines through unused portions of the prescription; and
  - Keep blank prescription pads secure.
- If using desk-top prescription printing:
  - Use EMR-enabled security features such as watermarks.
  - Write a clear signature and do not use a scribbled initial.

- Promote the patient's use of a single dispensing pharmacy of their choice. Include the name of the pharmacy the patient would like to take the prescription to be dispensed, on the prescription.
- Fax (or electronically transmit when available) prescriptions directly to the pharmacy.
- If using fax or electronic transmission of the prescription (when permitted) ensure confidentiality, 87 confirm destination, and retain copies.

Security of Drugs

Narcotics and controlled substances require greater storage security than other drugs. It is recommended that drugs stored in a physician's office be in a locked cabinet, out of sight. Physicians are advised to avoid storing drugs in any other location, including their homes. Physicians are advised to never leave medical bags unattended or in plain view.

Advice for Patients 88

It is recommended that physicians advise patients on safe use at home and storage of narcotics and controlled substances. It is recommended that physicians consider communicating the following:

- Read the label and take the drug exactly as directed. Take the right dose at the right time.
- Follow the other directions that may come with the drugs, such as not driving, and avoiding the use of alcohol.
- Store narcotics and controlled substances in a safe place, out of the reach of children and teenagers, and keep track of the amount of drugs.
- Never share prescription drugs with anyone else, as this is illegal and may cause serious harm to the other person.
- Return any unused drugs to the pharmacy for safe disposal, in order to prevent diversion for illegal use and to protect the environment. Drugs must not be disposed of in the home (e.g., in the sink, toilet or trash).
- In addition, physicians may want to advise patients about what to do if they miss a dose, and remind them that crushing or cutting open a time-release pill destroys the slow release of the drug and can lead to an overdose with serious health effects.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Vision 2020: Modernizing the College of Nurses of Ontario's Governance

Guest Speaker: **Anne Coghlan RN, MScN**
Executive Director and CEO of the
College of Nurses of Ontario

Vision 2020

Modernizing the College of Nurses of Ontario's Governance

September 8, 2017 CPSO Council Meeting

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.


VISION 2020

Governance in the public interest

Leading in regulatory governance

Evelyn Kerr, RN, Chair

Don McCreesh

Anne Coghlan, RN

Rob Lapper

Ella Ferris, RN

Megan Sloan, RN, RPN

Past Presidents

Nancy Sears, RN

Angela Verrier, RPN

Why did our Council decide to look at governance?

We live in a moment in history where change is so speeded up that …

we begin to see the present only when it is already disappearing.

R.D. Laing

Regulation in the spotlight

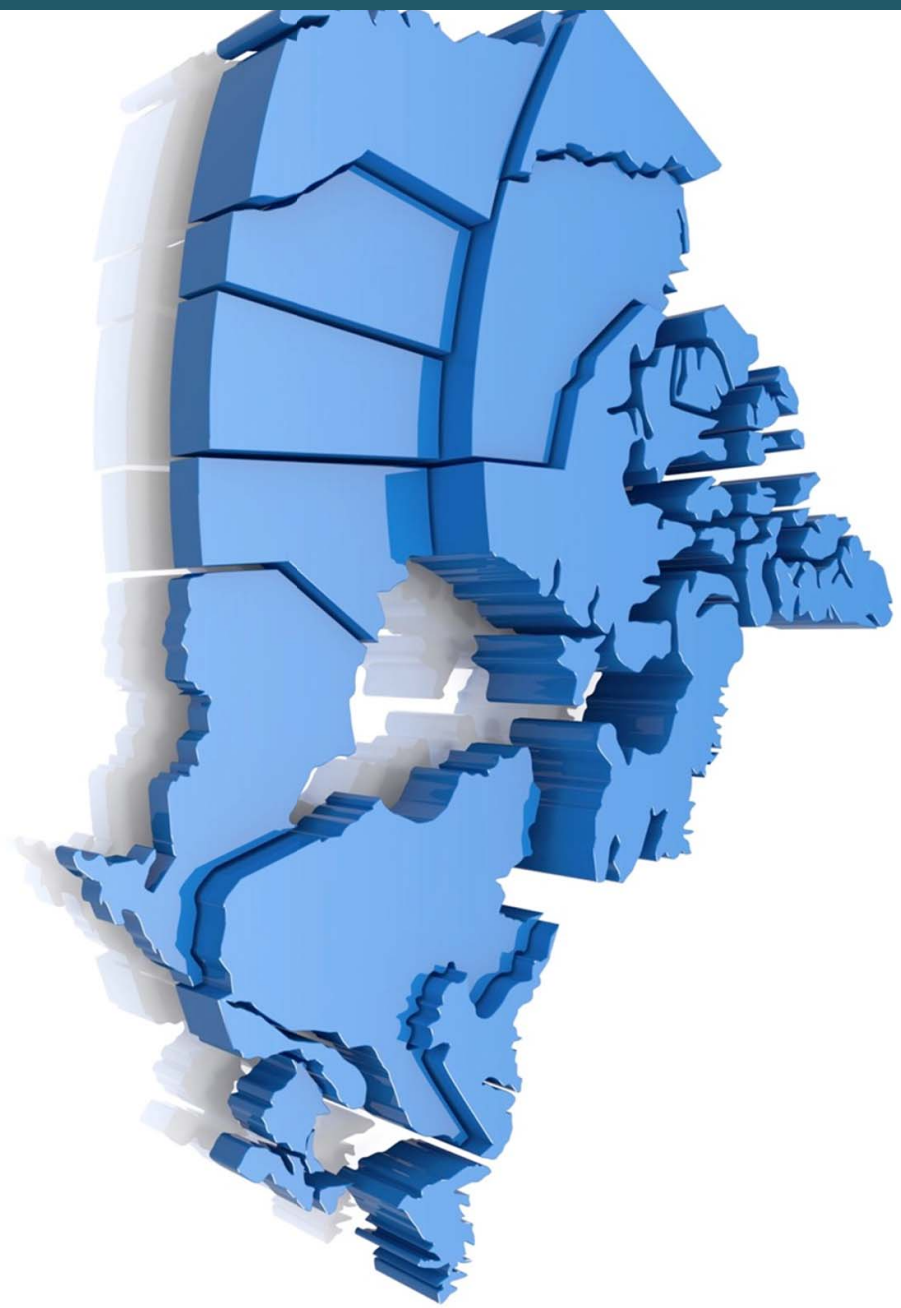
TRUST

Regulatory reform

professional standards authority

We oversee regulators to help protect patients, service users and the public

Closer to home



Bill 87- Protecting Patients Act

Outcomes

aligned with public interest

- Enhance transparency
- Address conflicts of interest
- Achieve outcomes

Governance Principles

Council is individually and collectively committed to regulating in the public interest in accordance with the following principles:

Accountability

- We make decisions in the public interest
- We are responsible for our actions and processes
- We meet our legal and fiduciary duties as directors

Adaptability

- We anticipate and respond to changing expectations and emerging trends
- We address emerging risks and opportunities
- We anticipate and embrace opportunities for regulatory and governance innovation

Competence

- We make evidence-informed decisions
- We seek external expertise where needed
- We evaluate our individual and collective knowledge and skills in order to continuously improve our governance performance

Diversity

- Our decisions reflect diverse knowledge, perspectives, experiences and needs
- We seek varied stakeholder input to inform our decisions

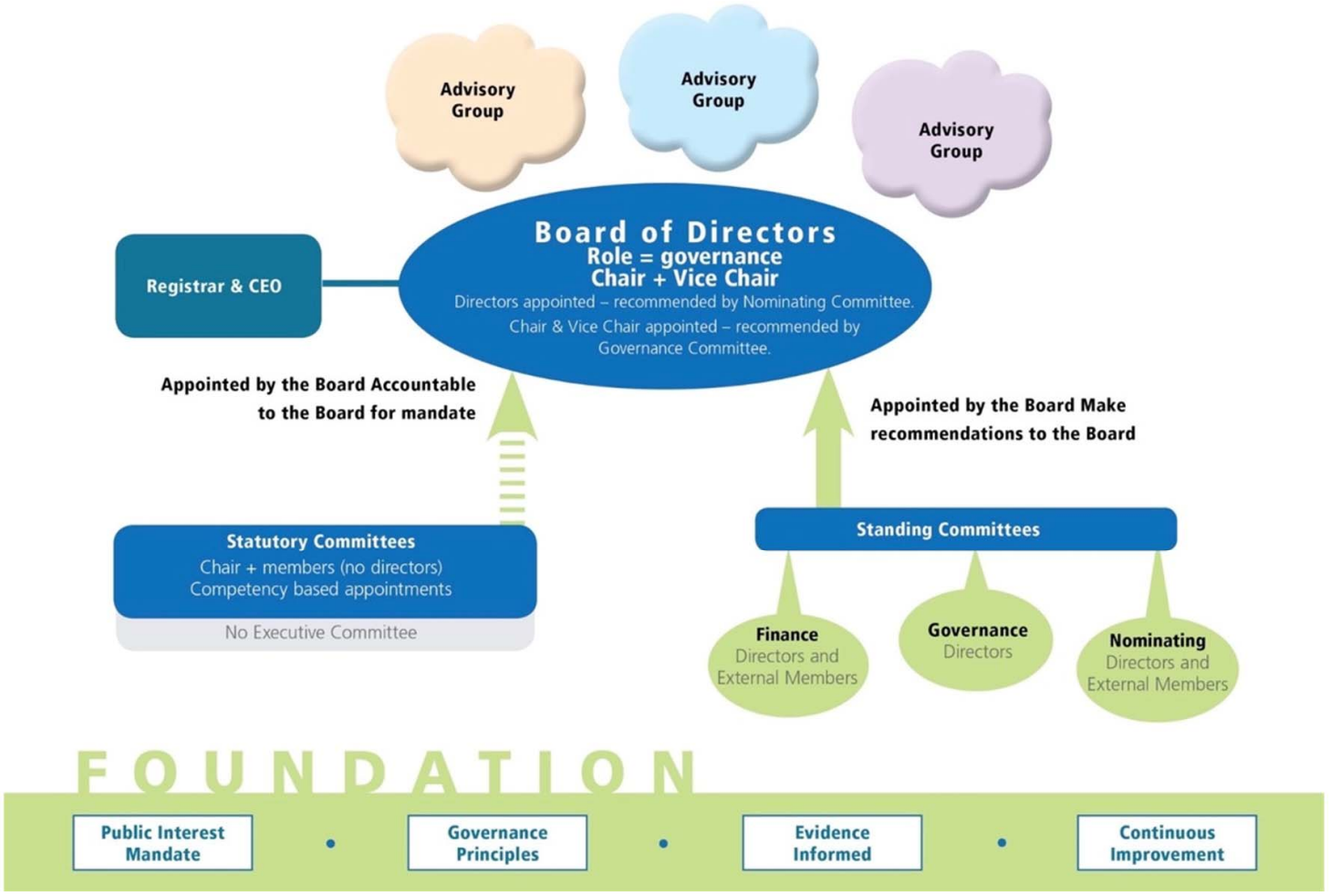
Independence

- Our decisions address public interest as our paramount responsibility
- Our decisions are free of bias and special interest perspectives

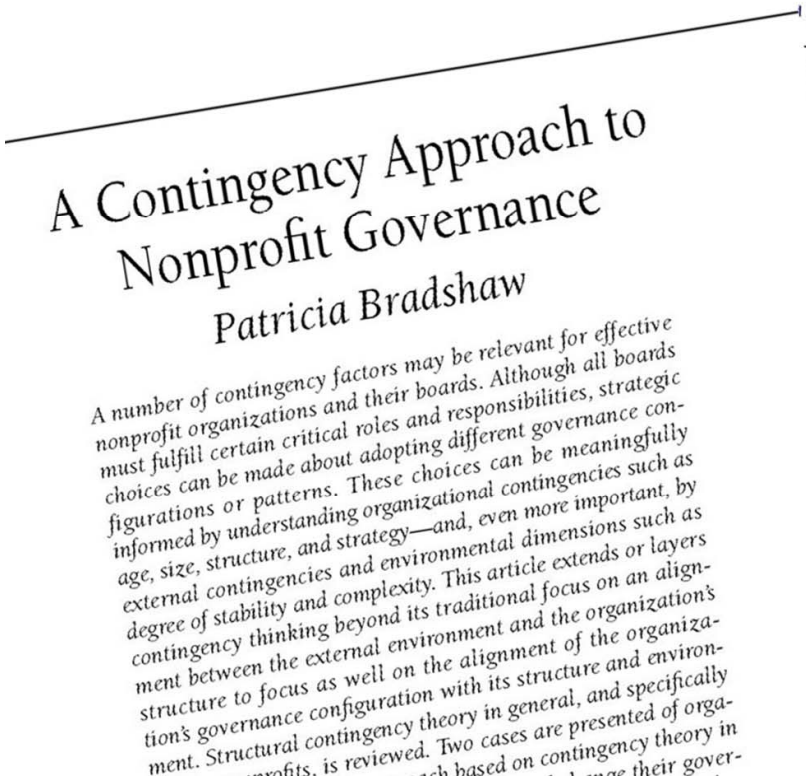
Integrity

Self assessment

Governance Model



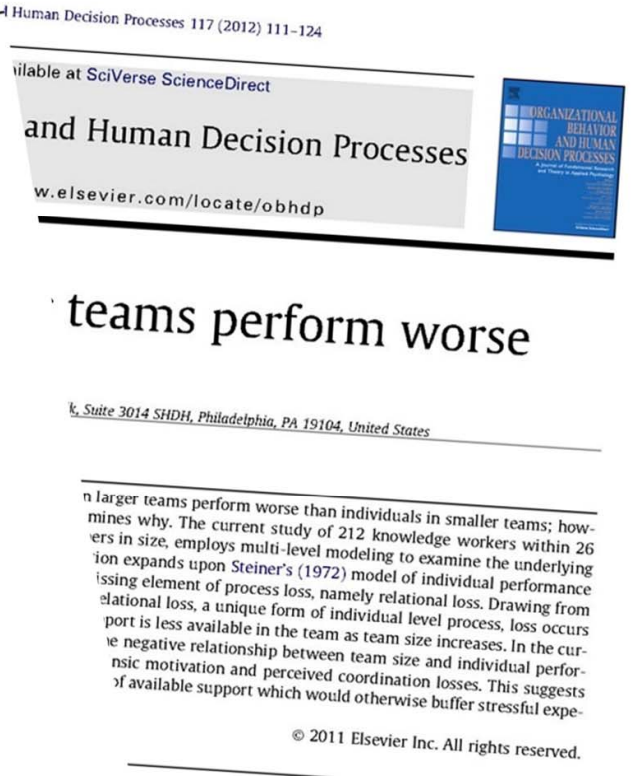
Smaller size, from 35 to 12...



A Contingency Approach to Nonprofit Governance

Patricia Bradshaw

A number of contingency factors may be relevant for effective nonprofit organizations and their boards. Although all boards must fulfill certain critical roles and responsibilities, strategic choices can be made about adopting different governance configurations or patterns. These choices can be meaningfully informed by understanding organizational contingencies such as age, size, structure, and strategy—and, even more important, by external contingencies and environmental dimensions such as degree of stability and complexity. This article extends or layers contingency thinking beyond its traditional focus on an alignment between the external environment and the organization's structure to focus as well on the alignment of the organization's governance configuration with its structure and environment. Structural contingency theory in general, and specifically



Human Decision Processes 117 (2012) 111–124

ilable at SciVerse ScienceDirect

and Human Decision Processes

w.elsevier.com/locate/obhdp

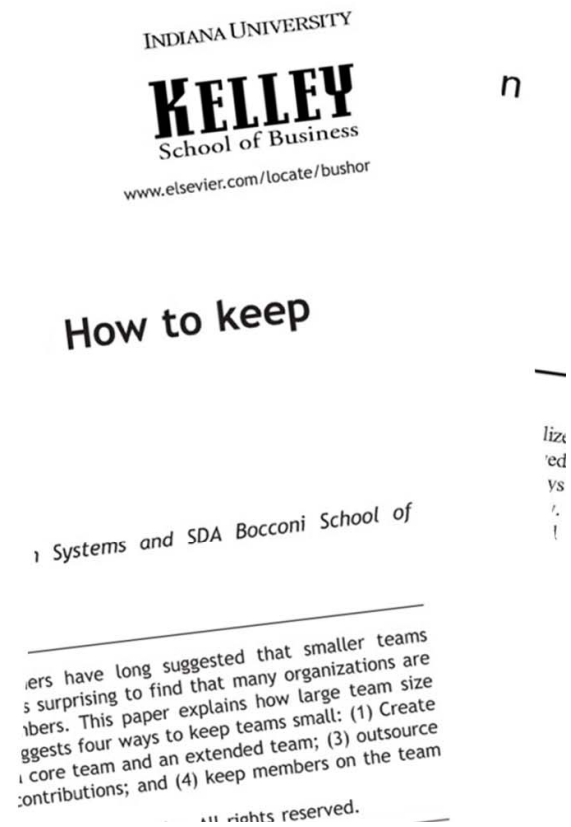
ORGANIZATIONAL BEHAVIOR AND HUMAN DECISION PROCESSES

teams perform worse

k, Suite 3014 SHDH, Philadelphia, PA 19104, United States

n larger teams perform worse than individuals in smaller teams; how- mines why. The current study of 212 knowledge workers within 26 ers in size, employs multi-level modeling to examine the underlying ion expands upon Steiner's (1972) model of individual performance issing element of process loss, namely relational loss. Drawing from elational loss, a unique form of individual level process, loss occurs port is less available in the team as team size increases. In the cur- ne negative relationship between team size and individual perfor- nsic motivation and perceived coordination losses. This suggests of available support which would otherwise buffer stressful expe-

© 2011 Elsevier Inc. All rights reserved.



Applied Economics, 2012, 44, 4313–4329

Board size and

INDIANA UNIVERSITY

KELLEY School of Business

www.elsevier.com/locate/bushor

How to keep

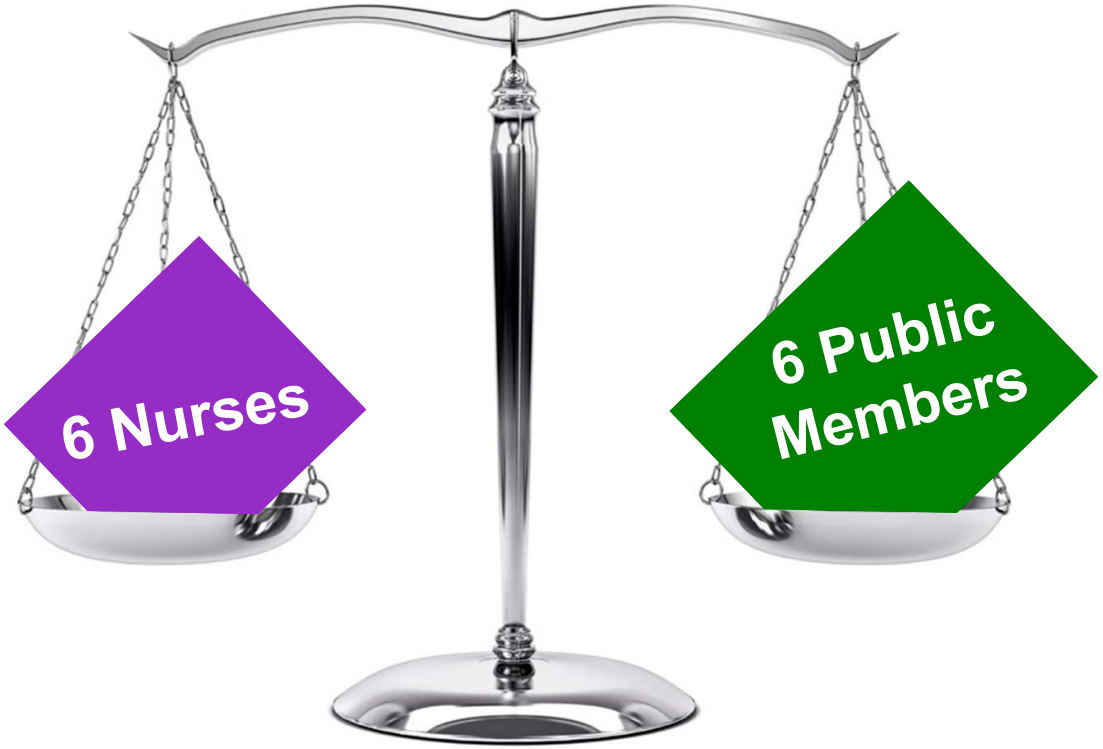
Systems and SDA Bocconi School of

ers have long suggested that smaller teams s surprising to find that many organizations are nbers. This paper explains how large team size ggests four ways to keep teams small: (1) Create core team and an extended team; (3) outsource ontributions; and (4) keep members on the team

Vision 2020

Diverse perspectives

Equal Numbers



Competency-based Board

Board Development Practic
and Competent Board M
Implications for Performa
William A. Brown

This study explores underlying assumptions about board opment practices in nonprofit governance. Specifically, a was developed to determine if using recommended recruitn board member orientation, and evaluation practices resulte more competent board members and if the presence of these bo members led to better board performance. The sample consist of 1,051 survey responses from CEOs and board chairs repre senting 713 credit unions. As member-benefit nonprofit organi- zations, credit unions rely almost exclusively on voluntary board members in an oversight capacity. Results support the contention that board development practices lead to more capable board members, and the presence of these board members tends to explain board performance. The study advances the under- standing of nonprofit board development practices by further defining the concept and proposing an empirically tested assess- ment strategy. Furthermore, the findings support using specific recruitment practices that should strengthen nonprofit boards.

THE BOARD is a critical asset for every nonprofit organization. Herman and Renz (1997) and others (for example, Brown, 2005; Jackson and Holland, 1998) have found that effective boards are associated with organizations that tend to perform better in terms of both fiscal performance and

Corresponding Author:

Dr Nevan Wright
Faculty of Business
AUT University
Private Bag 92006
Auckland

Email:
Nevan.wright@aut.ac.nz

Keywords:

Attributes of 'Experienced' Board Members

NEVAN WRIGHT
AUT UNIVERSITY

NICOLA DEACON
MANAGEMENT CONSULTA

Abstract: A grounded theo
term 'experienced board
board members expect of
derived from interviews
board members. A co
board member emerg
attributes is that th
agreement or dec
experienced Boa
contribute

The current issue and full text archive of this journal is available at
www.emeraldinsight.com/1754-243X.htm

The case for professional boards: an assessment of Pozen's corporate governance model

Thomas A. Hemphill and Gregory J. Laurence
School of Management, University of Michigan-Flint, Flint, Michigan, USA

Abstract

Purpose – Robert C. Pozen, Chairman Emeritus of MFS Investment Management and a long-time scholar of corporate governance, has proposed a model of professional board directorship that responds to the three main factors he believes underpin ineffective board decision making: the large size of boards; the lack of specific industry expertise; and inadequate director time commitment. The paper aims to discuss these issues.

Design/methodology/approach – The authors critically evaluate the efficacy of Pozen's proposed corporate governance model, addressing the three main factors underpinning ineffective board decision making.

Findings – A professional board consisting of retired executives with industry-specific expertise is vulnerable to a groupthink mentality, as well as to the availability of such individuals for board directorship seats. Moreover, while industry-specific expertise is a desired attribute of an independent board director, there are other attributes that firms are looking for, including international, regulatory/governmental, risk, technology, and marketing expertise. Lastly, Pozen's recommendations to reduce board size to seven members, as well as increasing the number of hours that independent directors spend on board-related activities (and commensurate compensation received), should be seriously considered as potential value-adding, corporate governance improvements.

Originality/value – The authors critically evaluate a corporate governance model that, based on director-related issues arising from the recent global financial crisis, has resurrected the concept of a "professional board" of directors. The authors utilize state-of-the-art academic literature from the fields of corporate governance and organizational behavior to evaluate the merits and de-merits of the proposed corporate governance model, and present their findings (and recommendations) for improvements in corporate governance practices.

Keywords Corporate governance, Board size, Director compensation, Groupt
Time commitment

Paper type Conceptual paper

Equal remuneration

Appointments

No election

Governance:

oversight, insight, foresight

unique role

accountabilities

competencies

Eliminate need for Executive Committee

Board of Directors

Role = governance

Chair + Vice Chair

Directors appointed – recommended by Nominating Committee.

Chair & Vice Chair appointed – recommended by Governance Committee.

3 Standing Committees

Finance
Directors and External Members

Governance
Directors

Nominating
Directors and External Members

Promoting ongoing learning and development

Evaluation is also a best practice

every three years


Effective Decision Making
Diversity
Stakeholders & Advisory Groups
Governance Committee
Nominating Committee
Evaluation
Orientation/development
Peer Feedback
Principle based
Competency Based Appointments
Planned Succession
Continuous Improvement
Distinct Clear Roles
Individual Competence
Leadership Competence
Size & Composition
Public Trust Through Exemplary Governance

Implementation


TOUGH
DECISIONS
AHEAD

References

Governance Literature Review, available at: cno.org/council

Governance as Leadership: Reframing the Work of Nonprofit Boards
Richard P. Chait; William P. Ryan; Barbara E. Taylor

Hartarska, V., & Nadolnyak, D. (2012). Board size and diversity as governance mechanisms in community development loan funds in the USA. Applied Economics, 44(33), 4313-4329.

Hoegl, M. (2005). Smaller teams–better teamwork: How to keep project teams small. *Business Horizons, 48*(3), 209-214.

Mueller, J. S. (2012). Why individuals in larger teams perform worse. *Organizational Behavior and Human Decision Processes, 117*(1), 111-124.

Bradshaw, P. (2009). A contingency approach to nonprofit governance. *Nonprofit Management and Leadership, 20*(1), 61-82.

References

Brown, W. A. (2007). Board development practices and competent board members: Implications for performance. *Nonprofit Management and Leadership*, 17(3), 301-317.

Wright, N., & Deacon, N. (2010). Attributes of 'Experienced' Board Members, New Zealand Journal of Applied Business Research, 8(1), 1-13.

Hemphill, T.A, Laurence G.J. (2014). The case for professional boards: an assessment of Pozen's corporate governance model. International Journal of Law & Management, 56(3), 197-214.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: COUNCIL AWARD

DATE: September 8, 2017

FOR INFORMATION

ISSUE:

At the September 8th meeting of Council, **Dr. Michael Stephenson** of Kitchener, Ontario will receive the Council Award.

BACKGROUND:

The Council Award honours Ontario physicians who have demonstrated excellence based on eight "physician roles".

- The physician as medical expert / clinical decision maker
- The physician as communicator
- The physician as collaborator
- The physician as gatekeeper / resource manager
- The physician as health advocate
- The physician as learner
- The physician as scientist / scholar
- The physician as person and professional

CURRENT STATUS:

Council member Dr. Jerry Rosenblum will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402

Date: August 22, 2017

Appendices: N/A

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice Policy – Draft for Consultation

FOR DECISION

ISSUE:

- The College's Changing Scope of Practice and Re-entering Practice policies are currently under review in accordance with the College's regular policy review cycle. The policies have been reviewed in tandem due to their common principles related to ensuring competence.

- A new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* has been developed, which addresses both topics (*attached as Appendix A*).

- Council is provided with an overview of the policy review process undertaken to date, as well as the draft policy. Council is asked whether it approves that the draft policy be released for external consultation.

BACKGROUND:

- The Changing Scope of Practice and Re-entering Practice policies, which were originally approved by Council in 2000, and last reviewed in 2008[1], respectively articulate expectations for physicians who have changed or intend to change their scope of practice and for physicians who wish to re-enter practice after a prolonged absence. These policies set out the requirement that physicians who intend to change their scope and/or re-enter practice report to the College and participate in a College process to ensure that they have the necessary competence to do so.

[1] Housekeeping amendments were also made in 2015.

- The policy review is being undertaken with the assistance of Dr. Bill McCauley (Medical Advisor), Ms. Lisa Wilson (Re-entry and Change of Scope Coordinator), and Ms. Alice Cranker (Legal Counsel).

a. Research

- The policy development process has been informed by an extensive research review, which included the following:

1) Literature Review: A comprehensive literature review of Canadian and international scholarly articles and research papers, was conducted. The topics considered included, but were not limited to:

- 'Skills fade' pertaining to physicians;
- 'Skills fade' pertaining to other professions; and
- Definitions of scope of practice.

  - The review highlighted that there is limited research on the rate of decline of skills ('skills fade') and there is no consensus in the literature on how long a physician can be out of practice before competency should be reviewed. Skills fade has been shown to be impacted by many variables including original training, the skill being examined, the experience of the professional prior to the absence from practice, and others.

2) Jurisdictional Research: A jurisdictional review of medical regulators and other healthcare professionals, both within Canada and internationally, was undertaken with respect to changing scope of practice and re-entering practice. (*Please see Appendix B for details of each position.*) The following issues were reviewed:

i. The definition of re-entry/extended absence from practice;
ii. The definition of scope of practice and change in scope of practice; and
iii. The processes for ensuring competence when changing scope of practice or re-entering practice.

- A summary of the jurisdictional research is set out below:

  - **Definition of re-entry/absence from practice:** The Canadian medical regulators who have positions on re-entering practice define an extended absence from practice as a period of *three consecutive years or more*. Some of the jurisdictions also set a standard for the number of days physicians must practice before reporting is required. For example, British Columbia requires physicians that have practised less than eight weeks a year in the preceding three years to report their absence.

- **Definition of scope of practice:** Many jurisdictions do not define scope of practice. Most that do (BC, AB and SK) capture the same elements of scope of practice that the CPSO does (patients cared for, procedures performed, treatments provided, and the practice environment).

- **Definition of changing scope of practice:** The definition of change in scope of practice slightly differs across jurisdictions (e.g., BC captures this as a *change in focus*; AB and YK capture this as *an intention to substantially change medical practice by adding medical services not provided frequently or continuously over the previous three years*).

- **Processes for ensuring competence:** Processes in other jurisdictions related to ensuring competence when a physician changes scope and/or re-enters practice are generally similar to the CPSO's.

3) **Internal Data Collection:** A review of common changes of scope that are seen by staff and inquiries from physicians pertaining to changing scope of practice and re-entering practice was conducted. Matters considered by the Investigations, Complaints and Resolutions (ICR) Committee, where the *Scope of Practice* and *Re-entering Practice* policies were relied upon, were also examined.

b. Preliminary Public Consultation and Committee Feedback

Consultation Process: Scope of Practice

- An external preliminary consultation on the topic of physician scope of practice took place from April 4 to June 2, 2016.[2]

- The College received a total of 163 responses to this consultation. This included 43 comments on the College's online discussion page and 120 online surveys[3].

- All stakeholder feedback has been posted publicly on the consultation-specific page of the College's website and a comprehensive report of survey results is available on the consultation page. [4]

[2] Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the College's entire membership. In addition, a general notice was posted on the College's website, Facebook page, and announced via Twitter. It was also published in Dialogue and Patient Compass (the College's public e-newsletter). The other Canadian Medical Regulatory Authorities were also invited to provide their members with a link to this consultation but the majority of the feedback has come from stakeholders within Ontario. Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to an online discussion page.

[3] 139 respondents started the survey, but of these, 19 did not complete any substantive questions – leaving 120 for analysis.

- The topic of scope of practice was looked at broadly in an effort to support both the policy review as well as a pan-Canadian Working Group, representing Medical Regulatory Authorities (including the CPSO), CPD professionals, researchers and national organizations, that was formed to focus on understanding and using scope of practice as an important contributor to effective medical regulation, patient safety and physician performance.[5]

- Survey questions pertaining to the policy review broadly focused on the definition of scope of practice and change of scope, the clarity of the current policy expectations, and the College's changing scope of practice process.

- Respondents provided a variety of feedback related to scope of practice. Generally, stakeholders expressed support for the current policy. In particular, the majority of online survey respondents felt that the current policy was clearly written, easy to understand, and well organized.

- The majority of physician respondents agreed that the description of scope of practice set out in the CPSO's current *Changing Scope of Practice* policy includes the right elements (the patients the physician cares for, the procedures performed, the treatments provided, and the practice environment).

- A number of physician respondents suggested that the following elements should also be considered when defining a physician's scope of practice:
  - Values including interests, goals, lifestyle, and remuneration;
  - Personal characteristics such as age, health, physical ability, languages spoken, and family; and
  - Resources such as access to specialists, supports, and other health care professionals.

- When asked how the policy could be made more clear and comprehensive, many physician respondents suggested the policy be updated to include more examples of what a significant change in scope would, and *would not*, be.

<u>Consultation Process: *Re-entering Practice* policy</u>

- An external preliminary consultation on the current *Re-entering Practice* policy took place from June 13 to August 12, 2016.

---

[4] Approximately 94% of respondents to the consultation identified themselves as physicians, 1% as organizations, and 4% as anonymous. The organizational respondents were the Professional Association of Residents of Ontario and the General Practice Psychotherapy Association.

[5] Feedback provided on the broader topic of scope was provided to the national Working Group in aggregate form to inform the national project.

- The College received a total of 29 responses to this consultation.[6] This included 13 written comments on the College's online discussion page and 16 online surveys.[7] This feedback is posted on our website in keeping with regular consultation processes and posting guidelines and a comprehensive report of survey results is available on the consultation page.

- Survey questions centered around the clarity and comprehensiveness of policy expectations, the topic of absence from practice related to competency, and the College's re-entering practice process.

- Respondents provided a variety of feedback on a range of topics related to re-entering practice after an extended absence. Survey respondents were generally divided about whether they found the current policy to be clear, easy to understand, well organized and clearly written. Survey respondents were also generally divided about whether they felt the policy was comprehensive.

- When asked about the expectations set out in the policy to ensure that physicians have the competency necessary to return to practice, the majority of respondents indicated that they agree that it is important that physicians who have been absent from practice for a prolonged period have a needs assessment prior to returning to practice. Respondents were divided, however, about whether it is important that these physicians undergo supervision and a final assessment prior to returning to practice.

- All feedback has been carefully reviewed and used to develop the draft policy.

Feedback from College Committees

- An earlier version of the draft policy was taken to the Quality Assurance and Registration Committees for feedback as these committees review applications of physicians who want to change their scope of practice and re-enter practice.

- Generally the committees were supportive of the version of the draft policy they reviewed.
- Both committees had some suggestions for minor revisions to the draft policy. All feedback from these committees has been carefully reviewed and used to refine the draft policy.

[6] Approximately 86% of respondents to the consultation identified themselves as physicians, 10% as organizations, and 3% as anonymous. The organizational respondents were: The College of Physicians and Surgeons of Saskatchewan (CPSS), the Information and Privacy Commissioner of Ontario (IPC), and the Professional Association of Residents of Ontario (PARO).

[7] 19 respondents started the survey, but of these, 3 did not complete any substantive questions – leaving 16 for analysis.

CURRENT STATUS:

- Based on research undertaken, and feedback received through the preliminary consultation, from staff in the program area, and from the Registration and Quality Assurance Committees, a draft *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy has been developed.

- Overall, the general expectations set out in the current policies have been maintained in the draft policy.

- Two substantive changes have been made:
    i. The threshold for reporting an intention to change scope of practice or to re-enter practice after an extended absence has been shortened from three years to two years; and
    ii. The draft policy no longer captures physicians in part-time practice (physicians who have practised less than six months in the preceding five-year period).

- A number of minor amendments have also been made.

- A high-level report of the minor amendments along with a description of the substantive issues and the corresponding considerations are set out below.

Minor Amendments

- **Combining policies:** The policies have been combined into one document, in light of the common principles and processes related to ensuring competence when changing scope of practice and re-entering practice.

- **Policy Scope:** The draft policy clarifies that the policy does not apply to physicians who intend to change their scope of practice to, or to those who intend to re-enter: teaching, research, or administrative practice, where there is no assessment or treatment of patients involved. This clarification was made to ensure alignment with the College's current practice. These physicians are not currently required to undergo the process for changing scope of practice and re-entering practice.[8]

- **Policy Principles:** In keeping with how other College policies have been drafted, the Principles have been updated to align with the Practice Guide.

[8] It should be noted that the draft policy requires all physicians to maintain competence.

- **Terminology Section:** In response to consultation feedback requesting clarity about terms in the policies, a separate terminology section has been added to the draft to clarify the meaning of scope of practice and changing scope of practice.

    - **Definition of Scope of Practice:** The draft definition maintains the content of the definition in the current *Changing Scope of Practice* policy and provides examples of what is meant by each element. It aligns with work conducted by the national Working Group, and an internal College Working Group and incorporates consultation feedback.

    - **Description of Change in Scope of Practice:** In response to the consultation feedback, a description of what constitutes a significant change of scope has been included in an Appendix to the draft policy. A description of *evolution of practice* has also been included to clarify what would *not* be considered a change of scope. (*This is attached as Appendix C*.)

- **Reporting Changes in Scope of Practice and Re-entering Practice:** The draft policy clarifies that physician reporting of the intention to change scope of practice or re-enter practice must be done *prior* to changing scope of practice or re-entering practice and that physicians must not practise in a new scope of practice or re-enter practice until the College approves their request.

- **Processes for Changing Scope and Re-entry:** The processes for ensuring competence when re-entering practice and changing scope of practice are very similar. A document which describes the process physicians must undergo before changing scope and re-entering practice has been developed. It will be attached to the final policy as an appendix. (*This is attached as Appendix D.*)

- **Cost Provisions:** The current policies require physicians to pay for the costs related to supervision and training associated with the changing scope and re-entering practice processes. The costs of the final assessment for physicians changing their scope of practice are borne by the physician while the costs of the final assessment for physicians who are re-entering practice are borne by the College[9]. Since there is no principled reason for these different payment structures, the draft policy now requires *all* physicians who wish to re-enter practice and/or to change their scope of practice to pay for their final assessment.

[9] Unless the physician is re-entering practice following a College investigation; discipline or fitness to practise hearing which led to the absence; or as part of an application to receive a certificate of registration in Ontario.

Substantive Changes

i. Threshold for reporting: From 3 years to 2 years

Extended absence from practice

- The current *Re-entering Practice* policy identifies an extended absence as *physicians who have been out of practice for a period of at least three years or who have practised less than a total of six months in the preceding five-year period*.

- The draft policy now considers an extended absence to be an absence from clinical practice for a period of at least *2 consecutive years*.[10]

- This change was made based on feedback from College staff who manage change of scope and re-entry requests. The three year absence was felt to be too long and the change to two years was felt to better protect the public.

    - This change is supported by the literature which suggests that the threshold for reviewing competence should be shorter than 3 years. A literature review undertaken by the UK's General Medical Council provides that skills have been shown to decline over periods ranging from 6-18 months out of practice.

    - Other medical bodies have also suggested a review of competence for absences shorter than 3 years. The American Board of Surgery requires physicians to undergo a re-entry program after two or more years absent from surgical practice and the Academy of Medical Royal Colleges[11] in the UK have Return to Practice Guidance

[10] Please note that as a result of the labour mobility provisions in the *Health Professions Procedural Code* and Registration Regulation, the time frame in the draft policy would not apply to a physician who is applying for a certificate of registration in Ontario (i.e. an applicant), if the applicant holds a license from any other province in Canada.

For these applicants who hold licenses somewhere else in Canada, the Registration Regulation (O.Reg 865/93) provides that the College may only require additional training and assessments if the applicant has been out of practice for a period of 3 years of more.

3.1(2) *…if the applicant "is unable to satisfy the Registrar or a panel of the Registration Committee that the applicant practised the profession of medicine to the extent that would be permitted by a certificate of registration authorizing independent practice at any time in the three years immediately preceding the date of the applicant's application, the applicant must meet any further requirement to undertake, obtain or undergo material addition training, experience, examination or assessments that may be specified by a panel of the Registration Committee."*

[11] The Academy of Medical Royal Colleges is the coordinating body for the UK and Ireland's 24 medical Royal Colleges and Faculties. They set standards for the way physicians are educated, trained and monitored throughout their careers.

that suggest that physicians' competence should be evaluated after an absence of three months or more**.**

Changing scope of practice

- To reflect current College practice, the draft policy explicitly requires physicians who intend to return to a scope of practice in which they have not practised for an extended period of time to report to the College (even if the physician has previously trained and had experience in this area). Similar to the position on re-entry, the threshold for reporting significant changes in scope has been shortened to two years.

ii. Removal of reporting requirement for physicians who practise less than 6 months in preceding 5 year period

- The current requirement for physicians to report to the College if they "have practised less than a total of six months in the preceding five-year period" has not been retained in the draft policy.

- This position was meant to capture physicians who were practising part-time, or less than approximately 2 days per month.

- Feedback from the program area indicated that this requirement presented an administrative burden, and was challenging for members to interpret (i.e., physicians were required to calculate days worked in the preceding 5 year period).

- Staff considered whether the reporting threshold for part-time physicians should be maintained, revised, or removed. Staff also considered whether physicians who work in multiple scopes of practice, one or more of which they practise less than 2 days a month, should be captured by the draft policy.

- Ultimately, a decision was made to not capture physicians practising part-time or in multiple scopes of practice (who work less than 2 days per month) in the draft policy.

- While there may be some risk to not capturing these physicians, the updated policy position requiring physicians to report after a two year absence instead of a three year absence is felt to sufficiently protect the public and be an improvement over the current policy position.

- Other considerations included:

    - There is no research to suggest how often (days per week/month/year) a physician must practise in order to maintain competence. Two days per month

(i.e., 6 months in 5 years) is an arbitrary number felt to reasonably ensure competence but is not evidence-based.

- Very few physicians report that they practise part-time (less than two days per month)[12].

- Many more physicians report practising in one or more practice areas less than 2 days per month [13]. However, analysis of the annual report data suggests that many of these are likely false reports. Specifically, many of these reports come from family physicians and general practitioners who have broken down their work in family medicine by Royal College specialty areas (e.g., obstetrics, psychotherapy, geriatrics, dermatology, pediatrics).

- If physicians who work in multiple scopes of practice were required to report, the College would need more resources to follow-up with this group, of which many are likely not actually practising in multiple scopes of practice.

NEXT STEPS:

- In keeping with College policy processes, the next stage in the review process will be to solicit feedback on the draft externally, through a consultation with the profession, the public, and other interested stakeholders.

- If Council approves the draft, the consultation will be held immediately following the September 2017 Council Meeting.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the draft *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy?

2. Does Council recommend that the draft policy be released for external consultation?

Contact: Lynn Kirshin, ext. 243
Tanya Terzis, ext. 545

[12] Annual Renewal Survey data from 2016 indicated that less than 1% of physicians (approximately 300) reported practising part-time (i.e. less than 2 days per month).
[13] In 2016, over 3500 physicians reported practising in one or more clinical practice areas less than two days a month.

Date: August 17, 2017

Attachments:

Appendix A: Draft Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice policy

Appendix B: Summary of Jurisdictional Review

Appendix C: Description of Significant Change in Scope of Practice

Appendix D: Process for Changing Scope of Practice and/or Re-Entering Practice

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

Introduction

Physicians may wish to change their scope of practice (e.g. if they become interested in a different area of medicine or if their personal circumstances change), and/or may be absent from practice for a period of time for a variety of reasons (e.g. going on an extended parental leave, taking a sabbatical, or taking on a teaching role).

Physicians are responsible for maintaining the medical knowledge and clinical skills necessary to provide the highest possible quality of care to patients. When a physician notifies the College of his or her intention to change his or her scope of practice or to re-enter practice, the College oversees the process that must be undertaken by the physician in order to ensure that he or she is competent to resume practice or to practice within a new scope.

This policy sets out the expectations related to reporting and maintaining competence with respect to changing scope and/or re-entering practice and outlines the applicable College processes related to ensuring competence.

Principles

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

1. Acting in the best interests of their patients by ensuring that they have acquired the necessary training and knowledge prior to changing their scope of practice and/or re-entering practice.

2. Demonstrating continued professional competence, by meeting the standard of care and acting in accordance with all relevant and applicable professional obligations.

3. Being committed to lifelong learning and maintaining the medical knowledge and skills necessary to provide the highest possible quality of care to patients.

4. Upholding professionalism and trust and protecting patient safety by only practising in the areas in which they are both educated and experienced.

5. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

Purpose and Scope

This policy articulates expectations to ensure that when physicians propose to significantly change their scope of practice and/or to re-enter practice they have the competence necessary to practise safely.

This policy applies to physicians who wish to change their scope of practice or to re-enter practice after an extended absence from practice, even if they have continuously maintained their certificate of registration during their absence. The policy also applies to physicians who would like to re-enter practice and change their scope of practice simultaneously.

This policy does not apply to physicians who intend to change their scope of practice or intend to re-enter practice in positions focused on teaching, research, or administration, where there is no assessment or treatment of patients.[1,2]

Terminology

1. **Scope of practice:** Scope of practice is influenced by factors including:
    - education, training, and certification;
    - the patients the physician cares for[3];
    - the procedures performed;
    - the treatments provided;
    - the practice environment[4].

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 above. When referring to changing scope of practice requirements in this policy, these

[1] For those physicians changing their scope of practice or re-entering practice in positions that involve teaching, research and administrative there are separate processes for ensuring competence. For example, there are credentialing requirements in hospitals. The College requires all physicians to maintain competence regardless of type of practice.

[2] 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) are captured by this policy and must report their intention to change their scope of practice.

[3] This would include populations (e.g. where a physician is practising as a Medical Officer of Health).

[4] Practice environment may include colleague supports, access to resources, payment systems, geographic or health system demands.

specifically pertain to changes that are significant. For information regarding whether a change is significant, please refer to Appendix 1.

Policy

The College expects physicians to practise medicine competently. As such, physicians must only practise in the areas of medicine in which they are educated and experienced.[5]

Physicians may wish to change their scope of practice and/or may take a break from practising for a variety of reasons. In order to ensure that physicians are practising competently, the following expectations will apply to physicians before they change their scope of practice and/or re-enter practice:

1. Reporting to the College; and
2. Undertaking a College Review Process.

Physicians must not practise in a new scope of practice or re-enter practice unless the College has approved their request.

Reporting to the College

Physicians must report to the College when they:

- wish to re-enter practice and have not been engaged in practice for a period of two consecutive years or more; and/or
- 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, even if the physician has previously trained and had experience in this scope of practice.

Reporting can be initiated by completing the applicable application form[6]. A physician must also indicate in the Annual Renewal Survey that he or she has made this report[7].

[5] 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* regulations under the *Medicine Act*, *1991*, state that it is professional misconduct for a physician to contravene a term, condition or limitation on his or her certificate of registration (Section 1(1)1).

[6] 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.

[7] In accordance with section 51(3) of the College's *General By-Law*.

If physicians are uncertain about whether they are required to report a change to their scope of practice or an intention to re-enter practice, they should contact the Inquiries Section in the Applications and Credentials Department of the College for further guidance at 416-967-2600 ext. 221 or by email at inquiries@cpso.on.ca.

College Review Process

All physicians who wish to change their scope of practice and/or re-enter practice must participate in a College review process to demonstrate their competence in the area in which they intend to practise.

The College oversees the process for changing scope of practice and/or re-entering practice. The process for re-entry and change in scope of practice will be individualized for each physician but in general includes a needs assessment, training, supervision, and a final assessment.

During the College review process, consideration will be given to the physician's specific situation including prior experience, any training the physician has undertaken, the continuing professional development the physician has engaged in, the risk of harm to patients, the length of time the physician has been away from practice[8], and the degree to which the discipline has advanced during the physician's absence[9].

For greater detail on the requirements for changing scope of practice and/ or re-entering practice, physicians should consult Appendix 2.

[8] This would apply in the re-entry or combined re-entry and change of scope cases.
[9] This would apply in the re-entry or combined re-entry and change of scope cases.

JURISDICTIONAL REVIEW – Changing Scope of Practice and Re-entering Practice

The chart below highlights guidance provided by medical regulators and other medical bodies, both within Canada and internationally, with respect to changing scope of practice and re-entering practice after an extended absence. The guidance has been categorized, where possible, according to the following themes:

(a) General Guidelines/Requirements Prior to Changing Scope or Re-entry;
(b) Definition of Scope of Practice and/or Change in Scope of Practice;
(c) Definition of Re-entry/Absence from Practice.

A. MEDICAL REGULATORS - CANADA	
British Columbia	**DOCUMENT TYPE: Professional Standards & Guidelines • TITLE: Re-entry to or Change in Practice • DATE: FEBRUARY 2012** **(a) General Guidelines /Requirements prior to Changing Scope and/or Re-entering Practice** • A registrant, prior to resuming practice, applying for registration or changing the focus of his or her clinical practice, must o notify the registrar in writing, o undergo a review and assessment of skill, knowledge and competency provide a written report of successful completion of such review and assessment, and o undergo retraining • Changing scope of practice: must, also meet the post-graduate training requirements for registration. **(b) Definition of Change in Scope of Practice** • A registrant who wishes to change the focus or scope of his or her clinical practice to an area in which he or she has not previously practised or demonstrated competence to the satisfaction of the College. • A registrant who wishes to *change the focus of his or her clinical practice* to an area in which the registrant has not practised for a consecutive period of three years or more, or who has practised less than eight weeks a year in that area in the preceding three years. • *Examples*: Registrants are required to obtain College approval prior to returning to a former scope of practice if they: o work solely as hospitalists and wish to return to general family practice o are employed or contracted to perform limited clinical work and wish to re-enter their former wide scope of practice

A. MEDICAL REGULATORS - CANADA	
British Columbia Cont'd	o work solely in administrative capacities and wish to return to clinical practice. **(c) Definition of Re-entry/Absence from Practice** • A registrant who has been absent from clinical practice for a consecutive period of three years or more or who has practised less than eight weeks a year in the preceding three years.
Alberta	**DOCUMENT TYPE: Standards of Practice and Supporting Documents • TITLE: Re-Entering Medical Practice or Changing Scope of Practice • Change of Scope Practice Assessment • Messenger Newsletter • DATE: JANUARY 1, 2010** **(a) General Guidelines /Requirements prior to Changing Scope or Re-entry** **Change of scope requests -** Physicians must: • Notify the College. • Provide documentation of training, experience and/or competence. • Registrar determines whether an assessment and additional training is required. • The College's requirements will vary depending on specific circumstances. • The College arranges the necessary assessment and training. Physicians are responsible for the associated costs. **Re-entry requests** - Physicians must: • Notify the College. • Undergo a review by the Registrar • May be required to complete an assessment and retraining prior to returning to medical practice. **(b) Definition of Change in Scope of Practice** • Physicians who intend to substantially change their medical practice by *adding medical services not provided frequently or continuously* over the previous three years. • Required to report *significant changes to practice*: this includes changing the types of patients cared for, the procedures performed, the treatments provided or practice environment. • *Examples*: Moving from a solely community-based practice to a hospital practice; expanding the scope of your practice (e.g. adding cesarean sections or GP anesthesia); switching medical disciplines (e.g., from internal medicine to general practice)

A. MEDICAL REGULATORS - CANADA	
Alberta Cont'd	**(c) Definition of Re-entry/Absence from Practice** • When the physician intends to return to medical practice after an absence or retirement of three (3) years or more.
Saskatchewan	**DOCUMENT TYPE: Policy and By-law • TITLE(S): Scope of Practice Change[1] and Bylaw Section 4.1 • DATE: SEPTEMBER 2014** **(a) General Guidelines/ Requirements Prior to Changing Scope and/or Re-entering Practice** • Physicians must first notify the College and complete an assessment and retraining before doing so. o The Registrar shall consider a variety of factors when considering a need for assessment and retraining , the physician's previous training and experience; the physician's related activity during absence from practice, including participation in continuing professional learning; the physician's intended scope of practice. o Assessments may include one or more of the following: Observed performance in practice-settings; structured clinical encounters; structured oral interviews; simulators; written examinations. o Retraining may include but is not limited to: Directed self-study; traineeships with identified preceptors; formal residency training programs; supervised practice. • The College will facilitate the process for changing scope of practice. **(b) Definition of Scope of Practice and Change in Scope of Practice** ***Scope of Practice:*** • Every physician's scope of practice is unique. • A physician's scope of practice is determined by the patients the physician cares for, the procedures performed, the treatments provided, and the practice environment. • A physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgment, which are developed through training and experience in that scope of practice. ***Change in scope of Practice:*** • A significant change in a physician's scope of practice is one in which the nature of the patient population cared for by the physician, the treatments provided by the physician or the environment in which the physician sees patients has changed in a significant way.

[1] This policy is almost identical to the CPSO's current Changing Scope of Practice policy.

A. MEDICAL REGULATORS - CANADA	
Saskatchewan Cont'd	• A significant change in a physician's scope of practice is also where a physician begins to practise outside of what would be considered the usual scope of practice for the physician's discipline, training and experience. • *Examples*: a family physician who wishes to perform cosmetic surgical procedures; or a specialist, such as a surgeon, who wishes to practise primary care medicine. **(c) Definition of Re-entry/Absence from Practice** • A physician who has not engaged in 5 months of clinical practice within the past 5 years must comply with the same requirements as physicians who have been absent from clinical medical practice for three years or more.[2]
Manitoba	**DOCUMENT TYPE: Statement • TITLE: Re-training of Inactive Physicians • DATE: SEPTEMBER 2008** **(a) General Guidelines/ Requirements Prior to Changing Scope and/or Re-entering Practice** • Requirements**:** assessment, and where required, relevant retraining before returning to practice. • A physician who wishes to re-enter practice must file with the College a written description of his/her specific practice plans according to one of the following options: o Method A: An assessment, followed by such retraining as is recommended by the assessor. Method B: A retraining proposal of not less than eight weeks. o Method C: A specific mentorship proposal. **(b) Definition of Scope of Practice and/or Change in Scope of Practice** • See *specific absence of practice* below- similar to *change in scope of practice* **(c) Definition of Re-entry/Absence from Practice** • All physicians who are planning to re-enter medical practice after: o having been absent from clinical practice for a continuous period of 3 years o not having practiced for more than 5 months in a period of 5 years.

[2] Section 4.1 of the Bylaw also states, "A physician who has been inactive due to illness or disability will be evaluated on an individual basis, as to the need for a formal assessment, irrespective of the length of time they have been absent from practice, and may be required to comply with the same requirements as physicians who have been absent from clinical medical practice for three years or more."

A. MEDICAL REGULATORS - CANADA	
Manitoba Cont'd	• Absence from medical practice **may be general** (i.e. absent from all clinical activity) **or may be specific** (i.e. the physician has excluded one or more specific fields of clinical practice either through restriction of practice or through practice in a specific setting). • A physician who has not performed an advanced elective procedure for more than 3 years is considered to be inactive for the purposes of obtaining or renewing hospital privileges for that procedure.
Québec	• N/A
Newfoundland	• N/A[3]
Nova Scotia	**DOCUMENT TYPE: Registration Regulation • TITLE: College of Physicians and Surgeons Registration Regulation made under Section 6 of the Nova Scotia Medical Act • DATE: AUGUST 26, 2005** **(a) General Guidelines/ Requirements Prior to Changing Scope or Re-entry** • Should a member wish to change the scope of practice , or wish to re-enter clinical practice the Council may request that the member provide the Council with evidence that he/she is competent to engage in that scope of practice. • All requests from members to change their scope of practice shall be handled on an individual basis. **(b) Definition of Scope of Practice and/or Change in Scope of Practice** • "**Scope of practice**" means the medical specialty in which the member is registered in the Medical Specialists Register, the discipline of family medicine or any other non-clinical medical practice. • **Change in Scope**: wish to change the scope of practice from the one that he/she has practised for the previous 3 years. **(c) Definition of Re-entry/Absence from Practice** • Wish to re-enter clinical practice after a 3 year absence.
New Brunswick	• **N/A**

[3] Scope of Practice position sets out expectations related to practicing in out-of-hospital premises: *Scope of Practice for Medical/Surgical Procedures in Non-Hospital Medical Facilities*

A. MEDICAL REGULATORS - CANADA	
Prince Edward Island	**DOCUMENT TYPE: Regulation • TITLE: Regulations[4] • DATE: MAY 1, 2014** **(a) General Guidelines/ Requirements Prior to Changing Scope or Re-entry** • Must apply to and obtain the consent of Council before undertaking such alteration. **(b) Definition of Scope of Practice and/or Change in Scope of Practice** • A member wishing to substantially alter his type of practice **(c) Definition of Re-entry/Absence from Practice** • N/A
Yukon	**DOCUMENT TYPE: Standards of Practice • TITLE: Re-Entering Medical Practice or Changing Scope of Practice • DATE: N/A** **(a) General Guidelines/Requirements Prior to Changing Scope or Re-entry** • A physician who is returning to medical practice after an absence or retirement of three (3) years or more must undergo a review by the Council and may be required to complete an assessment and retraining • A physician who intends to substantially change his or her medical practice by adding medical services which the physician has not provided on a frequent or continuous basis over the previous three (3) years: (a) must notify the Council, must provide evidence attesting to the acquisition of training, experience, and/or competence to perform the proposed change in medical services, and (b) may be required to complete an assessment and training or retraining prior to initiating the proposed change in medical services. **(b) Definition of Change in Scope of Practice** • A physician who intends to substantially change his or her medical practice by adding medical services which the physician has not provided on a frequent or continuous basis over the previous three (3) years.

[4] No information related to re-entry on website.

A. MEDICAL REGULATORS - CANADA	
Yukon Cont'd	**(c) Definition of Re-entry/Absence from Practice** • When the physician intends to return to medical practice after an absence or retirement of three (3) years or more.
North West Territories	• N/A
Nunavut	• N/A

B. INTERNATIONAL JURISDICTIONS: UNITED STATES, UNITED KINGDOM, AUSTRALIA & NEW ZEALAND	
American Medical Association	**DOCUMENT TYPE: Opinion • TITLE: •"Physician Re-entry": AMA Council on Medical Education Report Physician Re-entry • DATE: June 2008 A Physician Reentry into the Workforce Inventory** **(a) General Guidelines/Requirements Prior to Changing Scope or Re-entry** • N/A **(b) Definition of Scope of Practice and/or Change in Scope of Practice** • N/A **(c) Definition of Re-entry/Absence from Practice** • "A return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment." • Distinct from remediation or retraining. • No disciplinary or addiction related impairment issues. • A table highlighting re-entry regulations of State Medical Boards can be found here. (Average length of absence across boards is 2.8 years. Board requirements pertaining to absence from practice range from 1 to 10 years).

B. INTERNATIONAL JURISDICTIONS: UNITED STATES, UNITED KINGDOM, AUSTRALIA & NEW ZEALAND	
American Board of Surgery	**DOCUMENT TYPE: Guidelines • TITLE: Guidelines on Re-entry to Surgical Practice • DATE: September 2012** **(a) General Guidelines/Requirements Prior to Changing Scope or Re-entry** • The ABS endorses the following guidelines for surgeons seeking to re-establish their clinical careers. • A re-entry pathway should address the following elements: o Assessment of status of practice at departure: reference letters from the chair of surgery; and chair of credentials committee at the primary practice location at the time of departure from practice. o Specifics of the re-entry pathway should be constructed by the local physician champion and include assessment of the six competencies: medical knowledge; patient care; professionalism; communication; practice-based learning; and systems-based practice. o Proctoring plan: A local proctor who is a diplomate of the ABS must be identified and agree to serve in this role for the duration of the trial period. The proctor will provide a final assessment based on the six competencies. o Outcomes assessment: The hospital should complete a Focused Professional Practice Evaluation per Joint Commission guidelines within six months of beginning independent practice. o Maintenance of Certification: The individual will be required to come into compliance with the ABS Maintenance of Certification (MOC) Program, and must meet MOC requirements as needed based on his or her individual situation. **(b) Definition of Scope of Practice and/or Change in Scope of Practice** • N/A **(c) Definition of Re-entry/Absence from Practice** • A re-entry pathway is warranted after two or more years removed from surgical practice.

C. INTERNATIONAL JURISDICTIONS: UNITED STATES, UNITED KINGDOM, AUSTRALIA & NEW ZEALAND	

Medical Board of Australia	**DOCUMENT TYPE: Registration Standard • TITLE: - Registration Standard: Recency of Practice[5] • DATE: OCTOBER 1, 2016**
	
	(a) General Guidelines/Requirements Prior to Changing Scope or Re-entry
	• Physicians must practise within their scope of practice at any time for a minimum total of:
	  • four weeks full-time equivalent in one registration period, which is a total of 152 hours, or
	  • 12 weeks full-time equivalent over three consecutive registration periods, which is a total of 456 hours.
	  • Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours.
	• Medical practitioners who work part-time must complete the same minimum number of hours of practice.
	• Practitioners engaging in non-clinical practice can be registered and will continue to meet this standard as long as they do not change the scope of their practice.
	
	(b) Definition of Scope of Practice and/or Change in Scope of Practice
	• **Scope of practice:** the professional role and services that an individual health practitioner is trained, qualified and competent to perform.
	
	• **Practice**: Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession.
	
	• **Changing field or scope of practice:** A change to a subset of your current practice (i.e., narrowing scope of practice- no additional requirements);
	• A change to an extension of your practice that your peers might reasonably expect from a practitioner in that field (required to undertake any training that peers would expect before taking up the new area of practice); or
	• A change to a different field of practice (required to consult with the relevant specialist college and develop a professional development plan for entering the new field of practice for the consideration and approval of the Board.

[5] Sets out the Medical Board of Australia's minimum requirements for recency of practice for medical practitioners except those with non-practising registration and

C. INTERNATIONAL JURISDICTIONS: UNITED STATES, UNITED KINGDOM, AUSTRALIA & NEW ZEALAND	
	Medical Board of Australia Cont'd **(c) Definition of Re-entry/Absence from Practice** • *Re-entry*: Medical practitioners who have not practised for more than one year and who wish to return to practice. • *Recency of practice*: A health practitioner has maintained an adequate connection with, and recent practice in the profession since qualifying for, or obtaining registration.
Medical Council of New Zealand	**DOCUMENT TYPE: Policy • TITLE: Policy on doctors returning to medical practice in New Zealand after an absence of 3 or more years • DATE: December 2012** **(a) General Guidelines/Requirements Prior to Changing Scope or Re-entry** **Re-entry:** • If working in clinical practice, the doctor must submit a detailed induction plan including time to be spent as an observer (up to one week,). • Council staff will formulate conditions, specific to the doctor's practice intentions (with respect to supervision, place of practice/employment, and role of physician) **(b) Definition of Scope of Practice** • Defined areas of medicine and specialties i.e., the professional service a doctor is permitted to perform. • For example, surgery, general practice, or psychiatry. • Scope of practice includes the conditions/restrictions doctors may have on their licenses (as determined by a registration process, if the doctor's physical or mental health needs monitoring, or a doctor's competence or conduct.) **(c) Definition of Re-entry/Absence from Practice** • Absence of three years or more

recent graduates applying for provisional registration to undertake an accredited intern position.

Description of Significant Change in Scope of Practice

Scope of practice is defined in the *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy.

The policy states that scope of practice is influenced by factors, including:

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

The policy states that 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 above. Physicians may have questions about whether a change in scope of practice would warrant reporting to the College (i.e. is significant) or whether the change would simply be considered an evolution of practice.

A change in scope of practice has been considered "significant" in the following circumstances:

i. A physician completely changes his or her type of practice (e.g. a surgeon wants to practise in family medicine); or
ii. A physician is adding something to his or her practice that
    a) he or she has not done before, and
    b) 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
iii. A physician is changing the focus of his or her practice to an area in which he or she has not been active for at least two years; or
iv. A physician wishes to practise in a place where the healthcare system is significantly different from where they had been practising previously (e.g. an urban setting versus a rural setting).

[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.

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 fertility medicine;
- A physician who practises chronic pain management but who wishes to practise interventional pain management;
- A psychiatrist who wishes to practise sleep medicine;
- A neurosurgeon who wishes to practise palliative care;
- An orthopedic surgeon who wishes to practise family medicine;
- An emergency medicine physician who wishes to practise sports medicine.

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 of practice. An **evolution of 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 of 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 his or her general area of training, decides to narrow the focus of his or her practice to women's health issues or, an emergency medicine physician who is incorporating bedside ultrasound into his or her practice.

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 416-967-2600 ext. 221 or by email at inquiries@cpso.on.ca.

Process for Changing Scope of Practice and/or Re-Entering Practice

The changing scope of practice[1] 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

As part of the first stage in the changing scope of practice and/or re-entering practice process physicians are required to submit an application.[2] The College will review the application and consider whether the physician requires supervision and/or training. Decisions regarding training and/or supervision will be informed by the physician's specific situation, including prior experience, any training the physician has undertaken, the continuing professional development the physician has engaged in, the risk of harm to patients, the length of time the physician has been away from practice[3], and the degree to which the discipline has advanced during the physician's absence[4].

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. As part of the application process 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, he or she must provide the College with evidence of the training.

If the College determines that the physician requires training, he or she will be required to undergo supervision and then a final assessment after the training has been completed.

[1] This process only applies to changes in scope that are significant.
[2] 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.
[3] This would apply in the re-entry or combined re-entry and change of scope cases.
[4] This would apply in the re-entry or combined re-entry and change of scope cases.

Physicians who do not require training will proceed directly to supervision and then a final assessment.

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 required to undertake. More information about the frameworks that have been developed can be accessed here.[5]

Supervision

During this stage of the process a physician must find one or more physicians who will act as his or her 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.

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 that the physician wishes to practise in. During high level supervision the Clinical Supervisor is the Most Responsible Physician (MRP) for all patients.

[5] 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, physicians who intend to change their scope of practice to include caesarean section for non-obstetricians.

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.

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 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

The physician undergoing the changing scope of practice and/or re-entering practice process must pay for the costs related to training, supervision, and the final assessment.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: **Corporate Report and Dashboard – 2017 Q2**

DATE: **Sep 2017**

For Information

ISSUE:

The College's work is guided by its Strategic Plan which was approved by Council in September 2014. The Strategic Framework is attached for reference at Appendix A. The Strategic Plan charts the course to our vision: Quality Professionals - Healthy System - Public Trust.

College activities are focused on this framework targeted toward 4 high level priorities:

1. Registration
2. Physician Competence
3. Investigations, Discipline and Monitoring, and
4. Operations.

The CPSO is nearing the end of its current strategic plan, which extends until 2018. 2017 and 2018 will represent interim reporting years as the organization transitions to new leadership and begins preparations for a new strategic plan.

For 2017, a Corporate Plan has been developed to guide the College's strategic and operational activities. Progress towards the goals set out in both the Strategic and Corporate Plans is reflected in the attached Corporate Report and Dashboard for Q2, attached at Appendix B.

DECISION FOR COUNCIL: For information only

Contact: Rocco Gerace
Maureen Boon, ext 276

Date: August 18, 2017

Appendices:
A: Strategic Framework
B: Corporate Report and Dashboard – Q2

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

VISION

QUALITY PROFESSIONALS, HEALTHY SYSTEM, PUBLIC TRUST

PRIORITIES

- REGISTRATION
- PHYSICIAN COMPETENCE
- INVESTIGATIONS, DISCIPLINE & MONITORING
- OPERATIONS

STRATEGIC INITIATIVES

- QUALITY MANAGEMENT PARTNERSHIP
- EDUCATION
- TRANSPARENCY
- INFORMATION MANAGEMENT

PRINCIPLES

- INTEGRITY
- ACCOUNTABILITY
- LEADERSHIP
- COLLABORATION

Corporate Report – 2017 – Q2

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

Regulatory Initiatives	Objective(s)	Status
Facilities/Premises	Improved facilities oversight	Community Health Facilities legislation in development.
Investigations/Hearings/Monitoring	Process improvements Monitoring of Goudge recommendations & SATF response	Process improvements underway Protecting Patients Act (Bill 87) implementation underway
Registration	Modernization of registration regulation, including integration of pathways	This work is on hold due to competing priorities.
Assessments	Every doctor assessed every 10 years (EDEX) Peer assessment redesign implementation	Initial assessments underway in some scopes for peer assessment redesign implementation. Linked to physician factors work.
RHPA Review	To work with government to achieve best possible legislation relating to sexual abuse, transparency and committee structure	Protecting Patients Act (Bill 87) passed May 30, 2017. Implementation underway for sections currently in force. Regulations in development.

Risk Initiatives	Objective(s)	Status
Infection Control	Ensure risk level monitoring and processes in place to manage/minimize risk	Processes in place
Opioids	Improved ability to identify and respond to unsafe opioid prescribing Improved opioid prescribing	Investigations ongoing Opioids strategy framework approved by Council in May 2017 – implementation ongoing
Physician Factors	Understand the demographic, practice & environmental physician factors to inform effective programs and enhance quality practice	Pathways evaluation outcomes to come to Council in December.
Regulatory Modernization (Governance)	Provide regulatory expertise to government to shape regulatory structure in 2017 and beyond.	Public member president issue to be considered at September Council Collaboration with AGRE on governance issues

Dashboard – 2017 – Q2

Strategic Priority	Objective	Measure/Target	Q1	Q2	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks			Credentials Applications 3,077 of 3,078 applications is 99% Registration Committee Applications 490 of 518 applications is 95%
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year			Assessments completed as of June 30, 2017 – 1,101 assessments representing 42% of target. One Assessment Coordinator FTE position was reduced by .5 to create support for Peer Redesign initiative resulting in 125 fewer assessments. We will increase our efforts to meet our annual target.
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology			Data not yet available Initial reports will be provided to physicians later in 2017
	Increase input in policy	130 responses/policy			One policy consultation (preliminary) was held since May Council: Confidentiality of Personal Health Information. 120 responses were received.

Strategic Priority	Objective	Measure/Target	Q1	Q2	Comments
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years			80% of either current (have been reviewed in the last 5 years) or under review.[2] This result will change/be difficult to maintain as some policy reviews have been deferred to support other pressing College priorities and issues.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.			January 1st – June 30th, 2017: 90% of high risk investigations were completed in an average of 166 days, (39 investigations involving 22 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year			January 1 – June 30, 2017: 90% of hearings (25) began on average, 386.1 days (12.7 months) from the NOH date
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>			January 1 – June 30, 2017: 90% of uncontested decisions (15) were released, 38.3 days (1.3 months) from the last hearing date
		<u>6 months for contested (C)</u>			January 1 – June 30, 2017: 90% of contested decisions (13) were released , 136.7 days (4.5 months) from the last hearing date

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

Strategic Priority	Objective	Measure/Target	Q1	Q2	Comments
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)			A&C 16,647 of 20,265 = 82% live answer PPAS 15,879 of 17,800 = 89% live answer Combined 32,526 of 38,065 = 86% live answer
	Improve service level targets	10% call abandonment			&C 1,016 calls abandoned = 5% PPAS 1,400 calls abandoned = 8% Combined 2,416 calls abandoned =6%
	Media coverage	80-100% positive or neutral			The media continued to show great interest in the College in the 2nd Quarter with 335 stories analyzed. The tone of the news coverage was good overall, as follows: 19% positive (65 stories); 61% neutral (204 stories); and 20% negative (66 stories). We just met our dashboard target of having no less than 80% either positive or neutral in tone.

LEGEND

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
Optimize Registration	Reduce processing time for Registration Applications	Time from application received by College to (a) first application contact for non-registration committee cases; (b) first applicant contact for registration committee cases	90% of applications meet processing time of (a) 3 weeks (b) 4 weeks	= > 90%	70-89%	<70%
Assure and Enhance Physician Competence	Every physician assessed every 10 years	# of physician assessments in College programs	2600 assessments/year	Tracking to >= 2600	Tracking to 2300-2599	Tracking to <2300
	Quality Management Program – implementation	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology	80% of physicians receiving reports	80%+ receiving reports	50-79%	<50%
	Increase participation in development of policy	Average # of responses/policy	130 responses/policy	>130 responses	100-129 responses	<100 responses
	Existing policies are current & relevant	Policies reviewed and updated regularly	80% of policies reviewed within 5 years	80%+ reviewed within 5 years	60-79%	<60%
Optimize Investigations, Discipline and Monitoring Processes	Reduce time for completion of high risk investigations	# days to complete investigation	90% of High Risk investigations completed in ***243 days or less*.**	90% High Risk investigations done in <=***243 days*.**	90% High Risk investigations done in ***244-256 days***.	90% High Risk investigations done in ***257 days+***.
	Schedule discipline hearings more quickly	Time from referral (notice of hearing) to hearing date	Hearings begin within 1 year	90% began within 365 days (1 yr)	90% began w/i 366-457 days (12-15 mos)	90% began more than 457 days (15 mos)
	Reduce discipline decision release times	Time from hearing date to decision release date	Uncontested (UC): 2 months Contested (C): 6 months	90% released <= 2 mos (UC) <= 6 mos (C)	90% released 2-4 mos (UC) 6-8 mos (C)	90% released > 4 mos (UC) > 6 mos (C)
Operational Excellence	Improve service level targets	Live answer for PPAS and A&C	85% live answer	85% or greater	75-85%	Less than 75%
	Improve service level targets	Call abandonment rate	10% call abandonment	10% or less	11-15%	Greater than 15%
	Media coverage	Positive or neutral media coverage	80% positive/neutral media coverage	80-100%	60-80%	<60%

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Sept/2017

TOPIC: New Member Orientation

FOR DECISION

ISSUE:

- Council is being asked to approve that new applicants as a condition of being granted their first certificate of practice in Ontario be required to engage in education related to professionalism and self-regulation including; issues on boundary violations and sexual abuse prevention.

BACKGROUND:

- As part of an update on the Sexual Abuse Initiative Education plan, Council was presented at its meeting in December 2015, with an option to explore the feasibility of mandating education on preventing sexual abuse, or any other topic, for the CPSO membership or a targeted subgroup. This briefing note describes a proposal based on recommendations at that meeting. Subsequently, in March 2017, SMT approved a recommendation to scope out a potential new credentialing requirement for applicants:
    - *An orientation/education activity that will focus on ensuring applicants understand the laws, regulations and policies that govern professional regulation of physicians, and could include information about important and emerging content areas such as maintaining appropriate boundaries, the CPD regulatory requirement, medical record keeping, safe opioid prescribing etc.*

CURRENT STATUS:

- This work originally started as part of the Sexual Abuse Review Education Working Group[1] but due to an expansion of the topics to be covered, the work is now being completed by a working group that is part of the Education Strategic Initiative.
- The working group has conducted a review of similar requirements by other Canadian regulators.
- Content development, including learning objectives, is now underway and the delivery of this initiative would be through an online facilitated learning environment within the CPSO Secure Member Portal.
- The new member orientation proposal approach has been presented to, and supported by, both the Registration and Education Committees.

---

[1] The orientation requirement will include consideration of important CPSO policies such as *Maintaining Appropriate Boundaries to Prevent Sexual Abuse*; however its scope is broader than preventing sexual abuse.

CONSIDERATIONS:

EXTERNAL CONSIDERATIONS

- An external review *(Appendix A)* was performed to examine practices of other Canadian health regulators. This generally showed the following:
    - Many other Canadian regulators, including at least three medical regulatory authorities (Quebec, Alberta and Saskatchewan), have educational requirements for new applicants and/or current members related to the laws, regulations and policies that govern a regulated health profession.
    - 16 of 18 regulators reviewed require it for all new applicants as part of credentialing; two for new members (e.g., to be completed within five years of entering the profession).
    - No regulators reviewed have been legislatively challenged on making education a requirement.
    - Most regulators reviewed offer this education to members free of charge, but the College of Registered Psychotherapists of Ontario (CRPO) charges a fee of $60+HST to applicants; and the Royal College of Dental Surgeons of Ontario (RCDSO) charges $250 to members who want to complete their online program as part of a CPD opportunity.
    - Of the 18 regulators reviewed, eight have online educational modules, nine have high-stakes written tests or examinations and one (Quebec medical regulator, CMQ) has a face-to-face offering.

INTERNAL CONSIDERATIONS

- In 2016 there were 2093 first time applicants for registration. Currently, there is no system in place to ensure that new applicants are familiar with the regulatory landscape in Ontario. (While graduates of Ontario medical schools and/or residents who undertake training in Ontario may have had some exposure to these principles, it is not taught consistently or comprehensively across Ontario medical schools).
- The orientation credentialing requirement would ensure that all CPSO applicants are introduced to important content areas such as legal and ethical expectations of the profession and College processes and policies.
- An orientation requirement could also enable the CPSO to highlight other issues, for example medical assistance in dying, infection control and safe opioid prescribing, for new and potentially current CPSO members.
- An orientation requirement at registration would support the CPSO in meeting a requirement for member education on preventing sexual abuse laid out in the Section 84 of the Health Professions Procedural Code, i.e., by paying particular attention to the Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy.
- While the educational material would be mandatory for new applicants, the educational content used in the registration credentialing requirement could also be re-purposed for other uses, for example:
    - A CPD opportunity for current members.
    - Member committee training.

- While a cost recovery approach like other MRA's was considered it was recommended by the Education Committee and supported by the Executive Committee that given the broad applicability of this content to the whole profession that this should be offered free of charge.

PROPOSED EDUCATIONAL CONTENT AND FORMAT

- The Working Group considered the pros and cons of online education versus large group face-to-face as a format.
- There is recognized added benefit to the face-to-face meetings in that potential registrants are presented with a "human face" to the College from an early stage. Given that the half the applicant population is internet savvy and that the IMG population communicates currently with College from Overseas the online delivery seemed most accessible.
- Based on the review of other regulators with jurisprudence requirements, the large number of applicants the CPSO registers each year and early budget estimates, the Working Group decided on an online format.
- An external consultant was hired to scope out potential educational content using a combination of literature review, focus groups and key stakeholder interviews.
- A comprehensive high level curricular map was developed *(Appendix B)*.
- The content as a result of this map would need to be pared down to ensure the time required to complete this online learning is reasonable.
- A mock storyboard has been developed *(Appendix C)*. The storyboard describes the format of the online learning which would take an applicant through the journey of their career highlighting potential touch-points and interactions with the College. The intention is to introduce concepts and policies as the applicant progresses through the modules.
- It is envisioned that the experience would be 5-6 modules that might take the applicant 60-90 minutes to complete in total.

COST AND RESOURCE CONSIDERATIONS

- This project is expected to be developed (including content and technical development) to the point of piloting within 6-7 months.
- The costs associated with this work are estimated at approximately $60,000.00.

NEXT STEPS:

- Once approved, work will continue in 2017 on revising and finalizing content and planning for implementation.
- An internal cross College working group has been created. These members will work together to map the material in more detail prior to working with an IT specialist whose expertise is in curriculum design.
- The piloting and implementation date will be determined based upon other organizational project priorities and activities.
- Should we say they will get to see a demonstration of this before it goes live?

DECISION FOR COUNCIL:

1. Does Council support the creation of a mandatory new member orientation credentialing requirement?

Contact: Nathalie Novak, Ext: 432
Wade Hillier, Ext: 636
Bill McCauley, Ext: 434

Date: August 16, 2017

Attachments:

Appendix A: Jurisprudence Environmental Scan
Appendix B: Curriculum Map
Appendix C: Draft Storyboard

Appendix A - Review of Jurisprudence Education by Regulatory Bodies in Canada

I. Introduction

In follow-up to the recommendation that the CPSO consider developing education for new registrants around CPSO members' roles and responsibilities as self-regulated professionals, a more in-depth environmental scan was undertaken of 18 national health regulators and medical regulatory authorities (MRAs) that have jurisprudence educational requirements. The following builds on work conducted by the Centre for Effective Practice (CEP) in June 2016[1], and provides an in-depth summary of ten of programs reviewed:

1. Quebec, College of Physicians and Surgeons (CMQ) - Legal, Ethical and Organizational Aspects of Medical Practice in Québec
2. College of Physicians & Surgeons of Alberta (CPSA) - eAppointment
3. College of Physicians and Surgeons of Saskatchewan (CPSS) - eAppointment
4. College of Dental Hygienists of Ontario (CDHO) - Jurisprudence Education Module
5. College of Physiotherapists of Ontario (CPO) - Jurisprudence Education Program
6. College of Registered Psychotherapists of Ontario (CRPO) - Professional Practice and Jurisprudence (JRP) e-Learning Module*
7. College of Dietitians of Ontario (CDO) - Jurisprudence Knowledge and Assessment Tool (JKAT)
8. Royal College of Dental Surgeons of Ontario (RCDSO) - Jurisprudence and Ethics
9. College of Medical Radiation Technologist of Ontario (CMRTO) - Jurisprudence Course
10. College and Association of Registered Nurses of Alberta (CARNA)*

Information was collected through an in-depth review of college websites, and interviews with college personnel. Information on programs of other regulatory colleges in Ontario was collected as part of an initial, broader scan, but was not included in this more in-depth summary because of the high-stakes nature of these programs. For example, regulators that run a written, invigilated examination or have a program whose model is very similar to ones already reviewed were excluded. These include:

1. College of Chiropractors of Ontario - Legislation and Ethics examination

[1] In June 2016, CEP conducted three rapid reviews as part of the development of the Sexual Abuse Review – Education Plan: 1) a rapid review of mandatory education initiatives by Ontario health regulatory colleges and Canadian medical regulatory authorities; 2) a rapid literature review of eLearning and physician continuing professional development; and 3) an inventory of education resources for health care professionals pertaining to communication, boundaries, professionalism and sexual impropriety.

2. College of Veterinarians of Ontario - Jurisprudence Examination
3. College of Optometrists of Ontario - Jurisprudence
4. College of Nurses of Ontario - Jurisprudence Examination
5. Ontario College of Pharmacists - Jurisprudence Exam
6. College of Naturopaths of Ontario - Jurisprudence Examination
7. College of Psychologists of Ontario - Jurisprudence and Ethics Examination
8. College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario - Jurisprudence Course Test

II. Summary of Findings

How Do Regulators Define Jurisprudence?

- Most regulators reviewed take a similar approach to considering jurisprudence education and include the following content areas:
    - How the healthcare profession is regulated;
    - The importance and purpose of regulation; and
    - The ethical and legislative framework in which a health profession works.

- Some regulators also include explicit consideration of practice guidelines, standards, polices and important content areas for members-in-practice. For example, College of Registered Psychotherapists of Ontario (CRPO) online jurisprudence module includes content on maintaining professional boundaries, definitions and examples of sexual abuse, and mandatory reporting of sexual abuse.

- While the majority of health regulators reviewed use the term "jurisprudence", the three medical regulators included in this review do not use this term.
    - The Colleges of Physicians and Surgeons of Alberta and Saskatchewan use the term "E-appointment" to describe a mandatory credentialing activity during the registration process.
    - The Quebec, College of Physicians and Surgeons (CMQ), terms their three-hour, face-to-face session, the Legal, Ethical and Organizational Aspects of Medical Practice in Québec.

Why do Regulators Require Jurisprudence Education?

- Many regulators have required jurisprudence education to ensure members understand the registration process, the ethical and legislative framework in which the profession operates, and other College processes. Smaller health regulators include further content related to practice guidelines and standards.
    - Several regulators were motivated by content trends, specifically ethics and professionalism issues, in investigations and discipline cases.

- Most Colleges interviewed for the in-depth review also see the jurisprudence requirement as laying the foundation of a longer term relationship between member and regulator. The CMQ perhaps best embodies this as they are the only regulator with an in-person, face-to-face session; they estimate that since the inception of this delivery mode in 2007, staff at CMQ have met one quarter of its members.

Who Completes Jurisprudence Education?

- 8 of 10 Colleges reviewed require applicants to complete a jurisprudence activity *prior* to being granted a certificate[2].
    - In comparison, the College of Physiotherapists of Ontario (CPO) and the College of Dieticians of Ontario (CDO) require completion of a jurisprudence module *after* the certificate has been granted.
        - Both require members to complete this education every 5 years.
        - However, based on complaints trends, the CPO is currently exploring re-framing it as a credentialing requirement.
- The College of Dental Hygienists of Ontario (CDHO) sometimes uses their *Jurisprudence Education Module* as a remedial resource for members referred to Registration Committee.

[2] The eight additional regulators not considered in the in-depth review also require jurisprudence education prior to issuing a certificate of practice.

- The Royal College of Dental Surgeons of Ontario (RCDSO) offers their *Jurisprudence and Ethics* education to members as a continuing professional development (CPD) option; and the Quebec College of Physicians and Surgeons (CMQ) has received feedback that physicians are using the content of their open website on the *Legal, Ethical and Organizational Aspects of Medical Practice in Québec* to apply for CPD credit.

- Most jurisprudence education is offered to member free of charge, but the College of Registered Psychotherapists of Ontario (CRPO) charges a fee of $60+HST to applicants; and the RCDSO charges $250 to members who want to complete their extensive online program as a CPD requirement.

Program Design/Delivery

Regulators have taken different approaches to the development of their programs. Of interest:

- Some colleges determine and develop their own content without external engagement of members (e.g., CPSA, CPSS, RCDSO).

- Other regulators engage membership in content development in a variety of ways.

    - For example, when initially developing their jurisprudence education, CPO and CDO engaged members from different areas of practice to develop a blueprint, write items and pilot test their tools. Both also hired internal psychometricians to assist with validation and standard setting of the assessment components of their resources.

- All Colleges surveyed who have an online program have engaged the expertise of consultants to develop and deliver eModules; none surveyed host or manage their own platform.

    - Vendors most commonly used by these colleges are Yardstick and Skilsure.

- Development time varied depending on content availability, resources available and mode of delivery.

    - CDO, for example, took 3 years from project initiation to launch.

    - CDHO, who had content already identified and purchased assessment component questions from CPO, moved everything to an electronic system in three months.

- Costs varied depending on the services rendered. The most significant developmental costs were for interactive online modules that cost between $70,000 (RCDSO) and $120,000 (CPSA) to develop. This did not include ongoing maintenance costs that range from $2,000 - $6,000 annually.

Evaluation

- None of the regulators reviewed have done a formal evaluation of their programs, but some ask participants to complete a survey upon completion.
    - CDO, for example, asks participants to complete a survey that includes a question about whether their knowledge about the laws that affect their practice has improved as a result of completing the *Jurisprudence Knowledge and Assessment Tool (JKAT)*.
    - CPO had initially hoped to correlate introduction of their program with a decrease in complaints, but did not pursue this line of inquiry.

III. Details of Each Jurisprudence Program Surveyed

1.Regulatory Body	Quebec, College of Physicians and Surgeons, Legal, Ethical and Organizational Aspects of Medical Practice in Québec
Delivery Mode	Since 2007, an open website and three hour attendance at face-to-face session Pre-2007, mandatory examination
Year Implemented	1988 – 2007 examination for residents in family medicine 1996 to 2007 examination for residents in a specialty 2007 – present: mandatory training session for all applicants
Program Overview & Description	To provide members with a quick grasp of the essentials in the organization of the health care system and the legal and ethical framework of medical practice in Québec. These will also serve as guideposts enabling physicians to better situate themselves and better bear the moral burden of decisions they must make in the interests of their patients. The program addresses aspects of medical practice specific to Québec.
Target Audience	All physician applicants are required to attend the Legal, Organizational and Ethical Aspects of Medical Practice in Quebec (ALDO Quebec) to be eligible for a permit to practice. Physicians in practice are not required to participate in the program, but have access to the content online.

1.Regulatory Body	Quebec, College of Physicians and Surgeons, Legal, Ethical and Organizational Aspects of Medical Practice in Québec
	CMQ has also received feedback that physicians are using the content for CPD credit
Topics	**Organizational Aspects** • Introduction • The Health and Social Services System • The Professional Practice of Physicians • A Social Achievement Worth Preserving **Ethical Aspects** • Introduction • Historical and Legal Context in Québec • Duties and Obligations of Physicians • The Collège des médecins du Québec and other Associations of Physicians • Obligations of Physicians: Guideposts **Legal Aspects** • Introduction • The Law and Medical Practice in Québec • Medical Civil Liability • The Physician's Obligations under Certain Laws **Thematic Content** • Introduction • Consent • Professional Secrecy • End-of-Life Issues • Personal convictions
Design/Delivery	• 3-hr, face-to-face (in-person) group activity that covers the legal, ethical and organizational aspects of medical practice in Quebec • Attendees prepare by accessing the aldo.cmq.org website • Evaluation is based on attendance.

1.Regulatory Body	Quebec, College of Physicians and Surgeons, Legal, Ethical and Organizational Aspects of Medical Practice in Québec

	Delivery Evolved over Time:
	• In 1990s: initially a written published document limited to the laws of concern for the medical profession, on which a formal normative examination was made mandatory.
	  ○ Physicians had to reach a 60% success threshold to have access to their permit
	  ○ Some physicians had to repeat the exam a few times to reach the 60% threshold, consequently withholding the delivery of permits in some situations.
	  ○ No training sessions were offered at that time, and the validity of the exam was often challenged.
	  ○ Physicians indicated that it was a negative experience and a poor view of their College.
	• In 2007, based on feedback over time, changed from a normative exam into a formative 3-hour mandatory training session.
	• Sessions are an opportunity to put a human face on the College. Estimate they have met 1/4th of membership through this requirement.
	• Have plans to put into a video clip format for the public and the whole profession over the next years.

Successful completion – how defined and what happens if do not successfully complete	Not applicable
Appeal Process	Information not available
Legislative Challenges/ Stakeholder resistance	Information not available
Development process (including in-house, consultant etc) for initial and ongoing	Information not available
Length of time to develop	Information not available
Costs – development and ongoing	Information not available
Staffing/human resources – development and ongoing	Information not available
Evaluation results	Information not available
Notes	Site created in collaboration with Quebec's faculties of medicine.

2. Regulatory Body	College of Physicians & Surgeons of Alberta, eAppointment
Delivery Mode	Pre 2012, Face to face session Went online approx. 4 years ago
Year Implemented	Exact year unknown
Program Overview & Description	• This eAppointment is the final stage in application/registration process. • Applicants used to come in for an interview with the Registrar, evolved into info sessions with staff but scheduling became a challenge.
Target Audience	Applicants (~1200 year)
Topics	1. College overview 2. Accreditation Programs and Specific Approvals 3. Physician Prescribing Practices 4. Physician Achievement Review (PAR) Program 5. Complaints Investigation and Resolution 6. Physician Registration and Practice Permits 7. Annual Practice Permit Renewal 8. Practice Readiness Assessments 9. Ethics in Medical Practice 10. Physician Wellness 11. Communications 12. Communication Tools 13. College Finance and Operations 14. Resources 15. Keeping the College Informed 16. Continuous Professional Development 17. Professional Expectations 18. Practice Permits 19. Standards of Practice 20. Contacting the College
Design/Delivery	• eLearning module with video and resources. • Applicants have to confirm a declaration in the online tool that they have reviewed eAppointment in its entirety

2. Regulatory Body	College of Physicians & Surgeons of Alberta, eAppointment
	and that providing false or deceptive information may be unprofessional misconduct that could lead to discipline.
Successful completion – how defined and what happens if do not successfully complete	Not applicable
Appeal Process	Not applicable
Legislative Challenges/ Stakeholder resistance	None – physicians have indicated they are happy with the online tool
Development process (including in-house, consultant etc) for initial and ongoing	Based content on face-to-face sessions Each department does script – each dept decides what they think is important for the applicant to know Engaged Yardstick for eLearning module, video etc
Length of time to develop	~ 1 year – delays occurred on their part
Costs – development and ongoing	~100-120k no annual fee ~25k to update
Staffing/human resources – development and ongoing	Information not available
Evaluation results	Informal – very positive feedback
Notes	**Tool is available to CPSO to review**

3. Regulatory Body	College of Physicians and Surgeons of Saskatchewan, eAppointment
Delivery Mode	Pre 2015, Face to face session Went online in November 2015
Year Implemented	Unsure when program first implemented
Program Overview & Description	eLearning activity with tests built into modules and CPD credit
Target Audience	Applicants
Topics	SECTION A – INTRODUCTION TO THE COLLEGE A1: The College of Physicians and Surgeons of Saskatchewan SECTION B – LICENSURE INFORMATION B1-Licensure SECTION C – PRACTICE INFORMATION C1 - Communication C2 - Complaints and Discipline Process C3-Continuing Professional Development C4- Prescribing C5 – Privacy and Mandatory Reporting C6- Professionalism C7 - Professional Medical Corporations C8 - Record Keeping C9 - Scope of Practice SECTION D – OTHER RESOURCES D1 - Health Coverage in Saskatchewan D2 - The Rx Files D3 - The Saskatchewan Medical Association
Design/Delivery	• elearning module with 2 T/F questions at the end of each chapter (randomly selected questions by CPD office) ○ ~2 hrs in total to complete ○ Voice-over + ebook that they can use

3. Regulatory Body	College of Physicians and Surgeons of Saskatchewan, eAppointment
	○ Learners get feedback right away on correct answer • In some cases, will require applicant to come into the College (e.g., trouble with another jurisdiction, want to make sure u/stand expectations).
Successful completion – how defined and what happens if do not successfully complete	Applicants need to complete eappointment to be granted certificate and do not need to attain a cut score. Added questions to make sure learners are engaged. Program does not track whether applicants answered Qs correctly -- get feedback right away on what correct answer is. Just track completion.
Legislative Challenges/ Stakeholder resistance	None at all
Development process (including in-house, consultant etc) for initial and ongoing	• Work closely with CPD office at the University of Saskatchewan on delivery – CPD office hosts it • Content determined by CPSS – small college so know what's going on and what needs to be updated • Content development, beta testing etc – all done internally • Update as needed on an ongoing basis
Length of time to develop	• Wasn't sure, but transfer to electronic version happened fairly quickly (initiated process in May, had a few hiccups, live by November) • Voiceovers took less than 4 hrs
Costs – development and ongoing	Unknown.
Staffing/human resources – development and ongoing	Information not available
Evaluation results	Have not done
Notes	Also do an IMG orientation – condition of licence – IMGs do both orientation and eAppointment

4. **Regulatory Body**	College of Dental Hygienists of Ontario
Delivery Mode	Pre 2010, a half-day session (didactic lectures) eLearning module Jurisprudence Education Module (see also http://www.cdho.org/Jurisprudence_en.asp) Jurisprudence Education Module – open access
Year Implemented	March 2010
Program Overview & Description	CDHO recognizes that dental hygienists in Ontario are often challenged by the diversity and number of rules and expectations that apply to the practice of dental hygiene in Ontario. The Jurisprudence Education Module has been designed to assist dental hygienists in understanding and applying these rules and expectations. Dental hygienists are not asked to memorize the information, but to have a general knowledge, know where to find relevant information when needed, and be able to apply this information to situations that arise in practice.
Target Audience	• Applicants to the College (~1000 new registrants/yr) • In rare cases, a registered member (i.e. not a new registrant) who has been referred to the Registration Committee (where there is a clear need for jurisprudence brush up) will be asked to complete the Jurisprudence Education Module again.
Topics	The module is based on ten content domains: 1. Introduction to the Jurisprudence Module 2. Dental Hygienists as Regulated Health Professionals 3. Confidentiality and Privacy 4. Consent to Treatment 5. Record keeping 6. Conflict of Interest 7. Professional Boundaries 8. Mandatory Reports 9. Working for Yourself and Others 10. Responsibilities of the Council
Design/Delivery	• Online module divided into two parts: course and a final quiz ○ Course: realistic scenarios that dental hygienists could encounter in practice ○ Final test: 54 multiple choice questions

4. **Regulatory Body**	College of Dental Hygienists of Ontario
	• Given 90 minutes to complete the test. • Open book (participants are encouraged to review the CDHO website, particularly the section relating to Practice Guidelines and Resources and to have the CDHO Registrants' Handbook available for easy reference during the module) • No limits to the number of attempts participants take to successfully complete the final quiz. • Participants submit their responses once they have completed all questions and reviewed their answers. ○ Immediate feedback is provided upon submission. A list of all content domains will appear and indicate results in each domain. This information can be used to guide further self-study activities. • Once successfully completed final test, participants are to save and print a copy of the certificate of completion. A copy of the certificate must be submitted to the CDHO with application form. • Administered by a third party (Skillshore) which hosts and downloads the results. • No fee to take the quiz, but the non-refundable $75 initial certificate of application fee is required to be paid at the time of registering for the final quiz.
Compliance – process and consequences	• Not an issue as this is the first step in the registration/application process - if not complete, applicants cannot submit their application to register with CDHO. • Third party vendor: Skilsure provides CDHO with daily reports of applicants who have completed the module.
Successful completion – how defined and what happens if do not successfully complete	• Must correctly answer all questions (100%) to successfully complete • Successful completion must occur within the 12-month period immediately preceding the submission of the individual's application for registration
Legislative Challenges/ Stakeholder resistance	• Interviewee wasn't aware of any legislative challenges.
Development process (including in-house, consultant etc) for initial and ongoing	• Consulted with legal advisors – based on registration handbook Richard Steinecke helped develop. • Final examination is based upon materials developed by and with the permission of the College of Physiotherapists of Ontario • CPO followed a test development process to produce the final quiz, including a blueprinting phase, item writing, piloting and a validation phase (psychometrician went through questions). ○ CDHO obtained the right to adapt the CPO quiz to meet the needs of the CDHO. • Extensive communication with membership prior to roll out of new jurisprudence initiative (e.g. website, events, newsletters). • Content covered in the Jurisprudence Education Module is reviewed every two years

4. **Regulatory Body**	College of Dental Hygienists of Ontario
Length of time to develop	• ~ 3 months (note that had core content and questions already)
Costs – development and ongoing	• 20k – to purchase exam questions from CPO • 30k - costs to develop modules • ~3k/yr to maintain exam • ~20k currently updating content (Skilsure updates to slides and voiceovers)
Staffing/human resources – development and ongoing	• Dental hygienists on staff do this (Registrar, Deputy Registrar, 2 Practice Advisors)
Evaluation results	• No formal feedback or evaluation • However, CDHO moved to online delivery format to ensure completion by applicants.
Notes	• Completion of the Jurisprudence Module must be successful and occur within the 12-month period immediately preceding the submission of application, as per section 29. (4) 2. of Part VII - Registration of the Ontario Dental Hygiene Act, 1991 (Ontario Regulation 218/94) **Tool is available online – CPSO can review**

5. **Regulatory Body**	College of Physiotherapists of Ontario, Jurisprudence Education Program
Delivery Mode	Online module/learning tool realistic scenarios that physiotherapists/physical therapists could encounter in practice.
Year Implemented	Launched January 1, 2006; and became mandatory for all members April 1, 2006. Currently exploring some changes (see details below)
Program Overview & Description	• The program is a review of the laws, regulations and standards that govern the practice of physiotherapy in Ontario, and is designed to ensure that physiotherapists understand their legal responsibilities and how those responsibilities affect day-to-day practice. • In response to an increasing number of complaint investigations by the College where the member under investigation stated that they did not know that their actions violated a law or practice regulation – therefore a mechanism to ensure that all members are aware of the practice standards/regulations and ultimately improve patient outcomes.
Target Audience	• All physiotherapists holding Independent Practice or Academic Practice certificates are required to complete every 5 years (i.e. the College administers the module/exam to its general population on a 5 year cycle – next administration 2016). (~8k members) • New members (600-800) are required to complete the program at the next available opportunity after registration with the College. ○ Currently, thinking about making it a credentialing requirement because finding that more issues once in practice that could be prevented before become members (see Topics on planned changes to content)
Topics	The module is based on eleven content domains: 1. Confidentiality/privacy 2. Conflict of interest 3. Consent 4. Continuing competency 5. Practice management 6. Professional boundaries 7. Patient records 8. Registrants' obligations

5. **Regulatory Body**	College of Physiotherapists of Ontario, Jurisprudence Education Program
	9. Scope of practice 10. Use of title 11. Use of support personnel Currently, looking at including more ethics-related content as PT population has changed. More IMGs (provisional category used to be 0, then ~25% of the population, now ~50% of the PT membership) and have different ethical framework – seeing more ethical issues come up in this category).
Design/Delivery	• Members have six months to complete the program from the time the module is launched for that cycle/year • online module/learning tool realistic scenarios that physiotherapists/physical therapists could encounter in practice • 50 multiple choice questions • Participants can complete it while referring to their resources or through discussions with their peers – but solo login and each individual must complete their own module/test • Members are asked to review the Standards of Practice and Official Documents on the College website and Jurisprudence Education Guide to help them prepare for the Jurisprudence Module • Members are given immediate scores upon completion and feedback on the areas that they need improvement on (via online module) • Members can re-take the module/test up to a maximum of 4 times within the 6 month period during which it is open to obtain the pass score • Administered by an external third party vendor: Yardstick , who are responsible for developing the module and online hosting – but content selection overseen by the College • Currently looking to be charged a flat fee (trying to negotiate $20k) – charging fee per person • Used to be with Skilsure – wasn't happy with product and got sense they were having financial difficulty.
Compliance – process and consequences	• If they have completed it but not successful (i.e. in the 4 allotted attempt), referred to the Quality Management Committee for an onsite assessment • For non-compliance, referred to the Inquiries, Complaints, and Referrals Committee (ICRC). ○ If still not compliant, then referred to the Registrar for refusal to participate in program. • Most outstanding complete during time to referral – a few have received written cautions – one member was suspended indefinitely until module completed • Committee decides on a case by case what action to take with respect to non-compliance.
Successful completion – how defined	• Current pass rate for successful completion is a score of 75% (correct answers)

5. **Regulatory Body**	College of Physiotherapists of Ontario, Jurisprudence Education Program
and what happens if do not successfully complete	• If after the six-month period a physiotherapist/physical therapist has not yet completed the module successfully, he or she will be required to complete a Jurisprudence workshop (50-min webinar highlighting key concepts – walk the PT through what they want them to know). ○ After completion of the workshop, the physiotherapist/physical therapist must attempt the same module again. • Physiotherapists/physical therapists who are not able to successfully complete the module after this attempt will be referred to the Quality Management Committee to undergo the College's Quality Management process. • Currently, the College is planning to do away with the workshop – feel they have enough time.
Legislative Challenges/ Stakeholder resistance	• No legislative challenges; there was some initial resistance from a few members at implementation, however once people first undertook the module and completed it they reported finding value in it and appreciated the opportunity to discuss scenarios with their peers, etc.
Development process (including in-house, consultant etc) for initial and ongoing	• Began communicating 18 months beforehand to members that mandatory Jurisprudence was going to be implemented -- through newsletters, road shows, events, conferences, website, etc. – promoting awareness that it was coming – framed rationale for implementation as an opportunity to help improve practice and knowledge – consulted with legal team and government prior to implementation. • In developing the Jurisprudence Education Program content, the College reviews all College documents and other legislation relevant to the practice of physiotherapy/physical therapy in Ontario and identifies high priority areas. • Engage psychometrician when item writing and validating • Engage SMEs – 1-2 staff + physiotherapists + council/committee members and assessors • Engage PTs from across province and areas of practice. • Piloted first time, but not since and just remove poor performing questions.
Length of time to develop	~18 months, but they suggest they probably didn't need to take so long.
Costs – development and ongoing	Couldn't remember all of the costs associated with development Psychometrician (item writing and standard setting): ~25k Yardstick: fee per person, but trying to go for flat fee of 20k
Staffing/human resources – development and ongoing	Not a significant burden on staff at this point – more maintenance now.

5. **Regulatory Body**	College of Physiotherapists of Ontario, Jurisprudence Education Program
Evaluation results	• Feedback from informal member surveys and evaluation survey at the end of the Jurisprudence module has been positive, as has been general word of mouth feedback • No formal metrics e.g. reduction of complaints – originally hoping to correlate, but did not
Notes	• Jurisprudence Education Program Module 1: Companion Document • Evaluation report from the first cycle of the Jurisprudence Education Program is included below.

6. **Regulatory Body**	College of Registered Psychotherapists of Ontario, Professional Practice and Jurisprudence (JRP) e-Learning Module
Delivery Mode	eLearning Module
Year Implemented	Information not available
Program Overview & Description	It presents information about Ontario law that regulated health professionals need to know in order to practise safely and ethically. The module is divided into 16 'lessons' on several topics, including maintaining professional boundaries, definitions and examples of sexual abuse, and mandatory reporting of sexual abuse.
Target Audience	Applicants
Topics	16 'lessons' on several topics, including maintaining professional boundaries, definitions and examples of sexual abuse, and mandatory reporting of sexual abuse
Design/Delivery	• Online • Lessons can be completed in random order and at different times, over several days, weeks or even months • Total time to complete the program is approximately four to six hours or possibly longer • Each lesson covers a different topic, with question sets appearing at intervals throughout. Information is presented visually on screen and by voiceover (narrator). • All submitted answers will be saved in the system, and you will be able to resume work on the module at your convenience. • Failed question sets can be retried as many times as necessary to successfully complete them. • A lock-out period of one hour follows a failed question set, to allow the applicant to review relevant learning material. • Before starting the module, prospective members are advised to read the online document, Professional Practice and Jurisprudence for Registered Psychotherapists – it provides all the background information required • Participants set up their own account • $60 + HST
Successful completion – how defined and what happens if do not successfully complete	Information not available
Legislative Challenges/ Stakeholder resistance	Information not available
Development process (including in-	Information not available

6. **Regulatory Body**	College of Registered Psychotherapists of Ontario, Professional Practice and Jurisprudence (JRP) e-Learning Module
house, consultant etc) for initial and ongoing	
Length of time to develop	Information not available
Costs – development and ongoing	Information not available
Staffing/human resources – development and ongoing	Information not available
Evaluation results	Information not available
Notes	• Successful completion of the JRP e-Learning Module is required for registration with the College, and normally is completed prior to submitting an application for registration • Up to 2 years prior to application to the College (previously, an applicant could have successfully completed the Jurisprudence Learning Module three years prior to application for registration with the College. This window will be reduced to two years in the next version of the Registration Regulation. It is expected that this change will adversely affect very few, if any, applicants. It will, however, enhance the currency of the professional and legal knowledge of those seeking to become members of this College. To allow for a smooth transition from the 3-year to the 2-year window, Registration Committee will permit all applicants who successfully complete the Jurisprudence Learning Module prior to proclamation of the Psychotherapy Act, 2007 to take advantage of the original 3-year window.) • www.crpo.ca/wp-content/uploads/2015/05/CRPO-Professional-Practice-Jurisprudence-Registered-Psychotherapists.pdf

7. **Regulatory Body**	College of Dietitians of Ontario, Jurisprudence Knowledge and Assessment Tool (JKAT)
Year Implemented	2006-2008
Program Overview & Description	The JKAT is an online knowledge acquisition and assessment tool designed to improve a Registered Dietician's knowledge and application of laws, standards, guidelines and ethics relevant to the profession of dietetics in Ontario. The tool uses scenarios and multiple-choice questions to ensure that Ontario RDs can apply their jurisprudence knowledge to practical situations. References are provided online within the exam. RDs do not receive education in this area before entering practice. Wanted it to be educational and supportive, but also have a way to ensure content understood.
Target Audience	Every new member must complete the JKAT usually within the first year of Membership and every 5 years thereafter • 300 in single yr • 3k every 5 yrs
Topics	• Based on Jurisprudence handbook
Design/Delivery	• JKAT is run every year for a period of 90 days • Online web-based learning, live links to references, practical learning based on professional practice scenarios, multiple-choice questions to assess knowledge application • Three different versions based on the legislative requirements of those practice areas: direct patient care (70 Qs); private practice (70 Qs); general management (60 Qs) • Based on their area of practise, the member will complete the appropriate version of the JKAT • Within the 90 day period, members have three (3) opportunities to successfully complete the JKAT with a cut score of 90%. • Participants receive a summary of their results immediately after completion. The summary shows the correct and incorrect responses. A rationale for each incorrect response is provided in order to enhance the learning and assist on the next trial, if needed. • Used to be with Webassessor via Kryterion; moved to Skilsure b/c could edit content themselves
Compliance – process and consequences	• A member who is required to complete the JKAT and refuses to do so or does not contact the College to explain why they are unable to complete it, may be considered to have committed an act of professional misconduct and, consequently, may be referred to the Investigations, Complaints and Reports Committee (ICRC).
Successful completion – how defined	• 90%, three opportunities to complete

7. **Regulatory Body**	College of Dietitians of Ontario, Jurisprudence Knowledge and Assessment Tool (JKAT)
and what happens if do not successfully complete	• If unsuccessful after the third attempt, participant is required to submit a learning plan to improve their knowledge in jurisprudence. The plan should include some way of demonstrating that the knowledge was acquired. Very rare. Most recently, had one person – matter went to QAC, directed to reread sections that didn't do well in and take JKAT again
Legislative Challenges/ Stakeholder resistance	• no
Development process (including in-house, consultant etc) for initial and ongoing	• New bank of questions added and circulated • Item writing group since 2010 – SMEs adding new, throwing out old • Look at all questions in totality every year June: item writing Fall: pilot March: run JKAT • Don't have huge bank of questions
Length of time to develop	• New questions: 6-9 months • RFP in 2006; pilot in 2007; launch in 2008
Costs – development and ongoing	Initial costs • Psychometrician - $51k • Webmaster: $24k + 4000non-proctored exam bank – once that was used up, charged $18 per exam • Paid RDs a stipend for their work Skilsure: • 4k maintenance/yr • 20k to migrate over to Skilsure
Staffing/human resources – development and ongoing	• Most staff-intensive part of their program • Maintaining page number references in online module – decided to take out; item writing process; ensuring not getting away from the blueprint • tech issues and fact that original system didn't allow for single point of entry – new system links to CDO's system, so no need to have multiple user names and passwords
Evaluation results	• Survey every yr and comment in real time

7. **Regulatory Body**	College of Dietitians of Ontario, Jurisprudence Knowledge and Assessment Tool (JKAT)
Notes	• www.collegeofdietitians.org/Resources/Publications-CDO/Jurisprudence-Handbook-for-Dietitians-in-Ontario-(.aspx • www.collegeofdietitians.org/Resources/Quality-Assurance/Jurisprudence-Knowledge-and-Assessment-Tool-(JKAT)/JKAT-Frequently-Asked-Questions.aspx • www.collegeofdietitians.org/Resources/Policies-(1)/Quality-Assurance-Program/Quality-Assurance-Committee/QAC-JKAT.aspx **Has offered username/password for CPSO to access**

8.**Regulatory Body**	College of Medical Radiation Technologist of Ontario, Jurisprudence Course
Year Implemented	2001, preparing implementation of online tool in March 2016
Program Overview & Description	All applicants for registration with the CMRTO are required to have successfully completed a course in jurisprudence set or approved by the College. For this purpose, an applicant must complete the CMRTO Legislation Learning Package and review the appropriate statutes, regulations, policies and guidelines which relate to the practice of medical radiation technology generally and to the specialty for which the applicant is applying. Members may also use the package to maintain and improve their understanding of the legislation and legal requirements which impact upon their day-to-day practice in medical radiation technology. The College is preparing to move to an online system and will be adding questions per module
Target Audience	Applicants Members may also use; are considering making it mandatory for existing members to complete every 5 years
Topics	**Legislation Learning Package:*** • Module 1: Regulated Health Professions Act and Regulations • Module 2: Medical Radiation Technology Act and Regulations • Module 3: CMRTO Standards of Practice • Module 4: CMRTO Quality Assurance Program • Module 5: Orders Authorizing MRTs to Perform Procedures • Module 6: CMRTO Sexual Abuse Prevention Program • Module 7: Healing Arts Radiation Protection Act and Regulations (not applicable to Magnetic Resonance) • Module 8: Nuclear Safety Control Act and Regulations (not applicable to Radiography or Magnetic Resonance) • Module 9: Health Care Consent Act **Legislation, Policies, Guidelines:*** • Regulated Health Professions Act and Regulations

8.**Regulatory Body**	College of Medical Radiation Technologist of Ontario, Jurisprudence Course
	• Medical Radiation Technology Act and Regulations • Health Care Consent Act • CMRTO Sexual Abuse Prevention Program • Healing Arts Radiation Protection Act and Regulations (not applicable to Magnetic Resonance) • Nuclear Safety and Control Act and Regulations (not applicable to Radiography or Magnetic • Resonance) *Note: the College has revised these materials and will be posting new ones.
Design/Delivery	Self-study "course": Candidates review the documents and legislation in the Legislation Learning Package and other Legislation, Policies and Guidelines. Once a candidate has completed their review of the documents and legislation, they complete the Certificate of Completion, print, sign and date and submit the signed certificate with completed Application Form Will be moving to an online system that will launch in March 2016 Will include ~5-10 multiple choice questions per module Users will have as many trials as needed to reach 100% Resources to materials will be included No voice-overs or video
Successful completion – how defined and what happens if do not successfully complete	100% - have as many attempts as needed
Legislative Challenges/ Stakeholder resistance	none
Development process (including in-house, consultant etc) for initial and ongoing	Content for original package was prepared by the College of Medical Radiation Technologists of Ontario in co-operation with the Michener Institute for Applied Health Sciences When CMRTO staff updated materials and wrote questions, have engaged QAC, RC to vet Plan to have focus group of MRTs after first year of new tool to get info on questions They will track performance of questions – i.e., how many attempts it took an end-user to get the question correct – so that they can analyze performance and make decisions to remove/keep certain questions
Length of time to develop	Started reviewing content in April 2015 Bulk of work completed in October 2015

8.**Regulatory Body**	College of Medical Radiation Technologist of Ontario, Jurisprudence Course
	Going live in March 2016 Contact noted that had they had focused time to do this work, could have had it completed in 4-6 months
Costs – development and ongoing	~20k to set up Skilsure Ongoing maintenance fee is based on # of users anticipated to use
Staffing/human resources – development and ongoing	See above
Evaluation results	Will probably survey to validate tool and then at end of first year, but nothing planned as yet
Notes	**New online tool will be available to the public – we can review**

9. Regulatory Body	Royal College of Dental Surgeons of Ontario, Jurisprudence and Ethics
Delivery Mode	Online course (part of Lifelong Learning Program)
Year Implemented	• Pre 2010 was a face-to-face course delivered at College • ~2010 – converted to online course
Program Overview & Description	The College's Jurisprudence and Ethics course is the first LifeLong Learning program to go online. The course is meant to inform new dentists and remind current members of the College about: • How the dental profession is regulated in this province; • The importance and purpose of regulation; • Current practice norms and standards and the rules of practice; • The ethical and legislative environment in which health professionals work; • Risk management strategies that allow dentists to practise safely throughout their dental career
Target Audience	• New applicants for a general, specialty or academic certificate of registration must also successfully complete an examination in Jurisprudence and Ethics. • In order to qualify for this course, applicants must have already graduated or intend to graduate from dental school in less than 6 months. • Current members
Topics	The course is broken down into eight modules: 1. Introduction 2. Understanding the College 3. Legislative Mode 4. Rules That Govern Dental Practice 5. Professional Boundaries 6. Guiding the Profession 7. Ethical Expectations 8. Professional Liability Program
Design/Delivery	• Course is available in electronic format only and must be completed online • Includes a number of downloadable resources that can be accessed from directly within the course • Use Lifelearn and have base program and four streams of the course: 1. Registration; 2. CPD oppty for members; 3. Remediation; 4. Course curriculum at UofT school of dentistry • Free for applicants

9. Regulatory Body	Royal College of Dental Surgeons of Ontario, Jurisprudence and Ethics
	• $250 for members
Successful completion – how defined and what happens if do not successfully complete	• Registration – yes – pretty soft cutscore – not high stakes • Theoretically can take as many times as they want
Legislative Challenges/ Stakeholder resistance	• No challenges, but certainly stakeholder resistance
Development process (including in-house, consultant etc) for initial and ongoing	• Looking at re-visiting to include ethics and considering engaging external ethicist to develop case scenarios to explore ethical issues • Developed in-house and engaged vendor to do online module • Staff working group: 3 dentists, 2 lawyers (complaints and director of liability), Registration manager – write content • May get psychometrician, but it is considered low stakes so don't feel it is necessary • Currently looking at revising content as has not been updated since 2010 • No pilot process
Length of time to develop	• For updates to questions, expecting it will take ~ yr • Wasn't aware of how long it took at the beginning
Costs – development and ongoing	Wasn't aware Just did major upgrade to make interactive – 60-70k
Staffing/human resources – development and ongoing	See above
Evaluation results	• Has always been informal
Notes	• Results of this course and examination will only be valid for registration purposes for a period of 3 years from the date the exam was completed. Therefore, if it is not participant's intention to be registered to practise in Ontario for more than 3 years, advised to register for the course at a date closer to when they intend to apply for a licence. Applicant Application: www.rcdso.org/Assets/DOCUMENTS/Forms/Jurisprudence_and_Ethics/RCDSO_Jurisprudence_and_Ethics_Online_Course_Registration_Form.pdf • Member Application: www.rcdso.org/Assets/DOCUMENTS/Forms/Jurisprudence_and_Ethics/RCDSO_Examining_Practice_of_Dentistry_in_Ontario_through_an_Ethical_Lens_Form.pdf • Participation in the College's Jurisprudence and Ethics course is worth 15 CE credits for RCDSO members. New

9. Regulatory Body	Royal College of Dental Surgeons of Ontario, Jurisprudence and Ethics
	applicants for a general, specialty or academic certificate of registration must also successfully complete an examination in Jurisprudence and Ethics

10. Regulatory Body	CARNA, Jurisprudence
Delivery Mode	Online module
Year Implemented	Information not available
Program Overview & Description	Wanted to combine education and testing, ensure validity and reliability, engaging and defensible
Frequency of Program	Information not available
Target Audience	• Applicants – credentialing requirement • Part of CPD program for current members – every 3-5 yrs
Topics	• Governance • Requirements for registration and practice permit renewal • Continuing competence • Professional conduct • Practice standards and ethics • Scope of nursing practice
Design/Delivery	Online 100-150 questions < 4 hrs to complete educational and formative content – get feedback on correct answer assessment content – will not tell user if on the right track
Successful completion – how defined and what happens if do not successfully complete	after beta test, determined cutscore 60-70%
Legislative Challenges/ Stakeholder resistance	Information not available
Development process (including in-house, consultant etc) for initial and ongoing	• Followed an exam-development process: developed profession profile and then blueprint, identified competencies in JP • Engaged nurses across the province as SMEs • Rated through online survey to exatablish blueprint • Also IDd kinds of items that could be included in a game • Platform: trajectory IQ and yardstick
Length of time to develop	• 18 month planning before engaged developer

10. Regulatory Body	CARNA, Jurisprudence
Costs – development and ongoing	Information not available
Staffing/human resources – development and ongoing	Information not available
Evaluation results	• Completing along the way as developed • Doing pre and post evaluation

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
Section 1 Introduction: Participating in Professional Regulation	1. Demonstrated understanding of concept of prof. regulation 2. Demonstrated understanding of principles of practice and regulation in the day-to-day, e.g.: (focus on inv. trends) • Maintaining Conf. (Concept 6) • Advertising & Billing • Reporting Requirements (Concept 9) 3. Demonstrated knowledge of CanMEDS framework and regulation with a focus on Professional role (KC3): • Incl. CPSO's adoption in May 2015 & FMRAC's adoption in 2016	Legislation *1.* Medicine Act *2. Regulated Health Professionals Act (RHPA)* CPSO Policies and Positions *1.* CPSO Practice Guide 2. Registration policies (Ask Nathalie and Registration area) 3. Changing Scope of practice and Re-entry Potential Activities 1. Click through activity on registration process 2. Case example on inappropriate use of table Case example on use of title Supports Ask Nathalie and registration area Assessment Ideas	Supports 1. CPSO website, specifically the policy and legislation & by-laws sections 2. Links to CanMEDS (FM) frameworks 3. Policy ap (if applicable) 4. Link to CPSO whiteboard video about regulation Assessment Ideas 1. Multiple choice (to test knowledge targets) 2. Answer questions about case examples (to address professional regulation and CanMEDS Professional Role) 3. Drag and drop (navigation of	1. CanMEDS (FM) frameworks 2. CPSO Physician Assistance Services (PAS) 3. CPSO Medical Advisors (?) 4. Links to other physician organizations • RCPSC • CFPC • CMPA and Good Practice Guide • OMA	Key Practice Guide Content *"Society allows physicians to regulate themselves in return for the **covenant that this regulation is in the public interest**."* • Introduction (p.2) • Values of the profession (Compassion, Service, Altruism, Trustworthiness) (p.4) • Section B: Participating in Self-regulation (p.8) 2014 Investigations Trends In 2014, of 2,385 investigations, 48.8% included profess. Issues. Of those, most common: • Confidentiality (53.6%) • Billing (51%) • Advertising	1. Introduction to frameworks and role in regulation 2. **Professional** Role with a focus on **Key Competency (KC) 3**: *Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation*	N/A

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
	4. Demonstrated ability to access and apply elements of *CPSO Practice Guide* 5. Demonstrated ability to access and apply a key policy (e.g., Physician Behaviour) Demonstrated knowledge of how to get involved	1. Multiple choice (knowledge) 2. Answer questions about case examples Re-visit click-through activity on registration process	website/ap) Case example - application of a policy (e.g., Physician Behaviour in the Professional Environment)		(24.7%) • Reporting (33.3%)		

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
Section 2 The CPSO	1. Demonstrated knowledge and ability to access *Medicine* Act and *RHPA* 2. Demonstrated knowledge of CPSO organizational and decision making structure • Council incl. representation and elections • MS Committees • Other Committees 3. Demonstrated knowledge of key CPSO programs and how the pertain to member • Registration • Annual Survey • Peer Assessment • Investigations • Discipline 4. Demonstrated understanding of	Legislation 3. Medicine Act 4. *Regulated Health Professionals Act (RHPA)* CPSO Policies and Positions 4. CPSO Practice Guide 5. Registration policies (Ask Nathalie and Registration area) 6. Changing Scope of practice and Re-entry Potential Activities 3. Click through activity on registration process 4. Case example on inappropriate use of table 5. Case example on use of title	Supports Ask Nathalie and registration area Assessment Ideas 3. Multiple choice (knowledge) 4. Answer questions about case examples 5. Re-visit click-through activity on registration process	Ask Nathalie and registration area	Key Practice Guide Content • "The College is the embodiment of the ethics of the profession…" • Role of the CPSO (p.3) Registration Issues *Example 1: Failure to disclose* *Example 2: Inappropriate use of title (Note this also comes up in 2014 Inv. Trends)* *Example 3: Practicing without being registered* *Example 4: Late Paperwork in application process* *Example 5: Failure to participate in an assessment/MSF?*	1. Application of competencies change when a physician moves from training to practice 2. Professional Role	Include content on: use of title

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
	registration process and terms of a certificate						

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
Section 3: Professional Competence	1. Demonstrated knowledge of the CanMEDS **Medical Expert** role (focus on competence) 2. Demonstrated knowledge of the CanMEDS **Scholar** role 3. Demonstrated knowledge of CPSO definition for practice of medicine and implications for competency 4. Demonstrated understanding of common professional competence issues that are addressed by CPSO Committees. 5. Demonstrated knowledge of the CPD and self-assessment regulatory	Legislation QA Regulatory Requirement for CPD and self-assessment CPSO Policies and Positions *1.* CPSO Practice Guide *2.* Prescribing Drugs *3.* Medical Records *4.* Changing Scope of Practice *5.* Re-entering Practice Potential Activities 1. Review Social Network Analysis of CPD – NEW ASSET DEVELOPMENT 2. Do we want an opioid example?	General Supports 1. CPSO CPD/Practice Improvement site Supports to address emerging topics 1. Opioid Prescribing Guidelines 2. Infection Prevention and Control for Clinical Office Practice 3. CPGs & Other Guidelines Assessment Ideas 1. Multiple choice (knowledge content) 2. Answer questions about case examples 3. Drag and drop	1. CPSO Peer Assessment program 2. MSF? 3. CPSO Physician Assistance Services 4. CPSO CPD/Practice Improvement Site 5. CanMEDS and CanMEDS FM frameworks 6. RPSC CPD educators 7. CFPC CPD educators 8. Links to discipline specific societies?	Key Practice Guide Content • Section A – Demonstrating Professional Competence (p. 5) • Section B – Educating (p. 9) • Section B – Learning (p. 9) 2014 Investigations Trends In 2014, of 2,385 investigations, 78.7 % included clinical issues Of these, following were most prevalent: *Example 1*: Prescribing (13.7%) *Example 2:* Assessment 16.1%) (delay, incomplete) *Example 3:* Investigation (15.7%) (delay, incomplete) *Example 4*: Diagnosis (13.5%) *Do we want Opioid-specific content /*	**Medical Expert** Role incl: ***KC1:*** Practise medicine within their defined scope of practice and expertise **Scholar** Role with a focus on ***KC1:*** *Engage in the continuous enhancement of their professional activities through ongoing learning (incl. PLP)* ***KC3:*** *Integrate best available evidence into practice* ***KC4:*** *Contribute to the creation and dissemination of knowledge and practices applicable to health*	1. Focus on topics where doctors most frequently get into trouble; mundane and realistic, not sensational (e.g., medical records and documentation) 2. Focus on professional behaviour 3. Introduce emerging issues/topics to new members, e.g.: • telemedicine, • medical assistance in dying • opioids • social media

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
	requirements 6. Demonstrated understanding of how CPSO programs support life-long learning 7. Demonstrated understanding of how to address/consider emerging topics/medical issues • Role of CPSO • Role of physician *Do we want Opioid-specific content / example?*				*example?*		

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
Section 4 Communication and Collaboration	1. Demonstrated understanding of the role of good communication in physician-patient relationships 2. Demonstrated understanding of common patient communication issues that are addressed by CPSO Committees. 3. Demonstrated knowledge of scaffolding patient understanding of follow up and treatment plans 4. Demonstrated knowledge and understanding of the ethical issues associated with patient consent and patient abandonment 5. Introduction to	CPSO Policies & Positions 1. Consent to Treatment 2. Disclosure of Harm 3. Medical Assistance in Dying 4. Professional Obligations and Human Rights 5. Ending the Physician-Patient Relationship 6. Medical Records 7. Complementary/Alternative Medicine 8. Telemedicine 9. Test Results Management 10. Disruptive Physician Behaviour Potential Activities 1. CPSO Case examples that address common issues addressed by CPSO Committees 2. Trigger videos that demonstrate key concepts	Supports 1. CMPA video: Challenges to building rapport 2. Interview with Communication coach/ Instructors in individualized instruction 3. CMPA Video: Disruptive Behaviour Assessment Ideas 1. Multiple choice (knowledge) 2. Answer questions about case examples 3. Drag and drop 4. Multiple choice (knowledge) 5. Answer questions about case examples (understanding) 6. Drag and drop (accessing website)	1. CPSO CPD/Practice Improvement site 2. CMPA Resources 3. PHP resources 4. OMA resources 5. CPSO CPD/Practice Improvement website 6. CMPA resources on maintaining confidentiality and Good Practices Guide website	Key Practice Guide Content • Section A. Collaborating with Patients and Others (p. 6) • Section A. – Communicating with Patients and Others (p. 7) • Section B – Collaborating with other Healthcare professionals (p. 10) • Section C – Collegiality (p. 11) 2014 Investigations Trends In 2014, of 2,385 investigations 25.8% had to do with professional communication (91.7% of that with patients) *Example 1:* Consent *Example 2:* Communication relating to monitoring,	**Communicator** Role ***KC 1***: Establish therapeutic relationships with patients & families ***KC 2***: Elicit and synthesize accurate and relevant information, incorporating the perspectives of patients ***KC3:*** Share health care information and plans with patients and their families ***KC4***: Engage patient and their families in developing plans that reflect the patients health care needs and goals ***KC 5***: Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality & privacy	Focus on: • Disclosure of Harm Consent • Patient-centred and collaborative communication

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
	complementary/embedded topics? (Note: The following may eventually be included with the Communication topic but for now are subtopics) • Maintaining Appropriate Boundaries • Maintaining Patient Confidentiality 6. Demonstrated understanding of common collaboration issues that are addressed by CPSO Committees. 7. Demonstrated understanding of key elements of managing conflict 8. Demonstrated knowledge of Medical record keeping policy				test results *Example 3*: Follow up care *Other examples*: Issues associated with abandonment (tie to key policies) In 2014, of 2,385 investigations 21.6% included medical record keeping issues *Example 1:* Professional Communication *Example 2*: Disruptive Physician *Example 3:* Clinical Communication – Other Health care professionals *Example 4*:Managing conflict	**Collaborator** Role ***KC 1:*** Work effectively with physicians and other colleagues in the health care professions ***KC2:*** Work with physicians and other colleagues in the health care professions to promote understanding, manage differences and resolve conflicts **EC 2.2**: Implement strategies to promote understanding, manage differences, and resolve conflicts in a matter that supports a collaborative culture ***KC3***: Hand over the care of a patient to another health care professional to facilitate continuity of safe patient care	

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
	9. Demonstrated knowledge and understanding of key elements of managing conflict					**Professional** Role, **EC 4.3** Promote a culture that recognizes, supports, and responds effectively to colleagues in need	

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
Section 5: Professionalism 5A: Maintaining Appropriate Boundaries	1. Demonstrated understanding of: • Boundaries • Boundaries and relationships • physician responsibilities to maintain boundaries • boundary violations • boundary crossings 2. Demonstrated knowledge and application of the *Maintaining Appropriate Boundaries* policy 3. Demonstrated understanding of the influence of stress and wellness on maintaining appropriate boundaries	CPSO Policies and Positions 1. Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy 2. Updated Boundaries 2004 self-assessment tool *(See Appendix A for suggestions)* 3. CPSO Practice Guide Potential Activities 1. Completion of the updated 2004 Boundaries self-assessment tool	Supports 1. *RHPA* definition of Sexual Abuse 2. Other Colleges/jurisdictions resources on boundaries Assessment Ideas 1. Documented completion of boundaries self-assessment tool (Appendix A) 2. Answer questions from case examples taken from Maintaining Appropriate Boundaries module (Professionalism and Practice Program)	1. OMA Physician Health Program (Stress) 2. CMPA incl. wellness support resources and *Good Practices Guide* website Could we reference resources from other jurisdictions?	Key Practice Guide Content Cross reference with Professionalism and Practice module 2014 Investigations Trends Should we align with examples/cases in the *Professionalism and Practice* program module?	**Communicator** Role (focus on patient communication) ***KC 1:*** Establish professional therapeutic relationships with patients and their families **Professional** Role ***KC 1:*** Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards ***KC 2****:* Demonstrate a commitment to physician health and well-being to foster optimal patient care	1. Focus on professional behaviour. 2. Introduce emerging issues/topics: • Maintaining boundaries to prevent sexual abuse

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
5B: Maintaining Patient Confidentiality	1. Demonstrated knowledge and understanding of the Confidentiality of Health Information policy 2. Demonstrated knowledge and application of relevant sections of Medicine Act and PHIPA 3. Demonstrated understanding and knowledge of the CPSO position on Social Media 4. Demonstrated understanding of unique challenges/issues associated with Third Party Reports 5. Demonstrated understanding of when to contact the CMPA	Legislation *1. Medicine Act* *2. PHIPA* CPSO Policies & Positions *1.* Confidentiality of Health Information *2.* Social Medical – Appropriate Use by Physicians *3.* Third Party Reports Potential Activities 1. Case on an inadvertent slip (e.g., elevator conversation) 2. Exploration of a case of a breach via social media	Supports 1. CMPA video from Good Practices Guide: Police request in an emergency department Assessment Ideas 1. Multiple choice (knowledge) 2. Answer questions about case examples (understanding) 3. Drag and drop (accessing website)	1. CPSO CPD/Practice CMPA resources on maintaining confidentiality and Good Practices Guide website	Key Practice Guide Content • Section A – 2 Maintaining Confidentiality (p. 6) 2014 Investigations Trends Breaching Confidentiality Need different types of breaking/breaching confidentiality incl • Inadvertent slip in elevator • Social media	**Communicator** Role ***KC5:*** Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy ***EC5.3:*** Share information with patients and others in a manner that respects patient privacy and confidentiality and enhances understanding	

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
5C: Managing Conflicts of Interest	1. Demonstrated knowledge and understanding of how to recognize and manage a conflict of interest	Legislation ONTARIO REGULATION 114/94: General (See Conflicts of Interest) under the *Medicine Act 1991* Advertising Regulation under the Medicine Act CPSO Policies Policies • CPSO Practice Guide • Block Fees &Uninsured Services • Physician Treatment of Self, Family Members, or Others Close to Them • *Physicians' Relationships with Industry: Practice, Education and Research* • *Providing Physician Services During Job Actions*		1. CMA Code of Ethics 2. CMPA Resources	Key Practice Guide Content • Section A – Managing Conflicts of Interest (p. 7) 2014 Investigations Trends *Example 1*: Monetary Gain (e.g. physician refers a patient to a specific pharmacy where s/ he has propriety interest) *Example 2:* Personal gain (e.g., a physician is named in a patient's will) *Example 3:* Professional gain (e.g., physician exploits professional status)	**Professional** role **KC 1**: Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards ***E: 1.1*** Exhibit appropriate professional behaviours and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect altruism, respect for diversity and maintenance of confidentiality ***EC 1.4*** Recognize and manage conflicts of interest	

High Level Content					Maps To:		
	Desired Learning Targets	Resources and Availability	Learning Supports and Assessment	System Supports	CPSO Practice Guide and 2014 Investigations Data	CanMEDS 2015/CanMEDS-FM	Interview By Key Informants
Section 5D Ethical and Legal Obligations	Legislation CPSO Policies Policies 1. Mandatory and Permissive Reporting 2. Medical Records 3. Blood Borne Viruses 4. Third Party Reports 5. Confidentiality of Personal Health Information 6. Prescribing Drugs			Key Content from CPSO Practice Guide • Section B – Reporting (p. 9) 2014 Investigations Trends	Professional Role, KC 3 (expectations of regulation)		
? Section 6 Physician Health	TBD						

Appendix C

DRAFT Storyboard for New Member Orientation Education Series

1. Module I – Introduction to the CPSO
    a. General Scenario: Avatar welcomes participant to the modules, goes over mechanics, expectations etc. Covers the concepts of:
        i. Professional regulation
        ii. Relevant Legislation:
            1. RHPA
            2. Medicine Act
        iii. College governance
            1. Council and Committee Structure
            2. Role of the Registrar
        iv. CPSO Policy overview
            1. The Practice Guide

2. Module II – Candidate Registration
    a. General Scenario: Introduction to Dr. Jones – a graduating resident applying for membership. Covers concepts of:
        i. Requirements for Certification – "The Canadian Standard"
        ii. Alternate routes to registration
        iii. Practice restrictions (including everyone's practice restriction!)
        iv. Professionalism in application process

3. Module III – Early Career Years
    a. General Scenario – Dr. Jones starts out practice and encounters:
        i. Need to maintain CPD – CPD regulation
        ii. Inheriting a practice that contains many patients on chronic opiate therapy – highlight opiate problem and resource availability
        iii. A complaint about a social media breach – highlight the complaints process, ICRC, PHIPA, Policy on Confidentiality of Health Information, Social Media position statement

4. Module IV – Mid-Career
    a. General Scenario – Dr. Jones is in mid career and encounters the following:
        i. Being randomly selected for a Peer Assessment – highlights the process, the QAC, medical records keeping policy
        ii. Return to practice after parental leave – highlights Re-Entry/COS policies

iii. A complaint about a possible boundary violation e.g. hugs an opposite gender patient who gets the wrong message – highlight Maintaining Appropriate Boundaries Policy and Boundaries Self-Assessment Tool.
iv. Around the same time, Dr. Jones reads about a colleague with a finding of professional misconduct related to sexual abuse of a patient – highlight Discipline committee information, legislation around sex abuse, policy, prevention, mandatory reporting.

5. Module V – Late Career
    a. General Scenario – Dr. Jones has had a long and successful career, but encounters some challenges
        i. Complaint from a nurse about being spoken to in a condescending way – highlight physician behaviour in the professional environment
        ii. A long-time patient requests MAID – highlight MAID, conscientious objection, Human Rights Policy
        iii. Encounters a colleague who arrives at the office intoxicated - highlight mandatory reporting, PHP
        iv. Treating GP retires so starts prescribing for self and partner's regular medications – highlight treating self and others policy.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: Governance Committee Report

FOR DECISION:

- **Facilitating Public Member Presidents**
- **Election of 2017/2018 Academic Representatives on Council**
- **2018 Chair Appointments**

FOR INFORMATION:

- **Committee Appointment - Rescinded**
- **Public Member Reappointment**
- **2017 District 5 and 10 Election Update**
- **Completion of 2017 Council Performance Assessment (Form)**

FOR DECISION:

Facilitating Public Member Presidents

ISSUE:

Facilitating the election of public member Vice-Presidents/Presidents.

BACKGROUND:

- The Governance and Executive Committees have supported and discussed the concept of a public member president.
- While existing provisions in College By-Laws permit the election of any member of Council as College President (including public members), this is not well known, and there is a well-established process in place and an assumption that once a physician is elected to the Executive Committee, they will automatically progress to Vice-President and then President.

- The issue was taken to Council in May, 2017, and Council directed staff to work up the issue so it could be considered by the Governance Committee and brought back to the Executive Committee and Council for further consideration in 2017.
- The Governance Committee considered key decision points and options to facilitate the election of a public member president in July. The Chair led subsequent discussion to refine the approach in anticipation of discussion at August 8 meeting of the Executive Committee. The Executive Committee discussed the options and appeared to be generally supportive of the following approach described below.
- The Governance Committee further discussed the following approach at its meeting on August 25 and offered some additional recommendations noted below.

Recommended Approach

- Principles of transparency and clarity should underpin Council's election processes.
- Public members of Council should be encouraged to serve as College Vice-President and President.
- Progression has value and is very useful in preparing a future President and Vice-President, but it does not need to be contained in the By-laws.
- While EC would continue to be composed of six members, a new minimum of two public members and a minimum of two physician members would be instituted.
    - These minimum numbers would apply regardless of the positions held on EC. In other words, public members could be President and VP (without a requirement to have additional public members on EC). The By-laws would have to be amended to reflect this composition of the Executive Committee.
- The Past President will continue to serve as a member of the Executive Committee.
- The new President would be elected first.
- The current VP would generally progress to be President. An election would still take place to satisfy the Medicine Act but by convention and support for progression, the only nominee would normally be the current VP.
- There would no longer be an assumed progression path to VP position. However, the Governance Committee recommended that the election for the VP position be open (convention) to any current member of the Executive Committee (other than the current VP, President or Past President) or a member of Council who had been on Executive Committee during their current Council term. In other words, ideally, nominees will have served recently on the Executive Committee.
- The rest of EC (other than past President) would then be elected. Separate elections may be needed to properly fill the minimum requirements for 2 physician and 2 public members.

- The logistics of the elections will be considered further. Depending on the public/physician balance among Past President, President and VP, there may be flexibility in the numbers required for the rest of the Executive Committee.
- For instance:
  - Past President: physician
  - President: Public [election – current VP only nominee by convention]
  - VP: Public
  - Position 4: physician [election with just physician nominees]
  - Positions 5 and 6: could be 2 physicians, 2 public or 1 of each. [election open to physicians and public members, because the minimum requirements have already been filled]

- Consequential by-law amendments may also be required with respect to Governance Committee composition, flowing from Executive Committee composition amendments.
- The progression path from VP to President, and the principles or expectations for VP candidates would not be written in by–law, but it is recommended that progression be clearly communicated to ensure awareness and transparency.

NEXT STEPS:

- Council to consider the recommended approach.
- If Council is supportive of the overall direction, staff will draft revised By-laws and supporting communication material. They would be brought to a future meeting of Council.

DISCUSSION:

1. How does Council feel about the recommended approach (progression, composition of the Executive Committee)?
2. If supportive of the approach, does Council want the changes in place for the May 2018 election of the Executive Committee (2019 Council year), or the May 2019 election of the Executive Committee (2020 Council year)?

DECISION FOR COUNCIL:

1. Does Council agree with the proposed approach for facilitating public member presidents and the consequential changes to Executive Committee composition, as outlined above?

Election of 2017-2018 Academic Representatives on Council

- The Deans of the six medical schools have been asked to appoint their academic representative for the 2017/2018 session of Council. The following representatives have been appointed:

  Dr. Janet Van Vlymen, (Queen's University)
  Dr. Mary Bell, (new), (University of Toronto)
  Dr. Barbara Lent, (Western University)
  Dr. Akbar Panju, (McMaster University)
  Dr. Robert Smith, (Northern Ontario School of Medicine)
  Dr. Paul Hendry, (new), (University of Ottawa)

- The academic representatives will meet, prior to the September Council meeting, and recommend the three voting academic representatives for the 2017/2018 session of Council.
- Dr. Mary Bell is a new University of Toronto representative, and Dr. Paul Hendry is a new University of Ottawa representative to the CPSO Council. Appointments to Council will be effective following the induction of new Council members at the annual meeting of Council on December 1, 2017.

DECISION FOR COUNCIL:

1. Council will decide whether to approve the recommended slate of 2017-2018 voting academic representatives at its September meeting. [If the slate is not approved, a vote will be held at the September meeting of Council].

2018 Chair Appointments

- Committee Chairs, Co-Chairs and Vice Chairs are elected at the September Council meeting. These appointments will take effect following the November 30 and December 1, 2017 AGM.

- In considering nominations for these leadership positions, the Governance Committee followed Council's Nominations Guidelines. (Appendix A)
- All chairs, co-chairs and vice chairs are nominated and appointed annually pursuant to the General Bylaw.
- It is recommended that chairs serve for no more than three consecutive years as chair of a specific committee.
- Annual reappointment during the three-year term depends on criteria, including link to Council, role requirements, demonstrated key leadership and committee-specific competencies, succession planning, term limits and performance.
- In cases where committees have two chairs or vice chairs, chair appointments are staggered where possible, to ensure consistency in leadership from one year to the next, and for mentoring of new chairs.
- Role descriptions and key behavior competencies for Council and non-Council Committee Chairs are set out in the Governance Process Manual
- Committee Chairs must have an understanding of, and a commitment to the public interest mandate of the College.
- The Governance Committee nominates the following chairs, co-chairs and vice-chairs for 2018:

2018 PROPOSED COMMITTEE CHAIR/CO-CHAIR/VICE CHAIR NOMINEES

2018 Proposed List of Chair/Co-Chair/Vice Chair Nominees	
Committee	**Proposed 2018 Chairs/Vice Chairs**
Council Award Selection Committee	Dr. David Rouselle *(as per CPSO By-Law)*
Discipline Committee	Ms. Debbie Giampietri Dr. Carole Clapperton *(non-Council)*
Education Committee	Dr. Akbar Panju
Executive Committee	Dr. Steven Bodley *(as per CPSO By-Law)*
Finance Committee	Mr. Peter Pielsticker
Fitness to Practise Committee	Dr. Dennis Pitt
Governance Committee	Dr. David Rouselle *(as per CPSO By-Law)*
Inquiries, Complaints and Reports Committee	Dr. David Rouselle, *ICRC Chair* Dr. Carol Leet/Dr. James Edwards *(non-Council), Co-Vice Chairs, Settlement Panels* Ms. Lynne Cram/Mr. Harry Erlichman, *Co-Vice Chairs, General Panels* Dr. Edith Linkenheil, *(non-Council) Vice Chair, Obstetrical* Dr. Akbar Panju, *Vice Chair, Internal Medicine* Dr. Brian Burke, *(non-Council), Vice Chair, Mental Health and Health Inquiry Panels* Dr. Dale Mercer *(non-Council) Vice Chair, Surgical* Dr. Stephen Whittaker, *(non-Council), Vice Chair, Family Practise*
Outreach Committee	Ms. Lynne Cram
Patient Relations Committee	Ms. Lisa McCool-Philbin *(non-Council)*

Premises Inspection Committee	Dr. Dennis Pitt
Quality Assurance Committee	Dr. Brenda Copps Dr. Deborah Robertson *(non-Council)*
Registration Committee	Dr. Akbar Panju

DECISION FOR COUNCIL:

1. Council will decide whether to approve the recommended slate of 2018 Chairs/Co-chairs/Vice Chairs.

FOR INFORMATION:

Committee Appointment – Rescinded

- The Executive Committee has rescinded Dr. Pauline Abrahams' Patient Relations Committee appointment at the August 8, 2017 meeting.

Public Member Reappointment

- Mr. John Langs has received a three-year public member reappointment to the CPSO Council, effective August 13, 2017 to August 12, 2020.

2017 District 5 and 10 Election Update

- Nominations for the 2017 district elections closed on August 22 at 4:00 p.m.
- Two candidates from District 5 will be elected to sit on Council.
- The District 5 electoral district is composed of the County of Simcoe; The District Municipality of Muskoka and the regional municipalities of Durham, Peel and York.
- There will be an election in District 5.

District 5 Candidates:
Dr. John Thomas Bertoia
Dr. Rakesh Bhargava
Dr. Geoffrey Bond
Dr. Nazim Damji
Dr. Naveen Dayal
Dr. Brian Levy
Dr. David Rouselle
Dr. Elizabeth Samson
Dr. Winnie Wong

- Four candidates in District 10 have been acclaimed.
- The District 10 electoral district is composed of the City of Toronto.

District 10 Acclaimed Candidates:
Dr. Philip Berger
Dr. Haidar Mahmoud
Dr. Peeter Poldre
Dr. Patrick Safieh

Completion of 2017 Council Performance Assessment (Form)

- **All Councillors are asked to please complete the 2017 Council Performance Assessment Form, (Appendix B) and submit your completed form by the end of the September Council meeting to Debbie McLaren or Franca Mancini.**
- The College's performance assessment program is intended to inform and support ongoing development and continuous improvement.
- Completion of the Council Performance Assessment Form provides Councillors with an opportunity to assess and improve Council performance.
- The Council Performance Assessment Form will also be provided to Councillors as an attachment to an e-mail for ease of electronic completion and submission.
- The results will be tabulated and presented at the December meeting of Council.

Contact: Joel Kirsh, Chair, Governance Committee
Marcia Cooper, Ext. 546
Debbie McLaren, Ext. 371
Louise Verity, Ext. 466

Date: August 29, 2017

Attachments:

Appendix A: Nominations Guidelines
Appendix B: Council Performance Assessment Form (for completion)

Appendix A

Governance Practices and Policies

Nominations Guidelines

Purpose

The Nominations Guidelines contain eligibility criteria and other information utilized to inform and guide nominations related decisions made by the Governance Committee and the College Council. They apply to the selection of committee chairs and committee members.

The guidelines are also a resource to members of Council and committees, staff, members of the profession and others. They help explain the processes and basis upon which nomination recommendations and decisions are made.

Overview

A key goal in the College's 2001 strategic plan was to establish an effective and transparent governance model for the College. The College's General Bylaw and the Governance Process Manual contain the foundational elements of this model. The Nominations Guidelines reside in the Governance Process Manual.

Pursuant to the General Bylaw, committee chairs and committee members are nominated and appointed annually.

The General By-Law also sets out eligibility and disqualification criteria for members of Council and College Committees (Appendix 1).

The Governance Process Manual sets out governance roles and responsibilities, governance practices and procedures, College Committee mandates, a key behavioural competency model and a performance feedback process.

Relevant to nominations, the Governance Manual sets out role descriptions and key behavioural competencies for Council and Non-Council Committee Chairs and Council and Non-Council Committee Members.

Council members provide annual expressions of interest, and non-Council members apply and are recruited to work on College committees. Committee chairs are asked by the Governance Committee to identify committee needs and requirements.

Every new committee member undergoes screening. The screening process includes an interview usually with the Chair of the Governance Committee and the chair of the relevant committee.

The Governance Committee oversees the entire nominations process and recommends nominations for committee Chairs and membership to Council for approval. Council makes nominations related decisions. The Nominations Guidelines are based on best practices in areas including but not limited to:

- Defined competencies for committee chairs and members
- Commitment to orientation and training

- Commitment to succession planning and renewal

All committee appointments are for one year, coinciding with the College's AGM.

A. Chairs

Committee Chair Selection

The nomination and appointment of qualified committee chairs is essential to effective committee governance.

The majority of College committees have one chair, though some committees have co-chairs. In addition, one College committee; the Inquiries, Complaints and Reports Committee, has a number of vice-chairs who are responsible for chairing specific specialty panels.

All chairs and vice-chairs are nominated and appointed annually pursuant to the General Bylaw.

It is recommended that chairs serve for no more than three consecutive years as chair of a specific committee.

Annual reappointment during the three year term depends on criteria, including link to Council, role requirements, demonstrated key leadership and committee-specific competencies, succession planning, term limits and performance, as described below.

Link to Council

Many College committees exercise independent decision-making authority. Examples include the Discipline, Fitness to Practise, ICR, and Quality Assurance Committees. However, the College Council develops and sets the overall policy framework for the work of College committees within and consistent with the legislative framework. Therefore, it is critical that committees have a strong link to Council.

It is recommended that all College Committees be chaired by a member of College Council or a member of Council's Academic Advisory Committee. Non-Council members may chair when the chair responsibility is shared with a member of Council. The exception is the Patient Relations Committee (PRC). There are no Council members on the PRC to avoid conflict and any perception of bias in relation to other College committee processes. PRC membership is set out in the Council By-Law.

Committee Chair Role Descriptions

Role descriptions and key behavior competencies for Council and non-Council Committee Chairs are set out in the Governance Process Manual.

Committee Chairs must have an understanding of and a commitment to the public interest mandate of the College.

Committee Chairs must also have an understanding of and commitment to the mandate of the committee they lead and have expertise relevant to its mandate. The Chair must provide leadership so that committee goals are achieved in a fair, effective, and efficient, manner. The Chair liaises with staff and reports the work of the committee to Council and facilitates Council's understanding of committee

work. Further, Committee Chairs are required to assess whether their committee members have the resources and training to perform effectively within the mandate of the committee.

Key Behavioural Competencies

Key behavioural competencies for committee chairs accompany the role descriptions in the Governance Process Manual. Key competencies include:

Managing Competencies
- leadership
- planning and initiative
- continuous learning

Thinking Competencies
- creativity
- strategic thinking

Influencing Competencies
- relationship building
- effective communications

Achieving Competencies
- results oriented
- stakeholder focus
- team work

The managing competency, namely the ability to take on a role as leader, is required for the role of College President and Chair of Council as well as a Committee Chair. Leaders have integrity and create positive morale and spirit on their teams. They share wins and success and demonstrate a positive attitude, energy, resilience and stamina. Leaders also have the courage to take risks.

It is expected that all committee chairs will demonstrate these key behavioural competencies and, the additional committee-specific competencies as described in the chart below,

Committee	Committee-specific Chair Competencies
Council Award	Past-President*
Education	Academic. Knowledge of educational initiatives and policies (CPD),Awareness of issues / matters affecting Ontario medical education.
Executive	President*
Discipline	Knowledge and understanding of administrative law principles. committee practices and College processes. Acquired, or actively developing, adjudicative skills (writing and panel chair). Commitment to hearing schedule and case management.
Finance	Good understanding of financial processes, significant budgeting experience.
Fitness to Practise	Knowledge and understanding of administrative law principles, committee practices and College processes. Acquired, or actively developing, adjudicative skills (writing and panel chair). Commitment to hearing schedule and case management.

Governance	Past-President* (Whenever possible, it is recommended that the Chair should be a past president on Council or a past president who has not been off the Council more than 3 years)
Inquiries, Complaints and Reports (ICR)	Knowledge and understanding of administrative law principles, proper investigation practices, and College processes. Past or recent experience chairing a College screening committee.
Methadone	Familiar with methadone program, legislation, regulations, standards, guidelines.
Outreach	Interest and knowledge of member and public communications and stakeholder management.
Patient Relations	Proven awareness and understanding of sexual abuse and the impact of sexual abuse on patients, knowledge and understanding of boundary issues, knowledge of the field of psychological issues.
Premises Inspection	Familiar with College's premises inspection program and applicable legislation, regulations, standards and guidelines. Knowledge of I and R and QA processes.
Quality Assurance	Familiar with College practice assessment and enhancement activities, I and R and QA processes, legislation, regulations, standards and guidelines.
Registration	Familiar with College's registration policies, general understanding of credentialing, registration and certification processes. Understanding of medical academic issues an asset. Knowledge of QA and I&R processes.

*As per General By-Law

Succession Planning

Succession planning is essential to maintaining and enhancing committee capacity.

It is vital to:

- retain well qualified and experienced members to act in leadership roles, such as the role of Chair, and to mentor new members; and,
- bring in new appointments to refresh the membership on an ongoing basis.

This process of maintenance and renewal is necessary to ensure consistent committee capacity, and for ongoing succession planning.

Early identification and training of potential chairs as well as setting and adhering to term limits aid effective succession planning.

Length of Terms

Prior to 2006, there were no term limits for committee chairs. Council established term limits to guide nomination decisions and to foster committee renewal.

It is strongly recommended that chairs serve no more than three consecutive years as chair of a specific committee.

In cases where committees have two chairs or vice chairs, chair appointments are staggered, where

possible, to ensure consistency in leadership from one year to the next and for mentoring of new chairs.

Participation in Training Opportunities

Participation in College-mandated training is essential for all members of Council and committees. Committee chairs are expected to participate in all mandated training. This includes participating in Council's annual orientation day (February) and maintaining CPD. This may also include other prescribed training or development programming.[1]

Governance Committee key considerations in making chair nomination decisions:

1. ***Does the candidate demonstrate the key leadership competencies?***
2. ***Does the candidate possess the committee specific chair competencies?***
3. ***If the candidate has served as chair of the committee, or has previously chaired a College committee, what were the results of the chair performance assessment?***
4. ***How many years of eligibility does the candidate have on the College Council?***
5. ***If the candidate is a current committee chair, has he or she reached the 3 year term limit?***
6. ***Is the candidate willing to chair the committee?***

B. COMMITTEE MEMBERS

Committee Composition

Just as College committees need to be led by skilled chairs, they also need the right mix of members who together have the ability to effectively discharge the responsibilities of the Committee. Committees must also be rejuvenated with new ideas and people through adequate succession planning.

As per the College's by-laws, committee members are nominated and elected annually. Reappointment will depend on performance, length of tenure and committee-specific factors.

Committee requirements vary with the size, structure, mandates and panel composition and quorum requirements.

Annual reappointment criteria include, role requirements, demonstrated or commitment to develop committee-specific competencies, term limits, performance assessment, and succession planning as described below.

Committee Member Role Description

Role descriptions and key behavioral competencies for Council committee members and non-Council committee members are set out in the *Governance Process Manual*.

Committee members must have an understanding of and a commitment to the public interest mandate of the College.

Committee members must also have an understanding of and a commitment to the mandate of the

[1] This has included for example sexual harassment and awareness training and diversity training.

Committee.

Key Behavioral Competencies

The key behavioral competencies for Council and non-Council committee members are as set out in the Governance Manual.

The Governance Committee also considers committee-specific competencies and resource requirements.

Technical Competence and Diversity

Proficiency with technology is essential as the College utilizes webmail and sharepoint, conducts meetings with electronic materials and anticipates further technical advancement.

Other considerations include proficiency in French and the fulfillment of regional, practice area and other diversity interests including gender balance.

Succession Planning

Succession planning is critical to ensuring balance and renewal on College committees. Ensuring the delivery of orientation and training programs, as well as setting and adhering to committee membership term limits, are important components to succession planning.

Length of Terms

In the past, there were no term limits for committee members. As a consequence, committee renewal was limited and inconsistent. As a general principle, it is recommended that committees have a 20% turnover (where possible) in membership on an annual basis.

It is also recommended that committee members should serve no longer than five consecutive years on operating committees. Operating committees include the Outreach, Finance, Governance committees. This five year membership limit would not apply to committee chairs.

Capping the length of committee member terms has the added benefit of clearly managing expectations, facilitating succession planning.

Certain statutory committees, such as the Discipline, QA, Registration and ICR committees. are exempt from the five-year committee member term limit. They are exempt to ensure that they are able to meet statutory panel composition and quorum requirements as well as to ensure they have a roster able to perform the work of the committee. The work of these committees is technical and complex and committee members require considerable training and experience to facilitate performance.

Orientation and Training

The College supports the orientation, training and mentorship of Council and non-Council committee members to ensure that the College's statutory obligations and committee mandates are carried out in a fair, effective and efficient manner.

To this end, the College delivers an annual Council and Committee Orientation program. All Council and non-Council committee members are strongly encouraged to participate in the orientation program, held typically in February each year.

Council also has a mentorship program designed to welcome and support new members of Council. The assigned mentor is on Council and where possible, is on a Committee to which the new member is also appointed.

Annual committee-specific orientation, training and mentorship is developed and delivered by Committee Chairs and College support staff and may take place on multiple days throughout the year.

Council and committee members are expected to participate in defined training programs (i.e. annual orientation day, sexual harassment training as well as other training that may be identified).

Governance Committee key considerations in making committee membership nomination recommendations:

1. ***Does the committee have the necessary expertise and core competencies/skills to adequately discharge its mandate?***
2. ***Are there any new members on the committee?***
3. ***How many more years of eligibility does the candidate have on the committee?***
4. ***How many more years of eligibility does the candidate have on the Council?***
5. ***How has the committee member performed?***
6. ***Does the candidate member function in the public interest?***

Appendix 1

Eligibility and Disqualification Provisions in College By-Law

A summary of Council and committee eligibility and disqualification provisions that apply to elected members of Council, members of the Academic Advisory Committee and professional committee members in the College By-Law are contained below.

I Elected Members of College Council

Eligibility For Election

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

(a) the member is engaged in the practice of medicine in the electoral district for which he or she is nominated or, if the member is not engaged in the practice of medicine, is resident in the electoral district for which he or she is nominated;

(b) the member is not in default of payment of any fees prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the election;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(f) the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario;

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

(h) council has not disqualified the member during the three years before the election date, and

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

(2) A member is not eligible for election to the council who, if elected, would be unable to serve completely the three-year term prescribed by section 11 by reason of the nine-consecutive-year term limit prescribed by subsection 5(2) of the Health Professions Procedural Code.

Disqualification of Elected Members

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

(a) is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the discipline committee;

(b) is found to be an incapacitated member by a panel of the fitness to practise committee;

(c) with respect to a council member elected after October 1, 2011, ceases to hold a certificate of registration that is not subject to a term, condition or limitation other than one prescribed in any regulation made under the *Regulated Health Professions Act, 1991* or the *Medicine Act, 1991*;

(d) fails, without cause, to attend three consecutive meetings of the council;

(e) fails, without cause, to attend three consecutive meetings of a committee of which he or she is a member;

(f) ceases to either practise or reside in the electoral district for which the member was elected;

(g) is in default of payment of any fee prescribed by College by-law for more than thirty (30) days;

(h) fails, in the opinion of council, to discharge his or her duties to the College, including having acted in a conflict of interest or otherwise in breach of College by-law, the *Regulated Health Professions Act 1991*, or the College's governance policies;

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

(j) holds a position which would cause the member to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization.

II Academic Advisory Committee Members of Council

Academic Advisory Committee

24. (1) An Academic Advisory Committee shall be established and shall be composed of members appointed under this section.

(2) Between one and two months before the meeting of the council when the term of office of newly elected councillors starts, the dean of each faculty of medicine of a university in Ontario may appoint one member to the academic advisory committee.

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

(a) the member is on the academic staff of the faculty of medicine;

(b) the member is not in default of payment of any fee payable to the College;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the appointment;

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation; the member is not a director or officer of the Ontario Medical Association, the Canadian Medical Protective Association, the Canadian Medical Association, or the Coalition of Family Physicians and Specialists of Ontario; and

(f) the member does not hold a position which would cause the member, if appointed to the Academic Advisory Committee, to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization.

Disqualification of Selected Councillors

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

(a) is found to have committed an act of professional misconduct or is found to be incompetent by a panel of the discipline committee;

(b) is found to be an incapacitated member by a panel of the fitness to practise committee;

(c) with respect to a council member selected after October 1, 2011, ceases to hold a certificate of registration that is not subject to a term, condition or limitation other than one prescribed through regulation;

(d) fails without cause, to attend three consecutive meetings of the council;

(e) fails, without cause, to attend three consecutive meetings of a committee of which he or she is a member;

(f) ceases to be on the academic staff of the faculty of medicine from which the member was selected;

(g) is in default of payment of any fee prescribed by College by-law for more than thirty (30) days;

(h) fails, in the opinion of council, to discharge his or her duties to the College, including having acted in a conflict or otherwise in breach of a College by-law, the *Regulated Health Professions Act, 1991*, or the College's governance policies;

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

(j) holds a position which would cause the member to have a conflict of interest by virtue of having competing fiduciary obligations to both the College and another organization.

III Non-Council Committee Members of Council

Appointment of Members to Committees

1. (1) The council may appoint a member of the College to a committee only if, on the date of the appointment,

(a) the member practises medicine in Ontario or resides in Ontario;

(b) the member is not in default of payment of any prescribed fees;

(c) the member is not the subject of any disciplinary or incapacity proceeding;

(d) the member's certificate of registration has not been revoked or suspended in the six years preceding the date of the appointment; and

(e) the member's certificate of registration is not subject to a term, condition or limitation other than one prescribed by a regulation.

Appointment of Non-Members to Committees

(2) The council may appoint a person who is not a member of the College or a councillor to a committee.

180-19

Appendix B

2017
Council Performance Assessment Form

Your Name: ***(optional)*** _____

INSTRUCTIONS:

This questionnaire requires you to focus on and assess key areas that affect the Council's performance as a whole and its key responsibilities for governance of the CPSO.

Please answer each question by indicating the most applicable response. At the end of each section of the survey there is an opportunity for you to provide qualitative comments**.** At the end of the questionnaire there is also an opportunity for you to provide further input regarding your perspective of the Council's strengths and developmental opportunities for improved performance. Please answer all questions as candidly as possible. Thank you for your time in contributing to the growth and development of the Council.

Number of Years on Council: **1<** **1–2** **3–4** **5–6** **7>**

A. VISION AND MANDATE	**RATING**			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I understand the vision and the mandate of the College.				
2. The Council formally reviews its vision.				

COMMENTS: X

B. STRATEGIC PLAN AND PRIORITIES	**RATING**			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. The College's strategic plan is documented.				
2. The Council creates a set of key priorities that must be implemented in support of the strategic plan of the College.				
3. The Council establishes a small number of strategic initiatives to focus attention and resources to help achieve the College vision.				
4. The dashboard report presented by the Registrar clearly reports progress on College priorities.				

180-20

2017

Council Performance Assessment Form

COMMENTS: x

C. COUNCIL'S ROLE AND RESPONSIBILITIES	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I am familiar with the College's governance practices and policies.				
2. The Council effectively develops and approves principles and policies that fulfill its duty to protect the public interest.				
3. The Council effectively discharges its statutory functions.				
4. The Council periodically monitors and assesses its performance against its strategic direction and goals.				
5. The College has an effective system of financial oversight.				
6. The Council meets with external auditors, reviews their reports and recommendations and, ensures any deficiencies are corrected.				

COMMENTS: x

D. GOVERNANCE OPERATIONS	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. As a Council member, I understand my fiduciary obligations.				
2. I know and understand the Code of Conduct.				
3. I understand the Conflict of Interest Policy.				
4. As a member of Council, I declare potential conflicts of interest according to Council's conflict of interest.				

180-21

2017
Council Performance Assessment Form

COMMENTS: X

E. COUNCIL OPERATIONS	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I receive appropriate information for Council meetings.				
2. I receive information for Council meetings on a timely basis.				
3. Council's meetings are effective and efficient.				
4. The President chairs Council meetings in a manner which enhances performance and decision-making.				
5. I feel comfortable participating in Council discussions.				
6. Council has a formal written orientation package for Council.				
7. My orientation to the College Council was effective.				
8. I am aware that Council has a mentorship program.				
9. Council's mentorship program is helpful.				
10. I find Council's continuing education activities useful.				

COMMENTS: X

180-22

2017

Council Performance Assessment Form

F. RELATIONSHIP WITH REGISTRAR	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I understand that a committee of Council that reports to the Executive Committee approves the Registrar's annual performance objectives and conducts the Registrar's annual performance review.				
2. The President asks Council for feedback which informs the Registrar's performance review and advises Council of the outcome of the review.				
3. The Council maintains a collegial working relationship with the Registrar.				
4. The Council does not get involved in day-to-day operational matters.				
5. Committees do not get involved in day-to-day operational matters.				

COMMENTS: X

180-23

2017
Council Performance Assessment Form

STRENGTHS AND DEVELOPMENTAL NEEDS:

1. **List two strengths of the Council:**

X

2. **List two ways Council could be improved:**

X

3. **Additional Comments:**

X

Save File

Print

Council Committee Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Bill 87 Updates to College Policies and Boundaries & Sexual Abuse Module
2. Medical Assistance in Dying – Policy Update and Coroner's Lessons Learned
3. Marijuana for Medical Purposes Update – Draft *Cannabis Act*
4. Policy Consultation Update:
    I. Confidentiality of Personal Health Information
5. Policy Status Table

---

1. Bill 87 Updates to College Policies and Boundaries & Sexual Abuse Module

- Bill 87, the *Protecting Patients Act, 2017*, received Royal Assent May 30, 2017. Among other things, it contains a series of amendments to the *Regulated Health Professions Act, 1991 (RHPA),* responding partially to the Sexual Abuse Task Force report and the Goudge review.

- A number of amendments to the *RHPA* contained in Bill 87 came into force upon Royal Assent. Some of these amendments have implications for College policies and the College's *Professionalism and Practice Program* Boundaries & Sexual Abuse Module, including:

    - An expanded list of acts of sexual abuse that require mandatory revocation;[1]
    - An expanded list of acts to which mandatory revocation applies;[2]

[1] Section 51(5), paragraph 3 of the Health Professions Procedural Code, Schedule 2 of the *RHPA* (HPPC).

- Mandatory suspension where mandatory revocation doesn't apply;[3] and
- An increase in maximum fines for failing to make a mandatory report.[4]

- As such, minor updates have been made to related College policies (*Maintaining Appropriate Boundaries and Preventing Sexual Abuse*; *Physician Treatment of Self, Family Members or Others Close to Them*) and the Boundaries & Sexual Abuse Module to ensure they accurately reflect the provisions in Bill 87 that are currently in force. These minor updates are outlined below.

Maintaining Appropriate Boundaries and Preventing Sexual Abuse Policy

- A comprehensive review of the College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* Policy will commence in 2017. Minor updates to reflect relevant content from Bill 87 have been made in the interim.

- The majority of the updates were to the footnotes/endnotes of the policy. The key updates were as follows:

  - A note was added to the 'Purpose' section of the policy to clarify that the legislative provisions in the policy include the amendments to the *RHPA* contained in Bill 87 that are currently in force, and does not include the provisions that have yet to be proclaimed, along with any other requirements that will be developed in regulation.
  - The 'Background' section and corresponding notes (4-5) were updated to reflect the expanded acts of sexual abuse that require mandatory revocation, the expanded list of acts to which mandatory revocation applies, and the fact that the penalty ordered by the Discipline Committee must at least include a reprimand and suspension when mandatory revocation for sexual abuse is not required.
  - The 'Background' and 'C. Sexual Relationships after Termination of the Physician-Patient Relationship' sections of the policy were updated to prevent any confusion regarding the new definition of "patient" that will be proclaimed in the future. These sections no longer explicitly state that once a physician-patient relationship has ended, it is not defined as sexual abuse in the *RHPA*.
  - Notes 9 and 12 were updated to advise physicians that there are amendments to the Health Professions Procedural Code (HPPC) in Bill 87 that have yet to be proclaimed, along with a regulation to be developed, that will establish criteria for the definition of "patient" in relation to professional misconduct involving sexual abuse. This will specifically include defining an individual as a "patient" for at least one year following termination of the physician-patient relationship. Once this provision is in

[2] Section 51(5) of the HPPC.
[3] Section 51(5.2) of the HPPC.
[4] Section 92(3) of HPPC

force, a physician who has a sexual relationship with a former patient within one year of the end of the physician-patient relationship would be found to have engaged in sexual abuse.

- Minor updates were made to 'Section E. Mandatory Duty to Report Sexual Abuse', to reflect the new title of the College's *Mandatory and Permissive Reporting* policy and the new sexual abuse reporting requirement for facility operators that was included in the policy when it was reviewed and updated in 2012.

- Minor updates were also made to the formatting of the legislative references throughout the policy.

- The updated policy has been posted on the College's website.

Physician Treatment of Self, Family Members or Others Close to Them Policy

- A comprehensive review of the College's *Physician Treatment of Self, Family Members or Others Close to Them* policy was recently conducted and the updated policy was approved by Council in 2016.

- Minor updates to reflect relevant content from Bill 87 were made to footnote/endnote 17 of the policy to:

    - Accurately reflect the legislative provisions relating to sexual abuse; and
    - Advise physicians that the legislative provisions in the policy include the amendments to the HPPC contained in Bill 87 that are currently in force, but do not include the provisions that have yet to be proclaimed, along with any other requirements that will be developed in regulation.

- The updated policy has been posted on the College's website.

Boundaries & Sexual Abuse Module

- The College's *Professionalism and Practice Program* Boundaries & Sexual Abuse module was finalized and made available to all Ontario schools of medicine in November 2016.

- Minor updates were made to the Power Point presentation included in the module. These updates reflect relevant content from Bill 87. The updates made were as follows:

    - The 'notes' section of slide 30 was updated to reflect the changes made to the list of acts in Section 51(5) which would result in mandatory revocation of a member's certificate of registration.

  - The maximum fine for failure to report sexual abuse of a patient was updated on slide 35. Additionally, the 'notes' section of slide 35 was updated to reflect the changes made to Section 93(2), which indicates the maximum fine for failure to report the sexual abuse of a patient.

- Minor updates were made to the case studies document. One case was updated as follows:

  - Case #11 (duty to report sexual abuse) was updated to reflect the changes made to Section 93(2), which indicates the maximum fine for failure to report the sexual abuse of a patient.

- The updated Boundaries & Sexual Abuse module has been posted to the *Professionalism and Practice Program* section of the College's website.

Next Steps

- A comprehensive review of the *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy will commence in 2017. It will include consideration of the amendments to the *RHPA* that have yet to come into force, along with any other requirements that will be developed in regulation.

- Once the outstanding amendments to the *RHPA* are proclaimed, along with any other requirements that are developed in regulation, other related College policies (*Physician Treatment of Self, Family Members or Others Close to Them*; *Mandatory and Permissive Reporting; Ending the Physician-Patient Relationship*) and the Boundaries & Sexual Abuse Module will be reviewed to evaluate whether any additional updates are required.

- Council will be kept appraised of this work.

2. Medical Assistance in Dying - Policy Update and Coroner's Lessons Learned

- As Council is aware, in early May the province's *Medical Assistance in Dying Statute Law Amendment Act, 2017* (Bill 84) received Royal Assent and is now in force.

- In order to ensure that the College continues to provide accurate and timely guidance on MAID to the profession, the *Medical Assistance in Dying* policy has been updated to reflect the provincial MAID legislation.

- The revised policy is now posted on the College's website. The changes made to the policy are not substantive and do not alter the College's policy positions with respect to MAID. The revisions are to ensure alignment with provincial law.

- In addition to updates to the MAID policy, revisions have also been made to three supporting documents to reflect the provincial MAID legislation: (1)MAID Policy FAQs; (2) MAID Policy: 10 Things the Patient Should Know; and (3) Effective Referral Fact Sheet. As with the policy updates, these revisions are meant to ensure alignment with the provincial MAID legislation.

- An overview of policy updates are provided below.

Reporting Obligations

- The updated policy includes a new section titled, *Reporting Obligations,* that sets out physicians'obligation under the *Coroners Act* to notify the Office of the Chief Coroner of a medically assisted death.

- In fulfilling this reporting obligation, physicians must provide the Coroner with any information about the facts and circumstances relating to the medically assisted death that the Coroner considers necessary to determine whether the death ought to be investigated.

- The Coroner's office has advised College staff that this reporting obligation would typically be fulfilled by the physician contacting the Coroner and submitting the section(s) of the patient's medical record that pertains to the medically assisted death.

- Instructions on fulfilling this reporting obligation, including contact information for the Coroner's MAID Review Team, has been included in the updated policy.

Medical Record Keeping

- As indicated above, the patient's medical record will most often form the basis of a report to the Coroner's Office regarding a medically assisted death.

- To assist physicians in fulfilling their reporting obligation to the Coroner, the *Medical Record Keeping* section of the policy has been updated to provide physicians with additional guidance on the MAID-related information that must be documented where MAID is provided. This information includes:

    - The start and end-date of the required 10-day reflection period between the patient's signed request for medical assistance in dying and the date on which medical assistance in dying is provided;
    - The rationale for shortening the 10-day reflection period, if applicable (i.e. both clinicians and/or nurse practitioners are of the opinion that the patient's death or loss of capacity is imminent);
    - The time of the patient's death; and
    - The medication protocol utilized (i.e. drug type(s) and dosages).

Completion of Death Certificate

- Flowing from Bill 84, amendments to the *Vital Statistics Act* stipulate the parties who are authorized to complete the death certificate where MAID is provided, and in what circumstances. The policy has been updated to reflect these amendments.

- Specifically, upon receipt of a report regarding a medically assisted death, if the Coroner determines that an investigation is not required, the attending physician or nurse practitioner who provided MAID would complete the death certificate. However, if the Coroner is of the opinion that the death ought to be investigated, the death certificate must be completed by the Coroner.

- Further, this section of the policy now includes specific instructions on what physicians are to write on the death certificate where MAID is provided. Direction in this regard was provided by the province to all physicians following the proclamation of Bill 84. The CPSO circulated this guidance to the membership as part of the May 2017 Council Update.

- In accordance with this direction, the illness, disease or disability leading to the request for MAID must be recorded on the death certificate as the underlying cause of death. Physicians are to make no reference to MAID, or the drugs administered to achieve MAID on the death certificate.

Data Collection

- The previous iteration of the policy stated that the federal government had committed to creating a formal oversight and reporting body to collect data on MAID.

- Although a MAID reporting framework remains under development, the precise framework is unclear at this time.

- Given this uncertainty, the *Data Collection* section of the policy has been revised to indicate that federal data collection regulations remain under development, and the College will keep members abreast of any developments in this regard.

Coroner's Lessons Learned – Update Planned

- The College is collaborating with the Coroner's Office on an update to the MAID Early Lessons Learned document. Council will recall that this resource captures key issues identified by the Office of the Chief Coroner in fulfilling their MAID monitoring and oversight role.

- It is anticipated that the updated document will be released later this summer. Updates will include further guidance on record keeping in the MAID context; the

limited circumstances where the 10-day reflection period may be shortened; and the appropriate sequencing of events when fulfilling the legal requirement that a patient's written MAID request be witnessed.

Next Steps

- The College will continue to monitor all aspects of MAID closely and will keep Council apprised of developments.

3. Marijuana for Medical Purposes: Draft *Cannabis Act*

- On April 13, 2017, the Government of Canada introduced draft legislation (the *Cannabis Act*) which aims to fulfill their commitment to create a legal framework for the production, distribution, sale, and possession of marijuana for recreational purposes in Canada.

- The draft *Cannabis Act* follows public consultation, and has been informed by the recommendations of the Federal Task Force on Cannabis Legalization and Regulation.

- The draft *Cannabis Act* does not propose to alter the legal framework[5] which authorizes the use of marijuana for medical purposes in Canada, and which forms the basis of the College's *Marijuana for Medical Purposes* policy. Instead, the Federal Government has proposed two parallel but separate legal frameworks for recreational and medical marijuana.

Key provisions of the draft *Cannabis Act*

- If enacted as drafted, the *Cannabis Act* would:

    - Permit the legal sale of marijuana for recreational purposes to people who are 18 years of age or older;
    - Decriminalize the possession of fewer than 30 grams of cannabis (or its equivalent[6]) in public (possession in private would be allowed without the 30 gram limit);
    - Permit the possession of up to four plants per household, at a maximum height of one meter from a legal seed or seedling;
    - Eliminate criminal prosecution and criminal records for individuals under the age of 18 who possess small amount of marijuana (≤ 5 grams or its equivalent);

[5] *Access to Cannabis for Medical Purposes*, SOR/2016-230.
[6] This acknowledges the fact that marijuana for recreational purposes may be available in non-dried formulations, such as baked goods or oils.

- As with the medical regime, the *Cannabis Act* would establish a licensing framework for the production, importation, exportation, testing, packaging, labeling, sending, delivery, transportation, sale, possession and disposal of marijuana.

Implications for physicians

- As drafted, the *Cannabis Act* does not propose to alter the process for obtaining marijuana for medical purposes, and does not have direct implications for College policy; however, there are a numbers of ways in which the proposed legislative requirements for accessing marijuana for recreational purposes differ from the existing requirements (in policy and legislation) for accessing marijuana for medical purposes.

i. The minimum age of possession/use

Approach proposed by the draft *Cannabis Act*	Approach currently undertaken in the medical framework	General implications
The draft *Cannabis Act* proposes to establish a national minimum age of purchase and possession for recreational marijuana of 18 years, which is consistent with the recommendations of the Federal Task Force.[7]	While there is currently no minimum age for the possession/use of marijuana for medical purposes in legislation, the College's Marijuana for Medical Purposes policy limits the prescribing of marijuana to patients over the age of 25, except in very limited circumstances.[8] This reflects evolving evidence which suggests that the consumption of marijuana in adolescence	Should the *Cannabis Act* be enacted as drafted, it may effectively result in a lower minimum age of possession for recreational marijuana than is generally permitted by the College's policy for the purposes of medical use.

[7] In establishing 18 as the recommended minimum age of use/possession, the Task Force sought to balance the risk of harm posed by marijuana to the health of teens and young adults, with a practical recognition that young Canadians are significant consumers of illicit marijuana globally, and that forcing young Canadians to continue procuring marijuana from illegal sources would expose them to additional harms, potentially including more dangerous illicit drugs.

[8] These conditions include that all other conventional therapeutic options have been attempted and failed to alleviate the patient's symptoms, and that even after all other conventional therapeutic options have been exhausted, physicians are still satisfied that the anticipated benefit of marijuana outweighs its risk of harm.

	and early adulthood may have negative effects on the developing brain.	

ii. Limits on quantity permitted for personal possession

Approach proposed by the draft *Cannabis Act*	Approach currently undertaken in the medical framework	General implications
The draft *Cannabis Act* proposes to implement a personal possession limit of 30 grams of dried marijuana (or its equivalent) *in public* for recreational use, with a corresponding sales limit. It does not appear to limit the total amount of marijuana an individual can possess for personal use when they are not in public, and it does not appear to limit the frequency with which individuals are permitted to make additional purchases.	Under the medical regime, physicians are able to effectively restrict the quantity of marijuana a patient is permitted to possess at any one time: legislation limits patient to possession of a maximum of 30x the prescribed daily dosage. While legislation does not limit the quantity of marijuana a physician is permitted to prescribe, the College's Marijuana for Medical Purposes policy and available clinical recommendations emphasize prescribing the lowest quantity necessary to achieve symptom improvement.[9]	Should the *Cannabis Act* be enacted as drafted, it may permit individuals to purchase and possess greater quantities of dried marijuana (or its equivalent) for recreational purposes than would generally be possible under the medical regime.

- Overall, the draft *Cannabis Act* appears to propose establishing a framework for accessing and possessing recreational marijuana that may be more permissive than the parallel medical framework.

- Should the recreational framework prove to be more convenient and less expensive, individuals may become less likely to seek access to marijuana for

[9] For example, the College of Family Physicians of Canada released preliminary recommendations for the prescribing of dried cannabis for pain or anxiety, and they recommend prescribing no more than 400mg per day of 9% THC, or 12 grams per month.

medical purposes through their physician, and more likely to seek it out through commercial sales. Patients who are receiving a valid prescription for marijuana from their physician may also be more likely to supplement that prescription with marijuana purchased from a commercial source.

Next Steps

- Staff will continue to monitor the progress of the Cannabis Act and any related legislation to determine whether further consideration or action is needed, and all new developments will be communicated to Council at future meetings.

4. Policy Consultation Update

I. Confidentiality of Personal Health Information

- The Confidentiality of Personal Health Information policy is currently under review. The policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.

- As part of the policy development process, a preliminary external consultation was conducted between May 31 and July 31, 2017.

- The College received a total of 121 responses to this consultation (70% physicians, 14% members of the public, 7% other health care professionals, 7% organizations,[10] 1% medical students, and 2% who preferred not to say). These include 15 comments on the College's online discussion page and 106 online surveys.[11]

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website once analysis is complete.

- Stakeholders provided feedback covering a range of issues pertaining to the confidentiality of personal health information. A few of the key themes that have emerged throughout the consultation are outlined below.

[10] Organizations include: Information and Privacy Commissioner of Ontario, the College of Physicians and Surgeons of Saskatchewan, Mount Sinai Hospital, Sick Kids Hospital, The Ottawa Hospital, the University of Ottawa, the Canadian Armed forces, and the Ontario Medical Association.
[11] 108 respondents started the survey, but of these, 2 did not complete at least one substantive question, leaving 106 surveys for analysis.

i. General Comments

- The majority of respondents felt that the current policy is clear and comprehensive. However, others commented that given the complexity of legal requirements pertaining to the confidentiality of patient information, that the policy could be further simplified to ensure expectations are easily understood by a broad audience.

- Many respondents asked for examples to help clarify who would be considered to be within a patient's circle of care, how lock boxes are to be operationalized, and to provide insight into whether a physician can refuse care if the use of a lock box hinders their ability to safely provide care.

ii. Specific Comments and Suggestions

- **Electronic records and communication:** Consultation feedback included comments from physicians and patients on maintaining patient confidentiality where technology is relied upon. Of the physician respondents who completed the consultation survey, the majority indicated that they used an EMR/EHR solely, or in combination with paper records. The majority of non-physician respondents indicated that they did not have the option to communicate with their physician electronically, but that they would be comfortable, or somewhat comfortable, doing so.

- **Consent to disclose:** A majority of survey respondents indicated that the distinction between express and implied consent was clearly articulated in the current policy. However, a significant minority indicated it was not. Some respondents stated that it is not sufficiently clear when it is appropriate to rely upon implied consent, and when it is not. Some non-physician respondents voiced concern that implied consent is relied upon too liberally by health care providers.

- **Disclosure to authorities/others:** In the open-ended feedback, some respondents requested further clarity on the circumstances in which it would be appropriate to disclose personal health information to authorities that are not within the circle of care. Examples given included disclosure to the police, the courts, and the LHINs.

- **Legislative updates:** The Information and Privacy Commissioner of Ontario noted that in the next iteration of the policy, updates will be needed to reflect changes to PHIPA resulting from the passing of the *Health Information Protection Act, 2016*. It was suggested that although the provisions around electronic health records are not yet in force, that the next iteration of the policy should include information about health information custodians' responsibilities with regards to the electronic health record.

Next Steps

- All feedback received will be carefully reviewed alongside the research findings as a new draft policy is developed.

- Once a draft policy has been developed it will be presented, along with the full analysis of feedback received during the preliminary consultation, to the Executive Committee and Council for consideration.

5. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix A**. This table will be updated at each Council meeting.

- For further information about the status of any policy issue, please contact Andréa Foti, Manager, Policy, at extension 387.

DECISIONS FOR COUNCIL:

For information only

Contact: Andréa Foti, Ext. 387

Date: August 18, 2017

Appendices:

A. Policy Status Table

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Re-entering Practice	The current policy sets out expectations for physicians who wish to re-enter practice after a prolonged absence from practice and sets out requirements of physicians in demonstrating their competence in the area of practice they are returning to.	This policy is currently under review and being reviewed in tandem with the Changing Scope of Practice policy in light of the common principles and processes related to ensuring competence when changing scope of practice and re-entering practice. The two current policies have been combined into a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* has been developed and will be presented for consideration to consult externally at the September 2017 meeting of Council. Further information can be found in the Briefing Note contained in Council's September 2017 meeting materials.	2018
Changing Scope of Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice and sets out requirements of physicians in demonstrating their	This policy is currently under review and being reviewed in tandem with the Re-entering Practice policy in light of the common principles and processes related to ensuring competence when changing scope of practice and re-entering practice. The two current policies	2018

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	competence in the new area of practice.	have been combined into a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* has been developed and will be presented for consideration to consult externally at the September 2017 meeting of Council. Further information can be found in the Briefing Note contained in Council's September 2017 meeting materials.	
Prescribing Drugs	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.	Minor updates are being proposed to the Prescribing Drugs policy to reflect the new 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. This is an interim step to fulfill a commitment made by the College to update the policy by December, 2017. Council will consider this updated policy at their September, 2017 meeting. A full review of the policy is scheduled to begin in late 2017 / early 2018.	2017
Block Fees and Uninsured Services	The current policy sets out the College's expectations of physicians who charge patients for services not paid for by the Ontario Health Insurance Plan	This policy is currently under review. A newly titled Uninsured Services: Billing and Block Fees draft policy was approved for external consultation by Council in February 2017. The draft policy is being revised in light of the	2017

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	(OHIP).	feedback received, and a final draft of the policy will be presented to Council for consideration for final approval later this year.	
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy helps physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991 (RHPA)* regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	This policy is currently under review. The review will be informed by the College's Sexual Abuse Initiative, the Minister of Health and Long-Term Care's Task Force on the Prevention of Sexual Abuse of Patients, and Bill 87, the *Protecting Patients Act, 2017*. The initial stages of the review are underway and a preliminary consultation is scheduled to commence after the September Council meeting. The specific timelines for the review are dependent on when the outstanding provisions in Bill 87 will be proclaimed, and when the regulations that are alluded to in the Bill will be developed. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of	This policy explains the practice management measures physicians should take when they cease to practise or will not be practising for an extended period	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken between June and August, 2016. Further updates with respect to the status of this review	2018

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Absence or Close Their Practice Due to Relocation	of time.	will be provided at a future meeting.	
Physicians and Health Emergencies	The purpose of this policy is to reaffirm the profession's commitment to the public in times of health emergencies.	This policy is currently under review. A new draft policy entitled *Physician Services During Disasters and Public Health Emergencies* will be presented for considerationto consult externally at the September 2017 meeting of Council. Further information can be found in the Briefing Note contained in Council's September 2017 meeting materials.	2018
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	This policy is currently under review. A joint Working Group has been struck to undertake this review alongside the development of a new *Continuity of Care* policy. A preliminary consultation was undertaken between June and August, 2016. The working group has considered the feedback received and the research findings, and the development of a new draft policy that incorporates test results management is underway	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and	2018

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of the *Test Results Management* policy. A preliminary consultation was undertaken between June and August, 2016. The working group has considered the feedback received and the research findings and the development of a new draft policy is underway.	
Confidentiality of Personal Health Information	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was held between May and July 2017. Further information on preliminary consultation results and next steps may be found in the Policy Report included in your Council materials.	2018
Medical Records	This policy sets out the essentials of maintaining medical records.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation is scheduled to commence after the September Council meeting. Further updates with respect to the status of this review will be provided at a future meeting.	2019

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015/16	This policy provides guidance to physicians on disclosing harm to patients. The review of this policy has been deferred, due to competing priorities.
Fetal Ultrasound for Non-Medical Reasons	2015/16	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds. The review of this policy has been deferred, due to competing priorities.
Female Genital Cutting (Mutilation)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation. The review of this policy has been deferred, due to competing priorities.
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine.
Dispensing Drugs	2016/17	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016/17	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Third Party Reports	2017/18	This policy clarifies the College's expectations regarding physicians' roles in and standards of care for conducting medical examinations and/or preparing reports for third parties.
Delegation of Controlled Acts	2017/18	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Mandatory and Permissive Reporting	2017/18	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.
Prescribing Drugs	2017/18	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.
Anabolic Steroids, Substances and Methods Prohibited in Sport	2018/2019	The current policy articulates the College's expectations of physicians regarding the use of anabolic steroids and other substances and methods for the purpose of performance enhancement in sport (i.e., doping).
Social Media – Appropriate Use by Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest:	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)		September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making for the End of Life)	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.

POLICY STATUS REPORT – SEPTEMBER 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Members		
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.
Accepting New Patients	2022/23	This policy sets out the College's expectations of physicians when accepting new patients.
Ending the Physician-Patient Relationship	2022/23	This policy sets out the College's expectations of physicians when ending the physician-patient relationship.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2018 Council and Executive Committee Meeting Dates

Meeting	Date
Executive Committee	Thursday, January 18
Council Orientation	Thursday, February 22
Council	Friday, February 23
Executive Committee	Tuesday, March 20
Executive Committee	Tuesday, April 24
Council	Thursday, May 24 Friday, May 25
Executive Committee	Tuesday, June 19
Executive Committee	Tuesday, August 7
Council	Friday, September 7
Executive Committee	Tuesday, October 2
Executive Committee	Tuesday, November 6
Council	Thursday, December 6 Friday, December 7

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2017

TOPIC: **GOVERNMENT RELATIONS REPORT**

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Issues of Interest
3. Government Relations Activities

ONTARIO'S POLITICAL ENVIRONMENT:

- The fall session of the Legislature is scheduled to begin on Monday, September 11th and rises December 14, 2017.
- The next provincial election is scheduled for June 7, 2018, only nine months away. The last possible day for the election call (when the writ could be dropped) is May 9, 2018. It is possible that the government will call the election early, although this would not likely occur before the spring of 2018 – perhaps following the delivery of the Budget in March or April 2018.
- In the next general election, the number of electoral districts will increase from 107 to 124, assuming legislation passes this fall. This legislation would add two additional ridings to the already 15 new provincial ridings added to line up with the new federal riding boundaries and accommodate growth in the Greater Toronto Area and in Ottawa. These two additional ridings would bring forward the recommendations of the Far North Electoral Boundaries Commission, to enhance Indigenous and Francophone representation at Queen's Park.
- At this point, none of the political parties have nominated all of their candidates for the 2018 election; although the PCs are the furthest ahead with close to 100 candidates nominated, as of the writing of this note. The Liberals have nominated about 34 candidates and the NDP 25.
- The PCs have faced questions about some nomination meetings with allegations that voting rules have been breached. Hamilton police recently launched a criminal investigation into the events surrounding a May 7th nomination meeting for the riding of Hamilton West-

Ancaster-Dundas. There are also allegations in the ridings of Ottawa West-Nepean, Scarborough Centre, and Newmarket-Aurora.

- However, the PCs recruitment of Caroline Mulroney, daughter of a former Prime Minister for the riding of York-Simcoe has been well received. The PCs have also continued to be encouraged by high polling numbers and their record setting $16.1 million in political fundraising in 2016 that has far out-paced the other political parties.
- While the governing Liberals have continued to lag in the polls, there has been some upwards movement over the past few months and undoubtedly the government will be looking to increase these gains over the coming weeks and months with a busy upcoming legislative agenda. Lower hydro rates and prescription drug coverage for all Ontarians under 25 (to take effect on January 1, 2018), as well as broad workplace reforms are some of the key planks the government is hoping will work to increase their standing in the polls.
- In September, two court cases alleging corruption are set to begin. The so-called Sudbury byelection bribery scandal will commence on September 7th with charges laid under the Elections Act against the Premier's former deputy chief of staff Patricia Sorbara and Liberal fundraiser Gerry Lougheed. Only four days later, on September 11th, the prosecution of two top McGuinty aides over the cancellation of two gas plants in 2011 will also begin. The trials are scheduled to wrap up in October.
- Liberal MPP and Minister of Environment, Glen Murray announced his resignation from politics as of September 1st. Murray is set to become the head of the Alberta-based environmental organization, Pembina, as of September 5th. The Premier decided not to call a byelection to replace Murray, pointing to the significant costs of a byelection and the fact that a general election is not far off.
- A number of other prominent MPPs have also announced that they will not seek re-election in 2018. This includes Liberal Dave Levac, and the longest serving female MPP in Ontario's history, PC Julia Munro, has also announced that she will retire from politics in 2018. Munro was first elected in 1995 and has been a very dedicated and accessible MPP.
- The political chatter has been fairly quiet over the summer but with the return of the Legislature in the fall, and a provincial election nearing closer, we can expect an increased focus on legislative and political issues over the coming months.

ISSUES OF INTEREST:

Bill 87, the Protecting Patients Act, 2017

- Bill 87, the *Protecting Patients Act, 2017*, received Royal Assent May 30, 2017. Among other things, it contains a series of amendments to the *Regulated Health Professions Act, 1991 (RHPA)* responding partially to the Sexual Abuse Task Force report and the Goudge review.
- Implementation of Bill 87 is significant and work is underway at the College to ensure implementation of those sections of Bill 87 that are now in force and those that will be in the future. This work includes:
    - Assessment of open investigations and referrals.

  - Evaluation of the need for program changes to support the funding for therapy program and the impact on the Patients Relations Committee once those provisions come into force.
  - Minor updates have been made to related College policies (Maintaining Appropriate Boundaries and Preventing Sexual Abuse; Physician Treatment of Self, Family Members or Others Close to Them) and the College's Professionalism and Practice Program Boundaries & Sexual Abuse Module to ensure they accurately reflect the provisions in Bill 87 that are currently in force.
  - A comprehensive review of the Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy has begun. It will include consideration of the amendments to the RHPA that have yet to come into force, along with any other requirements that will be developed in regulation.
  - Assessment of new transparency obligations.
- Work is also underway to prepare for the implementation of amendments that will come into force at a later time.
- Council will be provided with implementation updates.

Public Member Appointments

- Advocacy has continued for changes to public member compensation rates and the appointment process more generally.
- The College has raised these concerns for many years and there has been limited progress with regards to the administration of claims and the application of the per diem rates.
- There are currently two public member appointment vacancies. We have been assured that the government is working to fill these vacancies in a timely manner.
- Conversations will continue about how to best modernize and streamline the appointment process and ensure that prospective public members are provided with accurate information about the time commitment and responsibilities of the position.
- Given that we are about to enter an election period, a time where public appointments typically slow down, we are working to ensure that the full quota of public members remains a priority for the government.

Other issues

- As the government is approaching the end of its mandate, there are quite a few loose ends that they are working to tie up including scope of practice changes (RN prescribing), governance reforms, and other potential changes to the regulatory system and the *RHPA.*
- Many of these areas will be of interest to the College and we anticipate that we will have a busy fall and winter contributing to and responding to these initiatives.
- Additionally, the College's work alongside and apart from government in areas such as MAID and the collaborative work to address Canada's opioids crisis will also remain a focus in the coming months.

GOVERNMENT RELATIONS ACTIVITIES:

- The College is in contact with a variety of government decision-makers to ensure that they have accurate and up-to-date information about the College, our activities, and our role in protecting the public interest. We have regular interaction with the senior decision-makers and all political parties at Queen's Park.
- Finally, the College continues to work particularly closely with government decision-makers on areas of shared focus including medical assistance in dying, oversight of fertility services and the regulation of out-of-hospital facilities, compensation of public members of council, the ongoing work to increase College transparency, and issues surrounding opioid and medication management.
- Given the number of very active files with government, and the nearing election, we anticipate that the next six months will be very busy.

This item is for information

Contact: Louise Verity, Ext. 466
Miriam Barna, Ext. 557

Date: August 18, 2017

Federation of Medical Regulatory Authorities of Canada

Fédération des ordres des médecins du Canada

Snapshot 2016 – 2017

FUTURE OF THE ORGANIZATION

ANNUAL MEETING & CONFERENCE

SURVEYS – MEMBERS AND OTHER STAKEHOLDERS

	I	II	III
June	Annual mtg and Conference	Opioids	MAiD
July	Registration Working Group	Committees Royal College	Annual mtg follow-up
Aug.	Accred'n Integration (*)	CMA General Council	FIRMS End of pilot
Sept.	Board	IAMRA And IPAC	Opioids Action Plan
Oct.	Risk Mgt Committee	PGME Gov. Council (*)	Accred'n integration
Nov.	MSF-360 (*) MCC	Canadian Medical Forum	Opioids Summit
Dec.	Move and settling in	NAC-PRA (*) MCC	FIRMS launch
Jan.	CanMEDS RC and CFPC	AFMC accreditation	Budget preparation
Feb.	Audit and Finance Ctee (*)	Board 2-day mtg	Rural health Care Summit
March	Medical Cannabis	PLDC Royal College	Mandatory CPD Reporting
April	FSMB-US	Mifegymiso Health Canada	AEAC PGME Surveys
May	Audit	CACME Partners' mtg	Physician Health WG

(*) several times over the year

Snapshot 2016 – 2017

Panoramic Version

Main activity in the past year:

- Future of the Organization

Activities that are ongoing throughout the year:

- Annual Meeting and Conference – preparation and program development
- Committee and Working Group meetings
- Surveys of Members and other stakeholders on a wide variety of issues, e.g.:
  - Representation to outside bodies
  - Prescription opioids
  - MAiD
  - Draft physician health document
  - Mandatory CME / CPD
  - Physician licensed in more than one Canadian jurisdiction
  - Licensing fees for physicians who work part-time
  - TOEFL as proof of English language proficiency
  - Operating reserves
  - Certificates of Professional Conduct (http://fmrac.ca/policy-on-disclosure-of-professional-information/)
  - Currency of practice and supervision
  - Mifegymiso
  - Student-run clinics
  - and others

June 2016

- Annual Meeting and Conference – in Banff AB from 10-14 June, including satellite meetings (Board retreat, Special Interest Groups and Physician Factors Group)
- Opioids – the theme of the 2016 FMRAC Conference, resulting in the following messages:

> FMRAC (the Federation of Medical Regulatory Authorities of Canada) and its members, the provincial and territorial medical regulatory authorities, met in Alberta this past week-end. One of the key issues discussed was the role of the MRAs in addressing the opioid public health crisis. It was agreed that, in addition to any specific provincial or territorial initiatives that were underway, there was a need for:
>
> - a cohesive regulatory approach across the country, including access to usable prescribing data that identify physicians who may not be prescribing safely
> - full implementation of effective prescription drug monitoring programs that provide information in real time (and across jurisdictions) to physicians and pharmacists to identify patients who may be multi-doctoring
> - enhanced education and prevention programs
> - strategic partnerships with key stakeholders such as educational colleges, regulatory partners (including pharmacy), governments and law enforcement.

- Medical Assistance in Dying (MAiD) – the second theme of the 2016 FMRAC Conference, with FMRAC agreeing to "wait and watch" further developments by the Federal Government, especially with respect to the three outstanding issues, i.e., mature minors, advance requests and requests where mental illness is the sole underlying medical condition.

July 2016

- Registration Working Group – addressed (a) implementation of the FMRAC *Model Standards for Medical Registration in Canada* (http://fmrac.ca/model-standards-for-medical-registration-in-canada-2/); (b) a request from the Application for Medical Registration in Canada (www.physicainsapply.ca) to consider hosting a common postgraduate training application form;(c) follow-up to the June 2016 Board workshop on routes to certification; (d) a common approach to gender neutral language in registration and licensure processes; and (e) cases of misrepresented credentials.
- Committees – Royal College and CFPC: illustrates the various outside committees to which staff and several MRA representatives devote time and effort, including working between meetings.
- Annual Meeting and Conference follow-up – evaluation; preliminary consideration for the 2017 event; and advocating at a pan-Canadian level for every province and territory to have a prescription monitoring program, with the data collected to be shareable across jurisdictions and accessible to medical regulatory authorities, physicians and other stakeholders.

August 2016

- Integration Committee (jointly among Royal College, CFPC and CMQ) – work on the revised standards, including rewording the broad standards to focus on an outcomes-based approach.
- CMA General Council – in Vancouver; the President and the Executive Director & CEO attended GC as well as the CMPA Annual Meeting and Educational Session (on opioid prescribing).
- FMRAC Integrated Risk Management System – the pilot involving three medical regulatory authorities was completed; FMRAC and HIROC agreed on co-branding for FIRMS.

September 2016

- Board of Directors – among other issues, the Board agreed to participate in the Opioid Prescribing Communication Strategy, and discussed Health Canada's request to identify action items for the upcoming *2016 Opioid Summit*. The Board reaffirmed the organizational priorities (MAiD, prescription opioids, physician practice improvement, physician health and FIRMS).
- International Association of Medical Regulatory Authorities (IAMRA) and International Physician Assessment Coalition (IPAC) in Melbourne, Australia – three presentations on physician practice improvement, FIRMS and regulation of physician assistants.
- Opioid Action Plan –

ACTION: The Board decided that Opioid Prescribing will be the theme of the June 2017 FMRAC Annual Conference, for the second year in a row. FMRAC hopes to have the revised Canadian guideline on opioid use for chronic, non-malignant pain by then, and some movement on the creation of useful and usable prescription monitoring programs. The conference will focus on both aspects of the prescription opioid crisis: (a) preventing the initiation of the use of prescription opioids; and (b) assisting those who are already on opioids to overcome their need for those drugs (including the paramount obligation of physicians not to abandon patients).

ADDITIONAL ROLE FOR FMRAC AND ITS MEMBERS: FMRAC and the medical regulatory authorities require data in order to do their work properly, hence FMRAC's repeated and ongoing request for prescription monitoring programs across the country. As stated above, FMRAC is also awaiting the release of the draft revised Canadian guideline.

While these are not actions per se, FMRAC must emphasize that, in the end, the medical regulatory authorities will be "at the pointy end of the stick" on anything related to physician prescribing. This means that FMRAC and its members must be at the summit to listen and participate in the discussions, and determine how best to participate in any "actions" going forward.

INDIVIDUAL MEDICAL REGULATORY AUTHORITIES: There may be other suggestions forthcoming from individual medical regulatory authorities that will be shared with Health Canada.

October 2016

- Risk Management Committee – addressed (a) Member feedback pertaining to privacy and transparency of information generated through FIRMS; (b) the results from the pilot study and any necessary changes; (c) the ongoing development of the "peer collaboration model"; and the readiness of FIRMS for launch.
- Postgraduate Medical Education Collaborative Governance Council – final meeting to agree on the mandate of this council before the 2017 inaugural meeting with the first elected Chair.

November 2016

- MSF-360 – initiative led by the Medical Council of Canada for physician in-practice assessment, following on the *FMRAC Physician Practice Improvement System* (http://fmrac.ca/physician-practice-improvement/). The initial tool was developed by CPSA several years ago.
- Canadian Medical Forum – FMRAC is a founding member of this Forum that assembles the Presidents and CEOs of ten national medical organizations, with two observer organizations. It is mostly a forum for discussion and, where appropriate, joint action, e.g., the current *CMF Evolving Role of the Physician Project*.
- Opioids – 18-19 November in Ottawa – Summit on Opioid Prescribing, followed by the meeting to develop the *Joint Statement of Action to Address the Opioid Crisis (*https://www.canada.ca/en/health-canada/services/substance-abuse/opioid-conference/joint-statement-action-address-opioid-crisis.html).

December 2016

- Move to the new office space in the brand new Medical Council of Canada building situated at 1021 Thomas Spratt Place in Ottawa.
- National Assessment Collaboration – Practice-ready Assessment (NAC-PRA) Family Medicine Committee meeting (*Medical Council of Canada*) – http://mcc.ca/about/collaborations-and-special-projects/practice-ready-assessment/
- FIRMS – launched at the end of December 2016 – on time and on budget!
    - *11 sets of standards* (governance, registration and licensure, complaints and resolution, quality assurance of medical practice, facilities accreditation / quality review programs, integrated risk management, finance, human resources, IT, facilities, records management)
    - *Using the HIROC Risk Assessment Checklist platform*
    - *Linking with the HIROC Risk Register*

January 2017

- CanMEDS – finalizing the terms of reference for the CanMEDS Consortium involving 13 medical organizations, including FMRAC; the media released went out the following month: file:///C:/Users/falefebvre/Downloads/canmeds-consortium-media-release-e.pdf
- Association of Faculties of Medicine of Canada – consultation with the Task Force on Undergraduate Medical Education Accreditation
- Annual budget preparation

February 2017

- Audit and Finance Committee – reviewed the draft budget; proposed changes to various policies; received an update on the FMRAC Pension Plan.
- Board of Directors – two-day meeting, including time to discuss the Future of FMRAC.
- Rural Health Care Summit – 22 February in Ottawa, with CFPC and Society of Rural Physicians of Canada (http://www.cfpc.ca/national_summit_focuses_improving_rural_health_care_access/).

March 2017

- Medical cannabis – discussions with the Office of Medical Cannabis at Health Canada on access to information about physician authorizations.
- Professional Learning and Development Committee – Royal College (Dr. Trevor Theman and Ms. Fleur-Ange Lefebvre)
- Mandatory CPD Reporting – once the Board agreed that an indication of "good standing" suffices for the purpose of receiving compliance reports from the national certifying colleges, the following definition was proposed (and subsequently approved):

> *To be considered to be in good standing **(green light)**, physicians must:*
> - *be enrolled in either the Royal College or CFPC Program (i.e., paying dues);*
> - *be participating in the Program to the satisfaction of the certifying college; and*
> - *have completed the requirements of their five-year cycle at the end of the cycle.*
>
> *A physician will be considered to be not in good standing **(red light)** if they:*
> - *are not enrolled (i.e., not paying the dues); or*
> - *are enrolled but:*
> - *are not responding to educational support concerning non-participation (zero credits) after two consecutive years; or*
> - *have not completed the requirements of their five-year cycle at the end of the cycle, as determined by the certifying college.*

April 2017

- Legalization of marijuana – FMRAC was invited to technical briefing in Ottawa on 13 April, while Bill C-45 and Bill C-46 were being introduced in the House of Commons. FMRAC had written to the co-Chairs of the Task Force on Marijuana Legalization and Regulation, requesting that there be no specific category of marijuana for medical purposes in any legislation intended to allow and control the use of marijuana for recreational purposes. This request was not heeded.
- Mifegymiso – FMRAC had several discussions with Health Canada and other stakeholders since April 2016 on the issue of physician prescribing of Mifegymiso and patient access: https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/fact-sheets/mifegymiso-myths-facts.html
- Accreditation and Education Advisory Committee (AEAC) – reviewed the role of FMRAC in accreditation of postgraduate medical programs and made several recommendations for the Board to consider on 10 June 2017.

May 2017

- Audit of FMRAC's finances and compliance with financial policies – two-day visit by representatives from Tinkham and Associates.
- Committee on Accreditation of Continuing Medical Education – FMRAC is one of eight partners on this committee, contributing approximately $15,000 / year. The meeting was hosted by AFMC and was focused on a review of the current system and possible ways to streamline the processes (and costs).
- Physician Health Working Group – discussed the feedback received from the external consultation on the draft *FMRAC Framework on a Regulatory Approach to Physicians with Health Conditions*. The group is recommending that this framework be approved by the Board at its meeting on 10 June 2017.

Discipline Committee
Report of Completed Cases - September 2017

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between May 6, 2017 and August 17, 2017. The decisions are organized according to category, and then listed alphabetically by physician last name.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Council Meeting Minutes of May 25/26, 2017**

Date of Meeting: **September 8, 2017**

It is moved by _____,

and seconded by_____, that:

The Council accepts the minutes of the meeting of the Council held on May 25/26, 2017.

- OR -

The Council accepts the minutes of the meeting of the Council held on May 25/26, 2017 with the following corrections:

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September, 2017

Motion Title: **Physician Services During Disasters and Public Health Emergencies - Draft Policy for Consultation**

Date of Meeting: September 8, 2017

It is moved by_____,

and seconded by_____, that:

The College engage in the consultation process in respect of the draft policy "Physician Services During Disasters and Public health Emergencies" (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September, 2017

Motion Title: **The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain – Proposed Updates to the Prescribing Drugs Policy**

Date of Meeting: September 8, 2018

It is moved by_____,

and seconded by_____, that:

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **September 8, 2017**

It is moved by_____,

and seconded by_____, that:

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September, 2017

Motion Title: **Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice - Draft Policy for Consultation**

Date of Meeting: September 8, 2017

It is moved by_____,

and seconded by_____, that:

The College engage in the consultation process in respect of the draft policy "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **New Member Orientation**

Date of Meeting: **September 8, 2017**

It is moved by_____,

and seconded by_____, that:

The College create a new applicant credentialing requirement related to professionalism and self-regulation and in particular, focusing on boundary violations and the prevention of sexual abuse.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **New Member Orientation**

Date of Meeting: **September 8, 2017**

It is moved by_____,

and seconded by_____, that:

The cost associated with the creation and delivery of the new applicant credentialing requirement be borne by the general membership, as opposed to by the new applicants.

Sexual Abuse - 5 cases

1. Dr. A

Name:	Dr. A
Practice:	Gynecology
Practice Location:	Ontario
Hearing:	Contested
Decision Date:	June 14, 2017
Written Decision Date:	June 14, 2017

Allegations and Findings

- Sexual abuse of a patient – **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **not proved**

Summary

Dr. A is an obstetrician/gynecologist. Patient X saw Dr. A for obstetrical prenatal care during her first pregnancy 11 times in 2007. Patient X alleged that in the course of these appointments, Dr. A digitally penetrated her vagina, in the guise of performing a digital vaginal examination, at every visit, except for two or three visits when she was accompanied by others. Dr. A denied performing digital vaginal examinations at any time, and denied touching Patient X's vagina in a sexual or inappropriate manner. The College and Dr. A agreed that there were no medical reasons for Dr. A to perform digital vaginal examinations in the prenatal medical appointments that he had with Patient X.

Patient X testified that during her appointments at Dr. A's office, Dr. A's assistant would take her weight and then would direct her to an examining room, where Dr. A took her blood pressure and then did a Doppler test with gel on her belly. She testified that she specifically recalled Dr. A putting a cloth or towel under her pants' waist in order to keep the gel from the Doppler off her pants. She also recalled after the Doppler examination being given a towel (a paper sheet) by Dr. A, and that Dr. A would leave the room while she undressed from the waist down. She also recalled the nurse giving her the paper sheet on some occasions, and probably telling her to undress from the waist down. On his return, Dr. A would have her lie down and he would insert two fingers in her vagina. Patient X testified that what she believed was a digital vaginal examination happened at every appointment that she attended when unaccompanied.

Patient X testified that she did not know that the alleged internal examinations were not right until this was suggested to her by others in about 2012. Subsequently, a friend told her how to report it to the College. She reported the incidents to the College in 2015, but was not prepared to have the College investigate the matter at that time. When she saw a counsellor for another matter, Patient X told the counsellor of the incidents in 2007 and the counsellor made a mandatory report. Patient X then proceeded with the complaint.

In cross-examination, Patient X testified that her memory of the incidents is better now than it was in the past, as she has been talking to others about the alleged abuse and thinking about it.

Dr. A testified that he had no memory of Patient X. He agreed that there were no medical reasons to perform digital vaginal examinations in the prenatal medical appointments he had with Patient X. Dr. A denied performing digital vaginal examinations at any time, and denied touching Patient X's vagina in a sexual or inappropriate manner. He provided a medical record of Patient X, which documented the medical care he had provided to her. Dr. A's OHIP billings corresponded to the dates in Patient X's medical records.

Dr. A indicated that he has 8,000 to 10,000 patient encounters a year in his practice and during his time in practice, he has had about 130,000 to 140,000 patient encounters. He indicated that in all of his patient encounters, he never did a digital vaginal examination as part of routine pre-natal care.

Dr. A's nurse assistant, who worked at the office at the time, also testified. Her duties were to record patients' blood pressure, weight and the test results of the urine sample, which she did in the chart of Patient X. Also, it was part of her job to clean the examination table and put a clean sheet in the examination table when a patient leaves the examining room after being examined by Dr. A.

Dr. A's assistant indicated that on the days when Patient X had her appointments with Dr. A, there were about 70 patients seen on obstetrical follow-ups by Dr. A. She indicated that if Dr. A conducted digital vaginal examinations on Patient X at every visit, as Patient X indicated, she would have noticed discharge on the sheets on the examining table and that the sheets would have been rumpled. In addition, there would be no top sheet to be rumpled and disposed of if the examination did not involve digital vaginal examination. The assistant also indicated that she would have asked Dr. A if something was wrong and why he conducted a digital vaginal examination as she knew the patients and the reasons for their attendances. Furthermore, given the high volume of patients seen by Dr. A on the days of Patient X's appointments, Dr. A doing digital vaginal examination would have caused an unusual interruption of the flow of the busy, efficient, routine of the day and would have been noticed by the assistant.

The Committee found Dr. A to be credible and his testimony reliable. The Committee also found Dr. A's assistant to be credible and her testimony reliable.

The Committee found that when testifying, Patient X was honest and sincere regarding her memories. However, the Committee found her testimony was not reliable. The Committee found that her overall memory was poor. The Committee did not accept her evidence that her memory of her appointments of 2007 was better today (in 2017) because she had talked to others about them and had thought about them.

The Committee accepted that it is normal and expected that Patient X did not recall details of the appointments with Dr. A as they took place over 10 years ago and did not find it surprising that she did not recognize the face of the office assistant. It was also not unexpected that Patient X did not recall having her abdomen measured to check the fetal growth on any of the 11 visits, nor did she recall that she gave urine samples on each visit. These procedures were recorded in the antenatal record and the Committee accepted that they were done.

Patient X testified she remembered that Dr. A took her blood pressure, when this is not what happened. The Committee accepted the evidence of Dr. A's office assistant that she took Patient X's blood pressure readings, prior to her seeing Dr. A, and that it was she who recorded the readings in the clinical record. This example of her poor memory indicated that Patient X had a mistaken and unreliable memory of Dr. A doing something that he did not do.

Patient X testified that Dr. A would sometimes give her a paper sheet or drape and ask her to undress from the bottom down and then he would leave the room. She indicated that when Dr. A returned, he performed "a digital examination". Dr. A's assistant testified that she would be the one to tell the patient to remove their bottoms and give them a sheet or drape on the date when the 36 week vaginal swab was to be completed. The assistant also testified that was the only time when she would give patients a drape and have them undress, which was inconsistent with Patient X's evidence that the nurse gave her a sheet and told her to undress from the waist down on occasions when Dr. A performed vaginal examinations. The Committee found Patient X's version of events implausible and inconsistent with the routine of the pre-natal examination and the role of Dr. A's Assistant.

Further, Patient X's testimony was inconsistent in how long the digital vaginal penetration lasted. In her first interview with the College investigators, Patient X said it lasted a few seconds. A few weeks before the hearing, she said that it was 10, 20 or 30 seconds. At the hearing, Patient X testified that it was a minute or less. Patient X's version of events is not consistent with her two earlier statements, varying from a few seconds to one minute. The Committee found that the time element appeared to be embellished, or the memory distorted, as the events were re-told by Patient X.

The Committee found that Patient X had memories of Dr. A doing her blood pressure, doing the Doppler exam, and then giving her a sheet, leaving the room, and returning to penetrate her with his fingers when, in the Committee's view, it was not plausible that this happened. The Committee accepted that, except for the 36 week swab, the assistant did not give Patient X a sheet and tell her to undress from the waist down, nor did Dr. A.

Disposition

The Committee found that the evidence to support the allegations was not clear, cogent and convincing and therefore found the allegations not proven on a balance of probabilities.

2. Dr. B

Name:	Dr. B
Practice:	General Practice
Practice Location:	Ontario
Hearing:	Contested
Decision Date:	June 26, 2017
Written Decision Date:	June 26, 2017

Allegations and Findings

- Sexual impropriety - **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **not proved**

Summary

Dr. B is a general solo practitioner. At the time of the hearing, Patient A was in her late forties. Patient A alleged that when she saw Dr. B as a family doctor for medical appointments about 30 years ago, he massaged her neck and back and touched her vagina and clitoris in a sexual manner. Dr. B denied the allegations.

Patient A's memory of these events was repressed or forgotten for about 30 years. Patient A recalled them either gradually in 2013-2014, or more rapidly during an intake session at the Mood and Anxiety Program at a hospital in October, 2014.

<u>Patient A's Testimony</u>

According to Patient A, she remembered incidents when at the beginning of her appointments Dr. B would leave the room while she undressed. Patient A testified that Dr. B re-entered the room; no one else was present. She testified that on two occasions Dr. B massaged her neck and back, leading to massaging her thighs, vagina, and clitoris. Patient A testified that she does not remember if Dr. B wore gloves, or if he had anything in his hands. She testified that the timing of the appointments was later in the afternoons, after her work. She was unable to remember if the receptionist was still in the office or the length of each appointment. She said, "It seemed like forever, because you're trying to fight off feelings that are normal, but not normal for your doctor to be touching." She believes she saw Dr. B for six to 12 months, and saw him for massage for only a "couple" of appointments.

In about 2013, Patient A began experiencing symptoms of anxiety and depression. Patient A attended an information session at a hospital in October 2014 and indicated she wanted to pursue an assessment and treatment. She attended a clinical intake session conducted by a social worker. At that session, Patient A disclosed that she had been recalling memories of sexual abuse, including with a Toronto doctor, over the past year and a half, coinciding with the onset of anxiety and night sweats. She testified she had not remembered the abuse and "it was only when talking to [the social worker] that I recalled what happened." The social worker communicated with the College and then met again with Patient A to discuss her letter to the College.

A College investigator and intake coordinator met with Patient A on December 18, 2014, and conducted a taped interview, for part but not all of their meeting. There were several areas of inconsistency between the taped interview of 2014 and Patient A's testimony in the hearing as indicated below.

The College investigators showed Patient A a picture of Dr. B from the time period in which she alleged that he engaged in sexual impropriety with her. Patient A could not identify him. The Committee was confident that a doctor-patient relationship existed between Patient A and Dr. B, at some point in time when she resided in Toronto. Patient A provided a blood card dated in February 1987, which listed her doctor as Dr. B. She also provided an accurate description of Dr. B's practice location at the time, which was confirmed by the College investigator.

Ms Z

Ms Z testified that she did not recall Patient A telling her about the alleged incidents, although she and Patient A confided in each other frequently and were close friends at the time. Ms Z testified that she was never a patient of Dr. B.

Dr. B

Dr. B denied the allegations. Although Dr. B testified that he did not recall Patient A and could not find her name in any of his patients' medical records, he did not deny that she could have been his patient.

Dr. B testified that if a patient came to him with severe neck and back pain, he would have conducted a physical examination, which may or may not have been with the patient lying on her stomach. Dr. B testified that at that time he would have also provided the patient with a gown or a drape to cover her while she was on the examining table. In the 1980s there would have been no chaperone present. He testified that although massage therapy might have been a reasonable treatment for Patient A, in 1980s, he referred people for massage to other professionals. He testified that he did not perform massage himself as he is not trained in massage therapy.

The Committee found Dr. B to be a credible witness whose evidence was reliable and his account was consistent.

Although the Committee determined that Patient A was a credible witness as the central part of her story was consistent around the main events and she believed the events happened as she described, the Committee concluded that there were several areas of inconsistency in Patient A's testimony that were significant:

- There was significant inconsistency with regard to the frequency of the massages, during which she claimed she had been touched in a sexual way by Dr. B. In her testimony at the hearing, she said, "from what I remember, it happened a couple of times", while in her interview with the College investigators, Patient A said that Dr. B was her doctor for six months to a year and that her appointments were specifically for massage.
- Patient A testified that she worked either in one of two different places at the time of the alleged incidents, while at the interview she indicated that she worked in an office with bookkeeping.
- Patient A testified that Dr. B had nothing in his hand as he massaged her, while the interview transcript records Patient A indicating that she remembered Dr. B having some kind of device in his hand during the appointments.
- At the hearing Patient A testified that there was no talking during the massage, while at the interview Patient A said that as Dr. B was working, he commented how tight or stressed she was.
- Patient A testified at the hearing that she repressed memories or forgot about the incidents for a very lengthy period of time and that her memories returned when she was talking to a social worker, while the social worker recorded Patient A's view that her memory recovery had been underway for about a year or a year and a half prior to her disclosure of the incidents to the social worker.
- Patient A was clear in her testimony at the hearing that she had spoken to her friend and roommate, Ms Z, about the alleged abuse by Dr. B, while Ms Z testified at the hearing that she had not been informed by Patient A that she had been abused and only learned about the alleged abuse many years later when Patient A spoke to her about the complaint to the College.
- Patient A testified that she thought her girlfriend, Ms Z, was a patient of Dr. B, when Ms Z confirmed in subsequent evidence that she was not.

Disposition

Although the Committee accepted that Patient A believed that she had been touched in a sexual manner by Dr. B, the Committee found Patient A's testimony to be unreliable because of multiple significant inconsistencies, including that Ms Z's testimony did not support Patient A's claim. Therefore, the Committee found the allegations of professional misconduct not proven.

3. Dr. C

Name:	Dr. C
Practice:	Pediatrics
Practice Location:	Ontario
Hearing:	Contested
Decision Date:	August 2, 2017
Written Decision Date:	August 2, 2017

Allegations and Findings

- Sexual impropriety – **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **not proved**

Summary

Dr. C is a pediatrician, practising in Ontario. Patients 1 and her sister, Patient 2, attended Dr. C as patients for 3 years in the early 1980s, when they were 4 and 3 years of age respectively. It was alleged that Dr. C sexually assaulted Patient 1 during medical appointments, when she was between the ages of 4 and 7, and also required her to stand in the corner of the room with her clothes off. Patient 2 alleged that Dr. C required her to stand in the corner with her clothes off. Dr. C denied the allegations.

Patient 1 claimed that on three of her 80 visits to Dr. C back in 1980s, she was seen by Dr. C with no adult present. Dr. C would stand near the door, and tell her to take all her clothing off. He would say she was “a bad girl” and that “big girls don’t cry.” Patient 1 said that he would watch her undress, instruct her to get on the examination table, raise her feet, and then he would get on the table himself. She testified that he put his fingers in her vagina and anus, pulled his pants and underwear down, and put his penis in her vagina. He would hold her arms down as he penetrated her. The three incidents were very similar in her mind and not distinguishable in their details.

Patient 1 testified that following this, Dr. C told her to stay in the corner of the room, while she was still undressed. She then put her clothes back on, went to see her mother and did not recall the details of going home after that.

Patient 1 testified that she had vaginal soreness after the alleged sexual assaults. She said she did not tell anyone, because of shame and because she did not want her mother to feel bad. She said she hid her underwear in the garbage, so her mother would not find them.

During the College investigation, Patient 1 indicated “blanking out” about what had happened and did not provide full details of the alleged incidents. She did not remember the timeframe for the alleged incidents and listed a period of 8 years in 1980s, as the approximate dates of the abuse, in her College application for funding for therapy.

Patient 1 also filed a complaint with the police, but was informed that no charges were laid against Dr. C due to lack of evidence.

Patient 2, who is Patient's 1 younger sister, claims that on her last visit with Dr. C, when she was 6 years old, she was crying and her mother was asked to leave the examining room. She said that Dr. C made her undress completely and stand in a corner, calling her a bad girl for crying. Patient 2 testified that she did not bring up this incident and did not complain to the College until her sister, Patient 1, told her about the alleged abuse by Dr. C. Patient 2 refused to complain to the police as she did not believe she was sexually abused.

The mother of Patient 1 and Patient 2 testified at the hearing. She said she had good relationships with her daughters and they often confided in her. She recalled that the girls were always upset before going to see Dr. C, but no concerns were raised by Patient 1 after appointments. With regard to Patient 1's testimony about soreness in the vaginal area, the patients' mother said this occurred at the time when she would have been bathing her daughter. She said that she would have noticed any bruising or lacerations, and would have heard about the soreness or discomfort from her daughter, but did not see or hear anything.

The patients' mother said that she did not go into the examination room with her two girls only on one occasion, and that on that occasion they came out together. She testified that the family stopped seeing Dr. C, after the incident when the girls came out crying. She was told that her younger child, Patient 2, was told to stand in a corner, wearing only her underwear. Following this upsetting experience, the mother took the girls to another pediatrician. The girls were happy seeing this pediatrician.

Dr. C denied Patient 1's allegation of sexual abuse on three occasions. He denied putting Patient 1 in the corner and said that the mother was always there.

With regard to his last visit with Patient 2, he said he would never ask the mother to leave the room when Patient 2 was crying as he would want the mother to comfort her child. Dr. C did not know why the family never returned after their last visit, stating that this is common experience for pediatricians.

Dr. C described his practice regarding the physical examination of patients, stating that with children under 8, the mother or a caregiver is always present during examination to provide the history and for soothing effect. He testified that children under eight are never completely undressed during examinations and that young girls would not take their underwear off, except if there was an indication of vaginal discharge, bedwetting after age 6, or concern about labial fusion in a very young child. He testified he does not check the genitalia of girls, but on cross examination acknowledged that he does examine the genitalia of girls up to age 4 and after that, when clinically indicated. He said he rarely does rectal exams, with the exception of when he is considering Hirschprung's Disease in newborns.

Dr. C described the setting of his two offices at the time when he saw Patients 1 and 2. Although his second office was bigger than the first one, he said that both offices were small and voices could carry readily and noises could be heard elsewhere. The examining rooms contained an examination table - 6 feet long, 2 feet wide and 33 inches high (he is 5 foot 11 1/2 inches). Dr. C testified that he saw patients in two examining rooms at the same time and would go back and forth between the two rooms.

A retired Registered Nurse who worked for Dr. C in the relevant time, testified at the hearing and said that there was always a responsible adult present in the examining room with children less than 8. She did recall the AA family, but was not aware of any difficulty on their last visit. She confirmed that the nurses would hear shouting in the small office area if any had occurred.

While sympathetic to the patients and their beliefs, the Committee found that the allegations were not proven.

Patient 1's testimony was unreliable, because of multiple significant inconsistencies in her accounts of the events. Patient 1's testimony was unreliable, because it was vague and contradictory. The logistics of the office made the alleged incidents highly improbable – a noisy busy small office with an examining table two feet wide would be unlikely place for such acts as described. Furthermore, crying or screaming would very likely be heard by others. The testimony of the mother contradicted the testimony of Patient 1 as to her memory of what happened 30 years ago.

Although some aspects of Patient's 2 story could have happened (i.e., being made to stand in the corner), it was unclear whether she was completely unclothed, as her mother was told that she had her underwear on.

Disposition

Therefore, the Committee found that the allegations of sexual impropriety and disgraceful, dishonourable or unprofessional conduct not proven.

4. Dr. D

Name:	Dr. D
Practice:	Psychiatry
Practice Location:	Ontario
Hearing:	Contested
Decision Date:	June 19, 2017
Written Decision Date:	June 19, 2017

Allegations and Findings

- Sexual abuse of a patient – **not proved**
- Disgraceful, dishonourable, or unprofessional conduct – **not proved**

Summary

Dr. D is general practitioner. Since 2014, he spends part of the week at the small group practice, with his wife and another physician (Dr. S).

Patient A alleged that at an appointment in December, 2014, Dr. D commented on her appearance and during the examination, squeezed briefly both of her breasts and then poked very briefly her abdomen. Dr. D denied the allegations.

Patient A's Prior Visits to the Clinic

Patient A's medical record indicates that prior to a December, 2014 appointment with Dr. D, she had had four visits with Dr. S at the clinic. According to her medical record, Dr. S diagnosed her with generalized anxiety disorder and prescribed medication, with a recommendation that she return for a physical examination and blood work. Patient A testified that she took medication for three months on an as needed basis, but did not like how it made her feel. Several months later, she attended a second appointment for seasonal allergies and did not mention anxiety. At her third appointment, she was diagnosed with excessive anxiety and was prescribed medication.

Patient A testified that after her last appointment with Dr. S at the clinic, she felt belittled. She wanted to obtain a referral to a mental health professional, but after four visits, Dr. S. had not given her a referral and her anxiety had not responded to the earlier medication. In her June 2015 letter to the College, Patient A noted that when she left the clinic after her last appointment with Dr. S., she had decided to see another doctor at the clinic.

Patient A testified she returned to the Clinic in December, 2014. She could not recall whether she called in advance or was a walk-in, or whether she asked to see another physician at the clinic.

Patient A's Appointment with Dr. D

Patient A testified that she attended at the clinic to request a referral to a mental health professional because she found the medication she had been prescribed on two previous appointments by Dr. S affected her work performance and made her drowsy.

Patient A testified that during the appointment, Dr. D asked about her use of drugs or alcohol, her previous breast examinations and Pap smears, and whether she had a recent vaginal discharge. Patient A also testified that Dr. D commented on how youthful she looked and enquired about whether she was married or single. She said that he

seemed really surprised that she was not married. Patient A further testified that Dr. D asked if she was sexually active.

Patient A testified that she recalled feeling very uncomfortable at the end of the questions, because they seemed very personal and different from what other doctors had asked her.

According to Patient A, there was no discussion of her family medical history or use of antidepressant medication. She testified that she told Dr. D she was not using any medication at the time.

Patient A testified that during the physical examination, Dr. D was standing to her left, took her blood pressure, listened to her chest and heart with a stethoscope and commented, “Your heart is beating really fast. Are you nervous?”. He then checked her eyelid. Patient A testified that Dr. D then put both hands on her breasts for about two seconds, explaining afterwards that he was checking for lumps. He then poked her stomach very briefly. During the encounter, Patient A was fully clothed, wearing four layers of clothing, including a bra, tank top, shirt, and sweater. She had taken off her coat.

Patient A testified that she did not say anything at the time this was going on, because she was shocked. She testified that this experience was very different from breast self-examinations and what she had read and had learned from a friend about breast examinations.

Patient A testified that after the physical examination, the phlebotomist/receptionist drew her blood, and she left the clinic. Patient A then called her mother, and two friends. She told her mother about the incident. Her mother became upset and she went in to the clinic the next morning to tell Dr. S and the office staff about what Patient A told her had happened. Dr. D was not in the clinic, but was informed that Patient A’s mother had come in to complain.

Dr. D testified and denied Patient A’s allegations. He testified that he never touched or squeezed her breasts, did not poke her abdomen and did not comment about checking for lumps or her youthful appearance. Dr. D acknowledged asking whether Patient A was single or married, but testified that he did not ask her why she was not married. He testified that he did ask her about a Pap smear history and if she had vaginal discharges. He explained that it is his pattern to consider other illnesses by asking one question from each major system and it is for that reason that those questions were asked.

Dr. D testified that he stood to Patient A’s right, as he always does when examining patients, because he is right-handed. Dr. D described the physical examination working from the head down. He testified that he looked under Patient A’s eyelids to check for anemia and examined her thyroid from the front standing to her right. Dr. D testified that

he would not have commented on her heart beating quickly, as he recorded her heart rate as “76”. He testified that he listened to her heart and lungs over her clothing.

Dr. D recorded in the medical record his assessment of Patient A as mood disorder with possible bipolar illness. Dr. D testified that his plan was to refer her to a psychiatrist after the laboratory tests were completed, and instructed her to attend an ER if she were suicidal or homicidal. Dr. D testified that he cautioned her strongly not to share medication with a family member and recorded this in her medical chart. Dr. D testified that he never discussed this patient with any other doctor and that his note reflected the history and physical he took of Patient A.

Dr. D testified that he recalled Patient A clearly, even though he had seen thousands of patients since her appointment with him, because there was a unique history of people sharing medications, and because he knew through the clinic staff that the patient’s mother had visited and complained about how her daughter had been treated.

The Committee found that the allegations were not proved.

On a number of issues, Patient A’s description was similar to that of Dr. D’s, including regarding her previous visits, the duration, date and timing of the appointment, and the location of the examining room. Both Dr. D and Patient A were in agreement about where Patient A and Dr. D sat, and the fact that Dr. D began with an introduction and a question regarding the reason for her visit. Dr. D and Patient A also agreed that Dr. D conducted a brief physical examination after talking with Patient A. Elements of the examination were described concordantly: Patient A was wearing her clothing (except for her coat), Dr. D examined her eye-bed by placing a finger under her eye and pulling down, Dr. D listened to Patient A’s heart and chest with a stethoscope over her clothing, and took her blood pressure. Also, that at the close of their meeting, Patient A went to the phlebotomist/receptionist for blood work.

However, the Committee noted several discrepancies between Patient A’s account, the patient record and other documentary evidence:

- Patient A was firm in her view that Dr. D did not take a medical history regarding her family, and maintained that Dr. D must have obtained this information from Dr. S’s clinical notes or must have spoken to Dr. S. Dr. D’s clinical record for Patient A indicates that he took a family medical history from Patient A. Dr. S’s clinical notes do not document the details of Patient A’s family medical history. This is consistent with Dr. D’s testimony denying that he spoke with Dr. S about Patient A, or obtained information from Dr. S’s notes in the medical record.
- Dr. D recorded in Patient A’s medical record that he gave a strong caution to Patient A regarding sharing antidepressant medications with a family member. Patient A denied any medication sharing or hearing about this from Dr. D, but believed this came from Dr. S. Dr. S’s clinical notes make no mention of Patient A sharing medications with a family member.

- Patient A described Dr. D commenting on her heart racing and questioning her nervousness. Patient A's medical record indicates that Dr. D recorded her heart rate as "76".
- Dr. S prescribed an anti-anxiety pill for Patient A in December 2013. Patient A testified that she took the medicine on and off for a few months, but did not like how it made her feel. In November, 2014, Patient A returned with concerns regarding anxiety, just after she had stopped working. She stated that she threw out the old medicine, while the clinical note describes she lost the medicine. Dr. S gave Patient A a new prescription but when she returned the next day, she had not taken the medication. In her letter of June 2015 to the College, she indicated that she did not like that it made her feel drowsy at work, even though by this time she had stopped working. Patient A claimed to have filled this prescription when, in fact, there was no record of her doing so.
- Dr. S's notes indicate that Patient A was given a note for three days-off; this was at the time when the patient acknowledged that she was not working.
- Patient A was firm in noting that Dr. S did not conduct a physical examination, but his note of November 2014 documents the results of a physical examination.

There were several areas of discrepancy between Patient A and Dr. D in their accounts of Patient A's visit:

- Patient A testified she was taken aback by some of Dr. D's questions in his history taking, i.e., whether she was married or single, whether she had a breast exam in the past, what was her history of Pap smears, whether she had a vaginal discharge. Dr. D explained these questions as part of his process in assessing a new patient thoroughly before referring a patient to a mental health professional and noted that it was his routine practice of asking one question from each major bodily system in such an assessment.
- Patient A claimed Dr. D commented on her youthful appearance. He denied this.
- There were discrepancies in the two versions of the physical exam. Dr. D insisted that he always stands to the patient's right as he is right handed. Patient A described a clear memory of him standing to the left.
- The two accounts differed in the order of the components of the physical examination. Dr. D testified that he always begins from the head and works down. Patient A recalled that the order of examination was: blood pressure, heart and chest, and then the eyelid.
- Patient A described a brief "poke" to the abdomen after the "breast squeeze". Dr. D denied squeezing or poking her breasts or poking her abdomen.
- Patient A testified that Dr. D explained he was checking for breast lumps. He denied this.

The Committee found Dr. D to be a credible witness, whose evidence was reliable. Dr. D provided plausible explanation for questioning Patient A about whether she was married or single, whether she had a breast exam in the past, what was, noting that these questions are part of his process in assessing a new patient thoroughly before

referring a patient to a mental health professional. He noted that it was his routine practice of asking one question from each major bodily system in such an assessment.

The Committee felt empathetic to Patient A and accepted that she believed that she had been touched by Dr. D in the manner she described. However, the Committee found it could not rely on Patient A's testimony because of multiple inconsistencies, in particular, as between her testimony and the clinical records of Dr. S and Dr. D.

Disposition

The Committee concluded that, on a balance of probabilities, the allegations were not proved.

5. Dr. R. Yaghini

Name:	Dr. Reza Yaghini
Practice:	Family Medicine
Practice Location:	Barrie
Hearing:	Contested
Finding/Written Decision Date:	December 21, 2016
Penalty/Written Decision Date:	June 20, 2017

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Yaghini is a family physician who practised at a community health centre and a hospital's emergency department.

Patient A, a teenage girl, had received an antibiotic from a doctor at the local hospital for a kidney infection in April 2012. She then developed an allergic reaction consisting of swelling and redness around her eye, and a rash on her stomach, back, neck and chest.

Since her parents were out of town, and her family doctor's office was far away, a family friend took Patient A to the Emergency Department of the hospital. Dr. Yaghini saw Patient A in the examination room of the hospital alone. The Committee found that Dr. Yaghini made a comment to Patient A during this examination at the hospital that she was pretty or very pretty. Patient A was discharged home with a different antibiotic prescription and instructions to return either to her family doctor, the Emergency Department, or Dr. Yaghini's clinic if she had further problems.

After this, Patient A again developed a rash on her stomach, neck, chest, back, and possibly her face. She made an appointment to see Dr. Yaghini at his clinic in April 2012. She attended there with a friend, who waited outside the waiting room. Dr. Yaghini examined Patient A at his clinic that day.

The Committee found that Dr. Yaghini made a similar comment to the “pretty” or “very pretty” remark to Patient A at her second appointment with him.

The Committee also found that, at this second appointment, Dr. Yaghini came close to Patient A and kissed her on the cheek. Then, with his hands on her face and jaw, the Committee found that Dr. Yaghini tried to kiss Patient A on the lips. This resulted in her feeling scared and uncomfortable as she said she felt, and led to the series of events that followed.

The Committee further found that Dr. Yaghini’s kiss on Patient A’s cheek and his attempted kiss on her lips constitute sexual abuse. The Committee concluded that it is obvious that kissing the cheek and then attempting to kiss the lips of a teenage girl in the context of a medical examination is a sexual act that violated the sexual integrity of the victim.

The Committee further found that during the second April 2012 appointment, Dr. Yaghini told Patient A that she reminded him of a woman he had dated or an ex-girlfriend, and, after the attempted kiss on Patient A’s lips when Dr. Yaghini apologized to her, he told her he was excited. The Committee found that these comments constitute sexual abuse, being behaviour or remarks of a sexual nature by the member towards the patient. The Committee also found the making of these remarks to a teenage patient in private during a medical examination to be conduct 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 and directed that:

- The Registrar suspend Dr. Yaghini’s certificate of registration for a period of nine months, to commence on the date this decision is released;
- The Registrar impose the following terms, conditions and limitations on Dr. Yaghini’s certificate of registration:
    a) Dr. Yaghini attend the Understanding Boundaries Course in London, Ontario within six months of the date of this Order; and
    b) Dr. Yaghini participate in a counselling program acceptable to the College to consist of counselling once per month, for a period of one year, which includes enhancing of insight, identification of any at-risk situations and prevention of circumstances that could put him at risk in the future.

- Dr. Yaghini appear before the Committee to be reprimanded within 30 days of the date this Order becomes final;
- Dr. Yaghini reimburse the College for funding provided to Patient A under the program required under section 85.7 of the Code, and shall post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within 30 days of the date of this Order, in the amount of $16,060.00;
- Dr. Yaghini pay costs to the College in the amount of $31,500.00, within 30 days of the date of this Order becomes final.

Appeal

On January 19, 2017, Dr. Yaghini appealed the decision on finding of the Discipline Committee to the Superior Court of Justice (Divisional Court). Pursuant to s.25(1) of the *Statutory Powers Procedure Act*, the appeal operates as a stay of the decision pending the outcome of the appeal. Therefore, the decision of the Discipline Committee is not in effect.

Guilty of an offence relevant to suitability to practise – 1 case

1. Dr. A. Sanchez

Name:	Dr. Arturo Sanchez
Practice:	Pediatrics
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	May 1, 2017
Written Decision Date:	June 15, 2017

Allegations and Findings

- Guilty of an offence that is relevant to suitability to practise - **proved**
- Sexual impropriety with patients – **withdrawn**
- Sexual abuse of patients – **withdrawn**
- Disgraceful, dishonourable, or unprofessional conduct – **withdrawn**

Summary

Dr. Sanchez was a paediatrician, practising in Toronto. Dr. Sanchez is no longer a member of the College. He resigned his certificate of registration on November 16, 2015.

On December 7, 2015, Dr. Sanchez was convicted of two counts of indecent assault with respect to Patient A and one count of indecent assault with respect to Patient F.

Patient A

Patient A was 14 and 15 years old when she was hospitalized twice at the Hospital for Sick Children (“HSC”) in Toronto in 1960s. During these admissions, Dr. Sanchez touched Patient A’s breasts and vagina for a sexual purpose. One night, during Patient A’s second hospital admission, Dr. Sanchez came in her room during the night, got on top of her and touched her breasts and vagina. This was done for his sexual gratification and not for any medical purpose.

Patient F

When Patient F was approximately 11 years old, she was prescribed weekly allergy shots. Dr. Sanchez would come to her home to give her these shots. On one of these weekly visits, Dr. Sanchez gave Patient F a hug from the back and put his hands down the front of her shirt. On another occasion, Dr. Sanchez touched Patient F’s breast for a sexual purpose.

Criminal Sentencing

On March 30, 2016 Dr. Sanchez was sentenced to 18 months incarceration. In imposing sentence, the trial Judge found that "the degree of responsibility attributable to the accused is at the high end of the scale – a deliberate breach of trust by a person of significant power and authority." The trial judge outlined the following aggravating factors: the victims were under 18 years of age, the accused was in a position of trust, the offences had considerable impact on the victims, and the assaults were persistent, lengthy, planned and deliberate and were not a spur of the moment thing.

Disposition

The Committee ordered and directed that:

- The Registrar suspend Dr. Sanchez's certificate of effective immediately.
- Dr. Sanchez attend before the panel to be reprimanded.
- Dr. Sanchez pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order becomes final.

Incompetence – 2 cases

1. Dr. D. J. Hill

Name:	Dr. David James Hill
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Contested
Finding/Written Decision Date:	December 2, 2016
Penalty/Written Decision Date:	May 17, 2017

Allegations and Findings

- Incompetence - **proved**
- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Hill, a family physician with a solo office practice in Toronto, retired from active practice in 2015.

Patient A, Dr. Hill's former patient, made a complaint to the College that Dr. Hill had missed a diagnosis of colon cancer. Patient A's complaint led to an investigation by the College. The matter was ultimately referred to the Discipline Committee.

<u>Failure to Maintain Standard of Practice</u>

The Committee found that Dr. Hill failed to maintain the standard of practice of the profession with respect to Patient A:

1. Although Dr. Hill saw Patient A on dozens of occasions, visits were devoted exclusively to treating episodic and chronic illness and minimal attention was paid to prevention of disease;
2. Dr. Hill's notes with respect to Patient A were vague and repetitive with little documentation of physical findings or specifics with regard to history, investigations, or treatment;
3. The cumulative patient profile (CPP) used by Dr. Hill was out of date and incomplete with important data on family history missing;
4. Dr. Hill failed to document a proper family history, which may have led to a screening colonoscopy; and
5. Dr. Hill failed to properly document or investigate Patient A's abdominal pain in 2010, which may have led to a delay in the diagnosis of his cancer.

The Committee also found that Dr. Hill failed to maintain the standard of practice of the profession in his record keeping in Patient A's case and in 24 of the other 25 patient cases that were reviewed.

An expert retained by Dr. Hill opined that Dr. Hill's charting fell below the standard of practice of the profession for recordkeeping, describing Dr. Hill's documentation of patient records as "unacceptably brief" and agreed with the College expert that there was a marked deterioration after 2010, saying "the documentation of patient encounters most often is too deficient to permit a full and fair determination of the quality of care Dr. Hill's patients receive."

The Committee also found that Dr. Hill failed to maintain the standard of practice of the profession with respect to his recordkeeping by copying sections of notes from one patient file to another.

The Committee additionally found that Dr. Hill failed to maintain the standard of practice of the profession with respect to his investigation of patient complaints and referrals for testing. In some cases, Dr. Hill under-investigated complaints; in other cases, he over-investigated.

The Committee further found that Dr. Hill failed to maintain the standard of practice of the profession with respect to his treatment of diabetic patients. The College expert opined that Dr. Hill's diabetic control for one particular patient was "terrible with no indication of referral to a diabetes education program, discussions with the patient, or a referral to an endocrinologist." The expert retained by Dr. Hill supported the College expert's concerns with respect to this patient.

Disgraceful, Dishonourable, or Unprofessional Conduct

The Committee found that Dr. Hill engaged in conduct that was disgraceful, dishonorable, or unprofessional in two respects: in his communications with Patient A; and in his falsification of patient records.

Although Patient A's demands for financial compensation following the diagnosis of his rectal cancer may have been inappropriate, Dr. Hill's response was unprofessional in trying to paint Patient A as a person with mental health issues.

The College expert testified that falsification of records by duplicating patient charts occurred in 11 of the 26 charts he reviewed. Chart pages were duplicated and reproduced in anywhere between one to five other patient charts. The College expert determined that for one chart, the entire clinical record was a forgery.

Dr. Hill admitted to copying charts, and testified that this practice went on over a period of five to seven years. However, the Committee found that forgeries were evident in the charts going back to 2004.

Incompetence

The Committee determined that Dr. Hill's charting and patient care reflects a lack of knowledge, skill and judgment to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted. The Committee found that Dr. Hill is incompetent.

The College expert concluded that since at least 2010, Dr. Hill's level of practice has seriously degraded to the point where he believes Dr. Hill to be incompetent and engaging in substandard care. He also concluded that Dr. Hill had significant knowledge gaps for common medical conditions and often under-investigated or over-investigated patients. There was no evidence that Dr. Hill had any insight into his failures or had changed his practice to comply with the standards of practice of the profession.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Hill certificate of registration, effective immediately.
- Dr. Hill attend before the panel to be reprimanded, within 60 days of the date this order becomes final.
- Dr. Hill pay costs in the amount of $69,538.00, within 60 days of the date this order becomes final.

Appeal

Dr. Hill appealed the Committee's December 2, 2016 Decision on Finding to the Divisional Court of the Ontario Superior Court of Justice. The Notice of Appeal was served on the College on December 27, 2016.

On June 10, 2017, Dr. Hill appealed the decision of May 17, 2017 of the Discipline Committee on penalty and costs.

Pursuant to s.71 of the Code, the Discipline Committee's decision remains in effect despite the appeal.

2. Dr. R.C. Wales

Name:	Dr. Roger Cyril Wales
Practice:	Ophthalmology
Practice Location:	Kingston Area
Hearing:	Contested
Finding/Written Decision Date:	January 14, 2015
Penalty/Written Decision Date:	August 3, 2017

Allegations and Findings

- Incompetence - **proved**
- Failure to maintain standards of practice of the profession – **proved**

Summary

Dr. Wales is a General Practitioner (GP) refractionist in solo practice in the Kingston area.

The findings of professional misconduct and incompetence pertain to the following areas of Dr. Wales' practice:

- his measuring intraocular pressure by touching the eye with his finger (finger tonometry) instead of using an applanation tonometer to measure numerically;
- his failure to measure intraocular pressure in certain age groups (under 40);
- his failure to dilate pupils to look at the fundus/posterior eye; and
- his failure to use cycloplegia in children to obtain proper refraction.

Dr. Wales' deficiencies in his care and treatment of patients demonstrated a lack of knowledge, skill, and judgment of such a nature and to an extent that he is unfit to continue to practise or that his practice should be restricted. The Committee found that the deficiencies Dr. Wales displays are current.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Wales' certificate of registration effective immediately;
- Dr. Wales appear before the Committee to be reprimanded within thirty (30) days of the date this Order becomes final; and
- Dr. Wales pay costs to the College in the amount of $23,340.00 within thirty (30) days of the date this Order becomes final.

Appeal

On February 11, 2015, Dr. Wales appealed the decision on finding of the Discipline Committee to the Superior Court of Justice (Divisional Court).

Pursuant to s.71 of the Code, the Discipline Committee's decision remains in effect despite the appeal.

Failed to maintain the standard of practice - 8 cases

1. Dr. K. W. Adams

Name:	Dr. Kenneth Werezak Adams
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Uncontested Facts and Joint Submission on Penalty
Decision Date:	May 15, 2017
Written Decision Date:	June 7, 2017

Allegations and Findings

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence - **withdrawn**

Summary

Dr. Adams received his certificate of registration authorizing independent practice in Ontario in 1983. At the relevant time, he practised medicine in Toronto.

Failure to Maintain Standard of Practice

On January 26, 2014 Patient A complained to the College about the care he received from Dr. Adams.

In August 2010, Dr. Adams provided a serious of four filler injections to Patient A in an attempt to correct hollows in his cheeks resulting from cosmetic procedures (liposuction and fat removal) several years prior with another physician.

For the injections, Dr. Adams used hyaluronic acid that was compounded at a compounding pharmacy as a filler, rather than a filler that was commercially available and approved by Health Canada.

Although Patient A was initially pleased with the result of the injections, the effects dissipated rapidly and the hollows re-appeared. In addition, about three months after beginning the series of injections, Patient A noticed what he described as a “rather ugly, hook or bow-shaped demarcation” above the jaw line on his face. Patient A’s family physician confirmed to the College that Patient A was left with a hard 1 cm mobile lump over his left mandible.

Dr. Adams provided a series of injections of Hyaluronidase, but the attempts to dissolve the lump were unsuccessful.

The College retained an expert certified in dermatology, who concluded that Dr. Adams failed to maintain the standard of practice of the profession in that he displayed a lack of judgment in using a compounded form of hyaluronic acid which is not commercially available. The expert noted that the use of compounded product is not the standard of practice. The expert further noted that perhaps in very rare instances where someone may have allergy to a component of the product, using a compounded product can be considered. However, this comes with risks and patients must be aware of these risks. The expert pointed out that there was no patient consent form in Patient A's chart and no documentation of potential side effects.

Commercial fillers have labels attached to them and the label is commonly affixed to the patient chart to confirm the dose and brand used and allows for tracking if there is something faulty with the filler. In this case, there was no label because Dr. Adams used a compounded filler.

The expert recommended that Dr. Adams use only commercially available fillers going forward and ensure that the patient records contain a signed consent form in respect of the treatment provided.

Disgraceful, Dishonourable, or Unprofessional Conduct

On July 20, 2016, the College received a complaint from the Associate Dean of a University, indicating that Dr. Adams had provided a medical note, dated April 22, 2016, for a student, for the purpose of seeking accommodation from an instructor at the University. The student is Dr. Adams' family member.

The instructor who received the medical note became suspicious, because the note indicated the student was incapacitated during a period in which the student had written an exam and because all possible symptoms had been checked off on the form.

When the instructor telephoned the number indicated on the medical note, which is Dr. Adams' private cellular telephone number, Dr. Adams confirmed that he had provided care to the student and would continue to do so. Dr. Adams did not reveal the fact that the student was his family member in the initial telephone conversation with the instructor.

In addition to the note dated April 22, 2016, Dr. Adams' authored four other medical notes for his family member submitted to the University.

In his response to the College investigation, Dr. Adams confirmed that the student is in fact his family member and confirmed that he had written the five medical notes provided to the College by the University. He also confirmed that had provided medical care to his family member.

According to Dr. Adams' family member's patient charts dating from April 2010 to December 2013 and from April to July 2016, Dr. Adams provided medical treatment for

his family member. In addition, he has provided and billed OHIP for treatment for his family member on two occasions in May and July 2016.

In his response to the College regarding the OHIP billings, Dr. Adams acknowledged that he ought not to have billed OHIP. Dr Adams has repaid OHIP for this improper billing.

The care that Dr. Adams provided to his family member violates professional boundaries and is contrary to professional obligations articulated in College Policy, which prohibits physicians from providing treatment for themselves or family members except:

i) for a minor condition or in an emergency situation, and
ii) when another qualified health-care professional is not readily available.

These conditions were not present when Dr. Adams repeatedly treated his family member.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Adams' certificate of registration for a three (3) month period commencing June 3, 2017, at 12:01 a.m.
- the Registrar impose the following terms, conditions and limitations on Dr. Adams' Certificate of Registration:

Instruction in Medical Ethics

(a) At his own expense, Dr. Adams shall participate in and successfully complete, within 6 months of the date of this Order, individualized instruction in medical ethics satisfactory to the College, with an instructor approved by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Adams.

Clinical Supervision

(b) Prior to resuming practice following the suspension of his certificate of registration, Dr. Adams shall retain, at his own expense, a College-approved clinical supervisor to review Dr. Adams' medical record keeping, who will sign an undertaking as the "Clinical Supervisor";
(c) For a period of six (6) months commencing within thirty (30) days from the date Dr. Adams resumes practice following the suspension of his certificate of registration, Dr. Adams may practice only on terms of the Clinical Supervision set out herein;
(d) Clinical Supervision of Dr. Adams practice shall contain the following elements:
    (i) Meet with Dr. Adams on a monthly basis and review a minimum of 15 charts for the duration of the supervision, to be selected in the sole discretion of the Clinical Supervisor;
    (ii) the Clinical Supervisor will keep a log of all patient charts reviewed along with patient identifiers; and

(iii) the Clinical Supervisor will provide reports to the College on a monthly basis for the six (6) month period of practice monitoring, or more frequently if the Clinical Supervisor has concerns about Dr. Adams' standard of practice or conduct.

(e) Dr. Adams shall abide by the recommendations of the Clinical Supervisor;

(f) If a clinical supervisor who has given an undertaking is unable or unwilling to continue to fulfill its terms, Dr. Adams shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time;

(g) If Dr. Adams is unable to obtain a clinical supervisor in accordance with this Order, he shall cease to practice until such time as he has done so;

(h) Dr. Adams shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Adams' compliance with this Order;

(i) Dr. Adams shall inform the College of each and every location where he practises including but not limited to hospital, clinics and offices, in any jurisdiction (collectively his "Practice Location(s)), within fifteen (15) days of this order and shall inform the College of any new Practice Locations within fifteen (15) days of commencing practice at that location, for the purposes of monitoring his compliance with this Order.

<u>Re-Assessment</u>

(j) Approximately six (6) months after the completion of the period of supervision as set out above Dr. Adams shall undergo a re-assessment of his medical record keeping by a College-appointed assessor (the "Assessor(s)"). The Assessor(s) shall report the results of the re-assessment to the College;

(k) Dr. Adams shall consent to the disclosure to the Assessor(s) of the reports of the Clinical Supervisor arising from the supervision, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor(s) and the College, as the College deems necessary or desirable.

- Dr. Adams be responsible for any and all costs associated with implementing this Order.
- Dr. Adams to appear before the panel to be reprimanded.
- Dr. Adams pay costs to the College for a one day hearing in the amount of $5,500.00 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 and Joint Submission on Penalty
Finding Decision Date:	June 12, 2017
Written Decision Date:	August 1, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Incompetence – **withdrawn**

Summary

Dr. Baranick is a family physician practising at Appletree Medical walk-in Clinics in Ottawa. He obtained his medical degree from the University of Ottawa in 1973 and has held an independent practice certificate with this College from 1979 to 1982 and from 1989 to present.

2012 Practice Re-Assessment

On February 15, 2010, Dr. Baranick signed an Undertaking with the College to practice under Clinical Supervision, to successfully complete Medical Record-Keeping and Ethics courses, and to undergo a re-inspection of his practice.

The College retained an independent medical expert to conduct the re-assessment of Dr. Baranick's practice pursuant to the 2010 Undertaking. The medical expert indicated that although Dr. Baranick is an experienced clinician who has worked in primary patient care for most of his career, he has recently made the transition from working in the Emergency Department of a hospital to seeing unscheduled patients in a number of ambulatory clinics.

The medical expert reported that Dr. Baranick admitted that he sees too many patients during his shifts, and this may be one factor that has resulted in poor notations on the charts of his patients. The medical expert noted that Dr. Baranick recently took one of the College's courses on record-keeping and should be familiar with the College's guidelines. In addition, the medical expert was surprised that Dr. Baranick did not seem familiar with "SOAP" format advocated by the College, and that he rarely uses that format to help him structure his patient assessments.

The medical expert concluded that Dr. Baranick fails to meet the standard of practice of a competent practitioner in his care of patients. Specifically, he found that beyond charting issues:

- Dr. Baranick's care displays a lack of medical knowledge of clinical conditions commonly seen in the walk-in setting, including upper respiratory tract infections, eye and ear problems, genito-urinary conditions and asthma. This hampers Dr. Baranick's abilities to appropriately assess patients and to effectively manage their problems.
- Dr. Baranick's assessment of ocular problems exemplifies that in some instances Dr. Baranick's care displays a lack of skill.

- Dr. Baranick's care displays a lack of judgment in management of patients requesting repeats of prescription drugs, with the potential to expose such patients to harm.

The medical expert recommended that:

- Dr. Baranick make efforts to limit the number of patients seen during his shifts, that he make efforts to identify areas of clinical weakness in addition to those identified during the medical expert's reassessment process, and that he take steps to increase his medical knowledge.
- Dr. Baranick's practice be supervised by a clinician whose practice is more closely aligned with that of Dr. Baranick and that his practice be subsequently reassessed.

2013 Practice Assessment

On April 17, 2013 the Inquiries, Complaints and Reports Committee considered the expert's report and directed another Undertaking for Dr. Baranick to restrict his practice to no more than 6 patients per hour, to complete the Comprehensive Family Practice Review (CFPR) course, to practice under supervision of a Clinical Supervisor, and to undergo a comprehensive practice reassessment.

An independent medical expert who conducted the comprehensive practice assessment opined that although Dr. Baranick is an experienced physician who has undergone reassessment and remediation of his practice in previous years, he still fails to meet the standard of practice of the profession in his record keeping due to legibility concerns and in not providing enough detail about some presenting complaints. Also, Dr. Baranick does not meet the standard of practice of the profession in assessing and managing community acquired infections, infant care, and chronic illness, such as arthritis, diabetes, and hypercholesterolemia. The medical expert concluded that Dr. Baranick demonstrates a lack of knowledge, skill, and judgment in these areas which have a potential to cause harm.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Baranick's certificate of registration for a period of two (2) months effective immediately.
- The Registrar to impose the following terms, conditions and limitations on Dr. Baranick's certificate of registration:
  (a) Dr. Baranick shall, within six (6) months of the end of the period of the suspension, complete a comprehensive Continuing Medical Education (CME) program acceptable to the College focusing on the areas of concern raised in the report of the College assessor dated March 30, 2016;
  (b) Dr. Baranick shall limit his practice to no more than six (6) patients per hour;

Clinical Supervision

(c) Within sixty (60) days of the date of this Order, Dr. Baranick shall obtain a clinical supervisor acceptable to the College, who will supervise Dr. Baranick for a period of six (6) months, and who will sign an undertaking in the form attached to this Order as Appendix A ("Clinical Supervisor");

(d) The Clinical Supervision shall be at a moderate level for six (6) months, commencing on the date following the expiry of the suspension of Dr. Baranick's certificate of registration. The Clinical Supervisor will meet with Dr. Baranick bi-weekly and review a minimum of ten (10) of Dr. Baranick's patient charts, discuss Dr. Baranick's patient care, treatment plan and follow-up, identify any concerns regarding the care, treatment plan and follow-up and make recommendations for improvement;

(e) Within three (3) months after the completion of the Clinical Supervision, Dr. Baranick will submit to a reassessment of his practice (the "Reassessment") by an assessor or assessors selected by the College (the "Assessor(s)"). The Reassessment may include a chart review, direct observation of Dr. Baranick's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. Dr. Baranick shall abide by all recommendations made by the Assessor(s), and the results of the Reassessment will be reported to the College and may form the basis of further action by the College;

(f) Dr. Baranick shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor(s) with respect to practice improvements and education;

(g) Dr. Baranick shall consent to the disclosure by the Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Baranick's compliance with this Order. This shall include, without limitation, providing the Clinical Supervisor with any reports of any assessments of Dr. Baranick's practice in the College's possession;

(h) If a Clinical Supervisor who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Baranick shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time;

(i) If Dr. Baranick is unable to obtain a Clinical Supervisor in accordance with paragraphs 4(b) or 4(g) of this Order, he shall cease practising medicine until such time as he has done so, and the fact that he has will constitute a term, condition or limitation on his certificate of registration until that time;

(j) Dr. Baranick shall co-operate with unannounced inspections and shall consent to the monitoring of his OHIP billings of his Practice by a College representative(s), for the purpose of monitoring and enforcing his compliance with the terms of this Order;

(k) Dr. Baranick shall inform the College of each and every location that he practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location; and

(l) Dr. Baranick shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Baranick attend before the panel to be reprimanded.
- Dr. Baranick pay to the College costs in the amount of $5,500.00, within thirty (30) days of the date of this Order

3. Dr. K.S. Billing

Name:	Dr. Kulbir Singh Billing
Practice:	Anaesthesiology
Practice Location:	Kitchener
Hearing:	Uncontested Facts and Contested Penalty
Finding Decision Date:	November 21, 2016
Penalty Decision Date	June 22, 2017
Written Decision Date:	June 22, 2017

Allegations and Findings

- Failed to maintain the standard of practice – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **withdrawn**
- Incompetence – **withdrawn**

Summary

Dr. Billing, an anaesthesiologist in Kitchener, has a practice primarily devoted to injection therapies for chronic pain, including nerve blocks, paravertebral blocks, epidural injections, and trigger point injections.

After receiving information from the Ministry of Health and Long-Term Care in 2011, the College commenced an investigation into Dr. Billing's clinical practice pursuant to s.75(1)(a) of the Health Professions Procedural Code.

As part of its investigation, the College obtained independent opinions from two experts, who reviewed dozens of patient charts and observed Dr. Billing's care of certain patients. Dr. Billing obtained independent opinions from two other experts, who reviewed the same patient charts and observed Dr. Billing's care of patients.

Dr. Billing's documentation in his patient charts had the following deficiencies:

- Initial patient histories are not always present. When present, the patients' histories often lack, or record an incomplete, past medical and medication history;
- Previous treatments for chronic pain are not always well-documented;
- The effect or efficacy of blocks administered to patients is not always well-documented;
- When recorded, changes in treatment plans or injection therapies are not explained in the chart;
- Changes in patients' diagnoses do not always reflect a change in treatment plans and no explanation is provided;
- The correlation between physical diagnoses or findings and the treatment provided is often not documented;
- Dr. Billing uses template-style reporting, or note-stamping, i.e. he "cuts and pastes" from patients' previous clinical notes, carrying over grammatical and spelling errors;
- Although Dr. Billing documents a review of the complications that may arise from nerve blocks in general, he does not document a discussion of the specific and unique complications that may arise when obtaining consent to a new kind of nerve block;
- Patient consent to procedures is often poorly documented; and
- There is often a failure to document changes, or lack of changes, in functionality or activities of daily living of patients.

Between 2006 and 2013, Dr. Billing submitted claims to OHIP for the maximum number of nerve blocks allowed under the Schedule of Benefits, namely eight blocks per patient per service date for many of his patients. From April 2010 to March 2014, Dr. Billing submitted claims to OHIP for an average of 10 to 11 injections per patient per service day.

Dr. Billing's evidence of individualized treatment plans had the following deficiencies:

- The records do not always indicate an attempt to create individualized treatment plans;
- Many patients receive more blocks than the maximum eight paid by OHIP. The rationale for providing patients with the maximum or greater than the maximum number of blocks is not always sufficiently documented;
- Many patients are given the same or similar sets of nerve blocks and trigger point injections without a documented rationale;
- Although Dr. Billing uses patient feedback to determine which blocks work best, this feedback approach is not always clearly reflected in his clinical notes;
- It is difficult to determine the effect or benefit of any particular block, given Dr. Billing's practice of routinely initiating multiple blocks simultaneously and his failure to record patients' responses to various blocks;
- In several instances, Dr. Billing did not adjust his treatment based on new evidence when new findings or diagnostic results, such as imaging became available, and/or he failed to record any adjustments to treatment based on new findings or diagnostic results; and

- When a patient notes a new area of pain, Dr. Billing often performs nerve blocks without documenting investigations to confirm the diagnosis.

Due to their proximity to the epidural space, paravertebral blocks (a block of the spinal nerve where local anesthetic is injected in the paravertebral space) must be done using appropriate sterile technique due to the rare, but potentially severe consequences of infection in this area, including epidural abscess and paralysis.

"Sterile technique" means that everything used in the injection must be sterile, including the target area on the patient's skin for the injection, which must be cleaned in a sterile fashion; the syringe, the needle, and the solution in the syringe; and the gloves, which must also be sterile.

Dr. Billing's technique in administering paravertebral blocks had the following deficiencies with respect to the sterile technique used:

- He only used only alcohol swabs to sterilize the general block area, not the stronger chlorhexidine spray. According to Dr. Billing, he began to use chlorhexidine spray when this issue was drawn to his attention by an expert;
- He administered injections to individual patients using the same needle that had already been used to perform occipital nerve blocks through the patients' scalps. The scalp area is notoriously difficult to sterilize;
- He did not appropriately maintain the sterility of his gloves, in that although he started with sterile gloves, while he was administering injections, he used gloves that had touched unsterilized areas of the patients, including their scalps.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Billing's Certificate of Registration for a two (2) month period effective thirty (30) days from the date of this Order.
- The Registrar impose the following terms, conditions and limitations on Dr. Billing's certificate of registration:
  1. <u>Clinical Supervision</u>
  (a) Within twenty (20) days of this Order, Dr. Billing shall retain a College-approved Clinical Supervisor or supervisors (the "Clinical Supervisor") with respect to his chronic pain management practice, who will sign an undertaking in the form attached hereto as Schedule "A".
  (b) For a period of twelve (12) months commencing on the date that the Clinical Supervision is approved by the College, Dr. Billing may practise chronic pain management only under the supervision of the Clinical Supervisor ("Clinical Supervision"). Clinical Supervision of Dr. Billing's practice will end after a period of twelve (12) months.
  (c) Clinical Supervision of Dr. Billing's chronic pain management practice shall contain the following elements:
  Moderate-Level Supervision

(a) For an initial period of four (4) months, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will meet with Dr. Billing every two weeks and will at minimum:

i. review a minimum of fifteen (15) of Dr. Billing's patient records, to be selected at the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Billing;
ii. directly observe Dr. Billing's treatment of patients, including patient consultations and his administration of injections, for a minimum of three (3) hours per visit;
iii. discuss with Dr. Billing any concerns the Clinical Supervisor may have arising from the chart reviews or the direct observations;
iv. make recommendations to Dr. Billing for practice improvements and ongoing professional development, and inquire into Dr. Billing's compliance with the recommendations; and
v. keep a log of all patient charts reviewed along with patient identifiers.

(b) The Clinical Supervisor shall consider the need for moderate supervision after the first four (4) months of Dr. Billing's Clinical Supervision, and at the beginning of every month thereafter for as long as the period of moderate supervision continues. If the Clinical Supervisor believes that Dr. Billing is ready to practise under low supervision, he/she shall provide the College with a report addressing the practice concerns raised in the Statement of Uncontested Facts on Liability.

(c) The College must agree to the transition to the next phase, based on the reports of the Clinical Supervisor.

Low-Level Supervision

(a) If the transition is approved by the College, for a period of a further eight (8) months, the Clinical Supervisor will engage in a period of low-level supervision, during which time the Clinical Supervisor will meet with Dr. Billing on a monthly basis and will:

i. review a minimum of ten (10) of Dr. Billing's patient records, to be selected at the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Billing;
ii. directly observe Dr. Billing's treatment of patients, including his patient consultations and his administration of injections, for a minimum of three (3) hours per visit;
iii. discuss any concerns the Clinical Supervisor may have arising from the chart reviews or the direct observations;
iv. make recommendations to Dr. Billing for practice improvements and ongoing professional development and inquire into Dr. Billing's compliance with the recommendations; and
v. keep a log of all patient charts reviewed along with patient identifiers.

Other Elements of Clinical Supervision

(a) Throughout the period of Clinical Supervision, Dr. Billing shall abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to patient care, record keeping, infection control, practice improvements, and ongoing professional development.

(b) The Clinical Supervisor shall submit written reports to the College at least once every month, or more frequently if the Clinical Supervisor has concerns about Dr. Billing's standard of practice.

(c) If the person who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its provisions, Dr. Billing shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

(d) If Dr. Billing is unable to obtain a Clinical Supervisor as set out in this Order, he will cease practising medicine until such time as he has obtained a Clinical Supervisor acceptable to the College.

(e) If Dr. Billing is required to cease practise as a result of section (5)(d) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register.

2. Re-Assessment of Practice

(a) Approximately three (3) months after the completion of Clinical Supervision, Dr. Billing shall undergo a reassessment of his chronic pain management practice by a College-appointed assessor (the "Assessor"). The assessment shall include a review of Dr. Billing's patient charts and direct observation of patient care. The assessment may also include interviews with staff and/or patients. The results of the assessment shall be reported to the College.

(b) Dr. Billing shall consent to sharing of information among the Assessor, the Clinical Supervisor, and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

3. Monitoring

(a) Dr. Billing shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

(b) Dr. Billing shall cooperate with unannounced inspections of his chronic pain management practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

(c) Dr. Billing shall consent to the College's making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.

(d) Dr. Billing shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Billing appear before the panel to be reprimanded within 30 days of the date this Order becomes final.
- Dr. Billing pay costs to the College for a one (1) day hearing in the amount of $5,000 within 30 days of the date of this Order becomes final.

Appeal

On June 30, 2017, Dr. Billing appealed the decision of the Discipline Committee to the Superior Court of Justice (Divisional Court). Pursuant to s. 25(1) of the *Statutory Powers Procedure Act*, the appeal operates as a stay of the decision pending the outcome of the appeal. Therefore, the decision of the Discipline Committee is not in effect.

4. Dr. E.A. Ghumman

Name:	Dr. Ejaz Ahmed Ghumman
Practice:	General Surgery
Practice Location:	Leamington
Hearing:	Uncontested Facts and Joint Submission on Penalty
Decision Date:	July 21, 2017
Written Decision Date:	July 31, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Incompetence – **withdrawn**

Summary

Dr. Ghumman is a general surgeon practising at the hospital in a city in Ontario. From 2007, Dr. Ghumman was a Chief of Staff at the hospital, but resigned his position in April 2017, following a referral of this matter to the Discipline Committee of the College. Dr. Ghumman received his medical degree in Pakistan in 1982 and a specialist qualification in general surgery in Ireland in 1991. In 1999, Dr. Ghumman obtained a certificate of independent practice in Newfoundland and received his specialist qualification in general surgery in Canada in 2004. In 2007, Dr. Ghumman received his certificate of independent practice in Ontario.

<u>Failure to Maintain Standard of Practice of the Profession: Patient X</u>
In June, 2015, Patient X complained to the College regarding Dr. Ghumman's care in conducting her laparoscopic gallbladder removal surgery and his post-operative care.

Several months prior to the complaint, Dr. Ghumman assessed Patient X for symptomatic gall stones. He explained to Patient X her treatment options, discussed the

potential risks and benefits of surgery, and obtained Patient X's informed consent for a laparoscopic gallbladder removal surgery, which was scheduled for the following month. On the day of the surgery, Dr. Ghumman discussed the surgical plan with Patient X in the day surgery area at the hospital.

During the surgery, the clip applier that Dr. Ghumman applied on Patient X's cystic artery unexpectedly jammed and could not be pulled off as it could damage an artery. Dr. Ghumman considered converting to an open procedure, but decided to continue laparoscopically and to take steps to divide the cystic artery in order to remove the jammed clip applier.

Following the anesthetist's suggestion to use Filshie clips, which are applied with a narrower clipper than other clips, Dr. Ghumman proceeded to place a Filshie clip, but was concerned that he might have mistakenly placed it on the common bile duct or the right hepatic artery. Dr. Ghumman directed nurses to make several telephone calls, but could not find a way to remove the Filshie clip without risking torn vessels or tearing the bile duct.

He continued with the procedure and applied another Filshie clip on the cystic artery, which allowed him to divide the cystic artery and remove the jammed clipper. Dr. Ghumman removed the gallbladder, which tore during removal, placed a drain and completed the surgery. He noted in his Operative Report that if a clip is on a common bile duct, he may have to refer Patient X to a Hepatobiliary Surgeon.

Following the surgery, Dr. Ghumman told Patient X that the surgery went well. He indicated that he encountered a complication when the clipper jammed, which he was then able to remove, but was concerned that he might have placed a clip on her right hepatic artery or common bile duct.

Patient X was discharged home the same day with instructions for monitoring and to return two days later for a CT scan and to remove the drain placed during surgery.

When Patient X returned two days later, she reported feeling unwell, was in pain, and was having trouble eating. Dr. Ghumman discussed the results of Patient X's CT scan with a radiologist at the hospital, who opined that Patient X's common bile duct looked normal and indicated that no clip was visualized on the common bile duct. Dr. Ghumman reported to Patient X's family doctor that he had a small incident during surgery but that he was satisfied, after the CT scan that the clip was not on the common bile duct. He indicated that he was concerned because he had applied the clip "a little bit blind", but now felt the clip was on tissues along the gallbladder, which was not a problem. Dr. Ghumman decided not to remove the drain that day and instructed Patient X to return three days later for removal of the drain and follow up tests.

When Patient X returned to Dr. Ghumman for drain removal three days later, she reported feeling itchy, was unable to eat, and her complexion was jaundiced.

The next day, Dr. Ghumman telephoned Patient X and informed her that according to her blood work results her bilirubin was high. Elevated bilirubin levels may cause jaundice and may indicate problems with the liver or bile duct, and may also account for the type of itching experienced by Patient X. Dr. Ghumman advised Patient X to drink plenty of fluids to stay well hydrated and call his office if her condition worsened.

In two days, Patient X contacted Dr. Ghumman and complained of increased itching. He booked an ultrasound appointment and blood work for the next morning. The ultrasound results suggested that the common bile duct was obstructed and blood work indicated that Patient X's bilirubin had increased over the previous three days. Dr. Ghumman advised Patient X that the clip he was concerned about had actually been placed incorrectly and had likely caused obstruction of the patient's common bile duct. He organized Patient X's immediate transportation to London Health Sciences Centre ("London") for emergency admission and surgery.

Following the surgery, the Hepatobiliary Surgeon noted that there was a clip going across Patient X's entire bile duct. The surgery was complicated by intra-operative and post-operative bleeding, which required transfusion of eight units of blood. Patient X remained hospitalized in London for approximately one week after the surgery.

In October, 2015, the College retained an expert, a general surgeon, to provide opinion regarding Dr. Gumman's care of Patient X. The expert opined that although the technical complication involving the clip applier during surgery was beyond Dr. Ghumman's control, his actions in response to the problem were below the standard of practice of the profession. He noted the following concerns:

- Dr. Ghumman failed to convert to an open procedure in order to first define the anatomy with careful dissection around the jammed clipper;
- Despite his concern of having injured an important structure, Dr. Ghumman failed to obtain the advice of a hepatobiliary surgeon or another general surgeon, either during or immediately following the surgery. Although there was only one other surgeon in a hospital in a small community where he works, he could have sought assistance through a service that provides urgent and emergent support for hospital-based physicians;
- Dr. Ghumman's operative note shows that he was aware of the need to obtain the critical view, but he placed the Filshie clip applier in the area of undissected tissue;
- The fact that there was a retained portion of a surgical bag after the surgical procedure demonstrates a lack of care and poor technique.

<u>Failure to Maintain the Standard of Practice of the Profession – Other Patients</u>

Subsequently, the College commenced an investigation under s.75 (1)(a) of the *Health Professions Procedural Code* into Dr. Ghumman's surgical practice. The College-retained expert and the expert retained by Dr. Ghumman reviewed Dr. Ghumman's

twenty-five patient charts. Both experts opined that Dr. Ghumman failed to maintain the standard of practice of the profession in the following areas:

- Prolonged and unnecessary use of prophylactic antibiotics post-operatively with respect to some patients. While there was no evidence of actual harm, overuse of antibiotics presents a risk of potential harm to patients, particularly in the hospital setting where there is a risk that antibiotic resistance will make treatment of infections more difficult. This issue was described as minor by both experts;
- Overuse of surgical drains in some patients, in the absence of evidence of an abscess requiring drainage or the development of post-operative collection of clear fluid. There was no evidence of actual harm or potential risk of harm to patients. This issue was described as minor by both experts;
- Deficient record-keeping pertaining to incomplete documentation of the patients' consent to a colonoscopy. There was no evidence of actual harm to any patient.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar impose the following terms, conditions and limitations on Dr. Ghumman's Certificate of Registration:

  Chief of Staff Role

  a) Dr. Ghumman shall not re-apply for the Chief of Staff position at any hospital until successful completion of the re-assessment described below.

  Clinical Supervision

  (a) Dr. Ghumman shall retain a College-approved Clinical Supervisor who will sign an undertaking in the form attached as Schedule "A" to the Order;
  (b) For a period of twelve (12) months commencing on the date that the Clinical Supervisor is approved by the College, Dr. Ghumman may practise only under the supervision of the Clinical Supervisor;
  (c) Clinical Supervision of Dr. Ghumman's practice shall contain the following elements:

  Moderate-Level Supervision

  a) For an initial period of approximately four (4) weeks, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will at minimum:
     (iv) Review materials provided by the College and have an initial in-person meeting with Dr. Ghumman to discuss practice improvement recommendations;
     (v) Thereafter, discuss with Dr. Ghumman once a week by telephone or secure electronic video conference to pre-clear all general surgery cases done in the operating room under a general anaesthetic;
     (vi) For on-call cases where Dr. Ghumman is not able to speak to his Clinical Supervisor prior to surgery, the Clinical Supervisor will review such cases as soon as possible after the surgery and in any event

within approximately 24 hours post-surgery by telephone or secure electronic video conference;

(vii) Provide reports to the College once every two (2) weeks, or more frequently if the Clinical supervisor has concerns about Dr. Ghumman's standard of practice or conduct;

(viii) Discuss with Dr. Ghumman any concerns the Clinical Supervisor may have arising from his meetings with Dr. Ghumman and case reviews;

(ix) Make recommendations for practice improvements and ongoing professional development, and inquire into Dr. Ghumman's compliance with any recommendations;

(x) Keep a log of all patient charts reviewed along with patient identifiers.

Low-Level Supervision Phase 1

a) After the first four (4) weeks of Dr. Ghumman's Moderate-Level Clinical Supervision, upon receipt of a written recommendation from the Clinical Supervisor that Dr. Ghumman is ready to practise under Low-Level Clinical Supervision, and subject to approval by the College, Clinical Supervision shall continue for a further period of eight (8) weeks during which time the Clinical Supervisor will at minimum:

(A) Meet with Dr. Ghumman once every two (2) weeks in person to discuss surgical cases and review a minimum of fifteen (15) patient charts, to be selected in the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Ghumman. If the Clinical Supervisor is of the view that fewer than fifteen (15) charts may be reviewed in this period, the Clinical Supervisor shall provide a written recommendation to the College and, subject to approval by the College, may review no fewer than ten (10) patient charts per visit for the remaining portion of this period of clinical supervision;

(B) Provide reports to the College once per month, or more frequently if the Clinical supervisor has concerns about Dr. Ghumman's standard of practice or conduct;

(C) Discuss with Dr. Ghumman any concerns the Clinical Supervisor may have arising from his meetings with Dr. Ghumman and chart reviews;

(D) Make recommendations for practice improvements and ongoing professional development, and inquire into Dr. Ghumman's compliance with any recommendations;

(E) Keep a log of all patient charts reviewed along with patient identifiers.

Low-Level Supervision Phase 2

a) After the first eight (8) weeks of Low-Level Clinical Supervision, upon receipt of a written recommendation from the Clinical Supervisor and subject to approval by the College, Clinical Supervision shall continue at Low-Level for the balance of the twelve (12) months of Clinical Supervision, during which time the Clinical Supervisor will at minimum:

(i) Meet with Dr. Ghumman once a month in person to discuss surgical cases and review a minimum of ten (10) patient charts, to be selected in the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Ghumman;

(ii) Provide reports to the College once every two months or more frequently if the Clinical supervisor has concerns about Dr. Ghumman's standard of practice or conduct;
(iii) Discuss with Dr. Ghumman any concerns the Clinical Supervisor may have arising from his meetings with Dr. Ghumman and chart reviews;
(iv) Make recommendations for practice improvements and ongoing professional development, and inquire into Dr. Ghumman's compliance with any recommendations;
(v) Keep a log of all patient charts reviewed along with patient identifiers.

Individualized Education Plan ("IEP")

a) The Clinical Supervisor shall facilitate completion of the education program, set out in an IEP to be provided to the Clinical Supervisor by the College, and shall report to the College in his/her reports as to Dr. Ghumman's progress in completing the IEP.

Other Elements of Clinical Supervision

a) Throughout the period of Clinical Supervision, Dr. Ghumman shall abide by the recommendations of the Clinical Supervisor and shall complete the IEP in co-operation with the Clinical Supervisor;
b) If a clinical supervisor who has given an undertaking as set out in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Ghumman shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time;
c) If Dr. Ghumman is unable to obtain a clinical supervisor in accordance with this Order, he shall cease to practice until such time as he has done so;
d) Dr. Ghumman shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Ghumman's compliance with this Order.

Re-Assessment

a) Approximately six (6) months after the completion of the period of supervision set out above Dr. Ghumman shall undergo a re-assessment of his practice, at his own expense, by a College-appointed assessor (the "Assessor(s)"). The re-assessment shall include the elements outlined in the IEP, to be provided by the College. The Assessor(s) shall report the results of the re-assessment to the College;
b) Dr. Ghumman shall consent to the disclosure to the Assessor(s) of the reports of the Clinical Supervisor arising from the supervision, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor(s) and the College, as the College deems necessary or desirable in order to fulfill their respective obligations.

Monitoring

a) Dr. Ghumman shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15)

days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

b) Dr. Ghumman shall cooperate with unannounced inspections of his practice and patient charts by one or more College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
c) Dr. Ghuman shall consent to the College's making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
d) Dr. Ghumman shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Ghumman appear before the panel to be reprimanded.
- Dr. Ghumman to pay costs to the College for a one day hearing in the amount of $5,500.00 within 30 days of the date of this Order.

5. Dr. H. Maal-Bared

Name:	Dr. Haya Maal-Bared
Practice:	Psychiatry
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	April 6, 2017
Written Decision Date:	June 12, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **withdrawn**

Summary

Dr. Maal-Bared is a psychiatrist who received her certificate of registration authorizing independent practice in Ontario on January 15, 2009 and started her solo practice as a psychiatrist in February 2009.

In and around 2009 to 2011, Dr. Maal-Bared provided individual psychotherapy treatment to Patient A (a teenager), Patient B (Patient A's mother), and Patient C (Patient B's common law spouse), collectively referred to as "the Family". Although Dr. Maal-Bared told Patients A and B that it was "not usually advisable" for psychiatrists to treat members of the same family in individual psychotherapy due to the possibility that one may forget the source of a piece of information thereby threatening confidentiality, Patients A and B said they were agreeable to her treating them both.

Failure to Maintain Boundaries

Dr. Maal-Bared and Patient B developed a friendship shortly after Patient B became her patient. While treating the Family, Dr. Maal-Bared socialized with them including visiting the Family at their home, attending Patient A's birthday party, going out to meals together, and attending one of Patient A's events. Dr. Maal-Bared and her husband, who was an artist, attended a "life drawing class" with the Family. Life drawing classes involve drawing a person from observation of a live nude model.

While socializing with Patient B, Dr. Maal-Bared shared information with her about her personal life and marital issues, gave Patient B skincare oil and some clothes she no longer wore. She also commissioned a piece of work from Patient A, which she paid for but ultimately decided not to accept. Dr. Maal-Bared and Patient B regularly exchanged emails and used nicknames for each other. Dr. Maal-Bared was "Eva" and Patient B was "Zsa Zsa", referring to the Hollywood actresses and sisters Eva and Zsa Zsa Gabor.

While Dr. Maal-Bared was her physician, Dr. Maal-Bared hired Patient B as her administrative and personal assistant. Patient A and Patient C were aware of and did not object to this arrangement. Patient B's administrative work provided her with access to Dr. Maal-Bared's patients' medical records. Patient B's responsibilities included organizing patient records and creating a database of patient contact information. Dr. Maal-Bared was aware that Patient B was working on a database of patient contact information from home and had made copies of patient contract information sheets. Dr. Maal-Bared's position is that she had no knowledge and did not permit Patient B to remove medical records from her office.

As Dr. Maal-Bared's personal assistant, Patient B worked in Dr. Maal-Bared's home, including organizing her closet, and helped Dr. Maal-Bared with personal errands, , such as driving her to the veterinarian once. Dr. Maal-Bared also hired Patient A to clean her office on a number of occasions. Patient B arranged for Patient C to purchase a computer for Dr. Maal-Bared and install software on it. Patient C also took professional photographs of Dr. Maal-Bared. Dr. Maal-Bared hired Patient B's sister to move a desk for her.

At Dr. Maal-Bared's request, as part of her administrative work, Patient B arranged to have her father who lived in the U.S. and sister pick up art work that Dr. Maal-Bared had ordered. Patient B's sister brought it across the U.S. border to Toronto for Dr. Maal-Bared. Dr. Maal-Bared later asked her father to pick up the artwork from the Family's home.

Dr. Maal-Bared attended in person at a hospital with the Family when Patient B's nephew became ill to advocate for his admission.
By the end of May 2012, Dr. Maal-Bared's relationship with the Family broke down, at which time Dr. Maal-Bared apologized to Patient B, and acknowledged that the situation was Dr. Maal-Bared's fault and that if they wanted to make a complaint to address their concerns, she would cooperate. In May 2014, the Family sent letters of complaint to

the College.. In her response to the Family's complaints, Dr. Maal-Bared acknowledged that she had compromised professional boundaries by developing a personal and employment relationships with the Family.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Maal-Bared's certificate of registration for a period of four (4) months effective immediately.
- Dr. Maal-Bared attend before the panel to be reprimanded.
- Dr. Maal-Bared pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order becomes final.

6. Dr. J.R.H. Matheson

Name:	Dr. Jeffrey Rice Holmes Matheson
Practice:	Family Medicine
Practice Location:	Ajax
Hearing:	Agreed Facts and Contested Penalty
Decision Date:	May 1, 2017
Written Decision Date:	June 28, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence – **withdrawn**

Summary

Dr. Matheson is a family physician practising in Ajax. Beginning in 2002, Dr. Matheson developed a specialty in Chronic Pain Management.

<u>Prescribing Practices</u>

During the period from July, 2013 to October, 2014, the College received four telephone calls from four pharmacists raising concerns about Dr. Matheson's prescribing practices.

The College retained an expert to review Dr. Matheson's opioid prescribing. The expert concluded that Dr. Matheson did not meet the expected standard of practice as outlined in the Canadian Guidelines either at the level of primary care physicians, or at a reasonably higher standard of physicians, like Dr. Matheson, holding themselves out as a specialist in the field.
The experts concerns included that:

- Dr. Matheson consistently demonstrated a lack of understanding of the expectations outlined in the Canadian guidelines with respect to instituting opioid therapy, following up, changing from one opioid to another and the medical implications of high-dose opioids.
- Dr. Matheson consistently demonstrated an almost cavalier approach to switching opioids, most often increasing the total daily morphine equivalent, by as much as 30% rather than allowing for incomplete tolerance and decreasing by 30 – 50%, all the time with no documentation of discussion around the driving or fall risk.
- Dr. Matheson's greatest failure of judgment is perhaps his complete lack of adherence to and recognition of the importance of the fundamental importance of the Canadian guidelines to an opioid practice. That he would initiate a specialty pain practice in October 2013, 3 years after the Canadian guidelines were published in large volumes without adequately tracing this process, all shows a significant lack of judgment to the point of negligence causing harm.
- Dr. Matheson's prescribing of opioids and failure to follow any standards of care beyond opioid agreements is nothing short of reckless…there is a risk to both his clients health and that of the public at large.

As a result of concerns raised by the College and its expert during the investigation, Dr. Matheson voluntarily ceased prescribing narcotics and controlled substances on March 16, 2015. On May 28, 2015, Dr. Matheson signed a formal interim undertaking to cease prescribing narcotics and controlled substances.

Out of Hospital Premises

Dr. Matheson was a medical director of premises that were subject to the inspection / assessment regime at the College under regulation. Pursuant to the regulation, no person may perform procedures as defined in the regulation, in premises, unless the College "passes" the premises or passes it with conditions that allow procedures to be performed.

On September 9, 2014, the College's Out of Hospital Premises Inspection Program received notice that Dr. Matheson's premises was intending to move in December 2014 and advised Dr. Matheson that the premises must be assessed prior to becoming operational.

The new premises were inspected on February 2, 2015. Dr. Matheson was provided with the Inspection Assessment Report, which noted some deficiencies, and was asked twice to submit feedback for consideration by the Premises Inspection Committee. Although Dr. Matheson was given deadlines on both of those occasions, he did not respond.

On June 11, 2015, Dr. Matheson's premises were subject to an unannounced visit by the Premises Inspection Program. During the inspection, Dr. Matheson acknowledged that he had been performing "Level 2" procedures at the premises since February.

On June 19, 2015, Dr. Matheson's premises received a grade of "Fail". The Premises Inspection Committee informed Dr. Matheson of its concern that there was a risk to patient health and safety as Dr. Matheson performed procedures at this premises without the approval of the Committee. The Committee further informed Dr. Matheson that he failed, by act or omission, to comply with any duty or requirement under the regulation.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Matheson's certificate of registration for four (4) months commencing May 1, 2017;
- Dr. Matheson appear before the panel to be reprimanded;
- The Registrar impose the following terms, conditions and limitations on Dr. Matheson's Certificate of Registration:

Prescribing Privileges

(1) Dr. Matheson shall not issue new prescriptions or renew existing prescriptions for any of the following substances:
   (a) Narcotic Drugs (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
   (b) Narcotic Preparations (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
   (c) Controlled Drugs (from Part G of the *Food and Drug Regulations* under the *Food and Drugs Act*, S.C., 1985, c. F-27);
   (d) Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act.*, S.C., 1996, c. 19); or (A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as **Schedule "A**"; and the current regulatory lists are attached hereto as **Schedule "B**"); and
   (e) All other Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 as noted in **Schedule "C"); and** as amended from time to time.

Posting a Sign

(2) Dr. Matheson shall post a sign in the waiting room(s) of his office, in a clearly visible and secure location, in the form set out at **Schedule "D"**. For further clarity, this sign shall state as follows: "Dr. Matheson shall not prescribe Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, or any other Monitored Drugs. Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca".

(3) Dr. Matheson shall post a certified translation in any language in which he provides services, of the sign described in paragraph 5.(2) above, in the waiting room(s) of his office.

(4) Dr. Matheson shall provide the certified translation(s) described in paragraph 5.(3), to the College within thirty (30) days of this Order.

(5) Should Dr. Matheson elect to provide services in any other language(s), he must notify the College prior to providing any such services.

(6) Dr. Matheson shall provide to the College the certified translation(s) described in paragraph 5.(4) prior to beginning to provide services in the language(s) described in paragraph 5.(5).

Coursework

(7) At his own expense, Dr. Matheson shall participate in and successfully complete, within 6 months of the date of this Order, the following programs:
   a) Medical Record Keeping;
   b) Opioid Prescribing; and
   c) Individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College.

Compliance

(8) Dr. Matheson must inform the College of each and every location that he practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within five (5) days of commencing practice at that location.

(9) Dr. Matheson shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the terms of this Order.

(10) Dr. Matheson shall co-operate with unannounced inspections of his Practice Location(s) and patient charts by the College and to any other activity the College deems necessary in order to monitor his compliance with the terms of this Order.

(11) Dr. Matheson shall provide his irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the Narcotics Safety and Awareness Act, 2010 and any person or institution that may have relevant information, in order for the College to monitor his compliance with the terms of this Order.

(12) Dr. Matheson acknowledges that the College may provide this Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where he practices or has privileges ("Chief(s) of Staff"), or other person or individual as necessary for the implementation of this Order and shall consent to the College providing to said Chief(s) of Staff, person or organization with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

- Dr. Matheson pay costs to the College in the amount of $6,663.60 within thirty (30) days of the date this Order becomes final.

7. Dr. P.W.N. Yau

Name:	Dr. Patrick Wing Nin Yau
Practice:	General Surgery
Practice Location:	Toronto
Hearing:	Uncontested Facts and Joint Submission on Penalty
Decision Date:	April 12, 2017
Written Decision Date:	May 16, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Incompetence – **withdrawn**

Summary

Dr. Yau is a general surgeon who received his certificate of registration authorizing independent practice in Ontario in 1998 and has held privileges at Scarborough General Hospital since 1999. In addition, he held the position of a medical director and practised general surgery, including bariatric surgery, at the Prince Arthur Surgical Centre Inc. ("the Clinic"), an Out of Hospital Premise, located in Toronto, which offered weight loss surgical procedures, including adjustable laparoscopic gastric banding. The Clinic ceased operations as of March 22, 2017.

Patient A

In November 2013, Patient A attended at the Clinic for bariatric surgery with Dr. Yau.

Prior to meeting Dr. Yau in 2013, Patient A had two previous bariatric surgeries. At the time of her initial surgery, Patient A had a Body Mass Index ("BMI") of 41 and was morbidly obese.

In a pre-surgery questionnaire, Patient A indicated that she hoped to reduce her BMI to 21. She also participated in a telephone pre-surgical consultation with a Clinic nurse, during which her BMI was noted to be 26, based on her self-reported weight and height. In addition, prior to surgery, Dr. Yau conducted a telephone consultation with Patient A, as she resided in another province, but did not note Patient A's BMI at the time.

On the day of the surgery, Patient A was weighed by Clinic staff. Her BMI was recorded as being 24.9, which is 10 lbs. less than the weight she self-reported during the telephone pre-surgical consultation with a Clinic nurse, and is considered to be in the normal range.

Patient A consented to the gastric banding surgery and Dr. Yau attempted the surgery on that day. However, the surgery could not be completed due to many dense adhesions that made dissection difficult. A tiny perforation was diagnosed and surgically

repaired. The surgery was aborted, a drain was placed and the patient was sent to the hospital for observation. She was ultimately discharged home without complications.

The College retained an expert in bariatric surgery, lap-band procedures and laparoscopy who opined that Dr. Yau fell below the standard of practice of the profession in deciding to perform the gastric banding surgery on Patient A when the bariatric surgery, including gastric banding, was not indicated given this patient's normal BMI. The expert further noted that Dr. Yau's decision to proceed with surgery exposed the patient to potential harm or injury, particularly given the risk that the patient's well-functioning gastric bypass could be damaged during surgery.

During the investigation, Dr. Yau advised the College that he missed the BMI noted as 24.9 on a computerized printout from an assessment done on the day of surgery and, inadvertently, proceeded with the surgery based on the initial numbers. Dr. Yau also advised the College that he has since, on his own initiative, implemented a number of changes to his practice, including improved documentation of patient discussions and indications for surgery, dictation of pre-operative notes and scrutinization of all patients' vitals, including morphological values, BMI, height and weight on the surgery day.

Patient B

In January 2012, Patient B attended the Clinic for a laparoscopic gastric banding procedure to assist him in losing weight. In addition to obesity, Patient B suffered from Type 1 Diabetes and hypertension, both of which were medically controlled.

During Patient B's post-surgery overnight stay in the clinic, the nurses documented abnormal and high glycemic results. At the time of his discharge from the clinic the next morning, Patient B's blood sugar and glucose levels were not verified or recorded by the Clinic nurse.

Following his discharge from the Clinic, Patient B boarded a plane as he resided in a different province. Upon landing, he checked into a hotel and was found deceased the following morning. The cause of death was attributed to bacterial meningitis and it was noted that diabetic ketoacidosis was a significant condition contributing to his death.

Dr. Yau was not on the premises during Patient B's post-surgery overnight stay at the Clinic. He was not notified about Patient B's elevated glycemic results and did not see Patient B prior to his discharge. At the time of Patient B's discharge, the Clinic's Discharge Protocol only required that a diabetic patient be advised upon discharge if he or she tested "outside of parameters".

The expert retained by the College concluded that Dr. Yau fell below the standard of practice of the profession in his role as a medical director of the Clinic in that he failed to ensure that an appropriate policy was in place at the Clinic for the post-operative management and discharge of diabetic patients.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Yau's certificate of registration for a period of three (3) months effective May 13, 2017, at 12:01 a.m.
- The Registrar impose the following terms, conditions and limitations on Dr. Yau's Certificate of Registration:
  (i) Dr. Yau will not perform the revision surgery referred to as band over bypass outside of a hospital setting;
  (ii) Dr. Yau will meet in-person with patients who reside in the GTA for a pre-surgical consultation in respect of gastric banding on a day that is prior to surgery and will document the consultation. For patients that reside outside the GTA, Dr. Yau will conduct a telephone consolation on a day that is prior to surgery day and will document the consultation; and
  (iii) Dr. Yau will not act as a Medical Director of an Out-of-Hospital Premise for a period of one (1) year.
- Dr. Yau attend before the panel to be reprimanded.
- Dr. Yau pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date this Order becomes final.

8. Dr. J.W. Young

Name:	Dr. James Wen Young
Practice:	Anaesthesiology
Practice Location:	Toronto
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	November 29, 2016
Penalty/ Written Decision Date:	June 19, 2017

Allegations and Findings

- Failed to maintain the standard of practice - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **withdrawn**
- Incompetence – **withdrawn**

Summary

Dr. Young, an anesthesiologist practicing in Toronto, received his specialist qualification in anesthesiology in 2003. Dr. Young has had privileges at the Humber River Regional Hospital (the "Hospital") since 2003 and currently practises full-time anaesthesiology there. During the relevant time period, Dr. Young worked at the Ontario Endoscopy Clinic one day per month as one of a group of anaesthesiologists from the Hospital.

Dr. Young entered a plea of no contest based on the following statement of uncontested facts:

Hepatitis C Outbreak at the Ontario Endoscopy Clinic

On April 28, 2014 the College received a complaint from a patient that she had contracted Hepatitis C as a result of a gastroscopy performed at the Ontario Endoscopy Clinic. The patient had obtained this information after being advised by Toronto Public Health regarding a Hepatitis C outbreak at the Ontario Endoscopy Clinic.

The Toronto Public Health investigation found that five patients became infected with Hepatitis C during their procedures at the Ontario Endoscopy Clinic on March 15, 2013, a day when Dr. Young was working as one of two anaesthesiologists at the Ontario Endoscopy Clinic. Toronto Public Health concluded that the source patient, Patient A, was the fourth of 10 patients who had procedures in the same procedure room with the same endoscopist and the same anaesthesiologist (Dr. Young) on that day. All except one of the patients who had a procedure following Patient A acquired Hepatitis C. The investigation ruled out contamination of the endoscopes as a source of the contamination since a different scope had been used on each of the five patients that contracted Hepatitis C.

Toronto Public Health conducted a review of Dr. Young's practice, including a direct interview and observation of his practice at the Ontario Endoscopy Clinic on August 16, 2013. Toronto Public Health also conducted a look-back of patients who had a procedure at the Ontario Endoscopy Clinic in the five years prior to the date of transmission and were cared for by Dr. Young. No additional newly Hepatitis C or HBV-infected individuals were found.

While observing that Dr. Young separated unused and used syringes on the anaesthesia cart, and observing that needles were not re-used and re-inserted into the medication bottle if more medication was required, Toronto Public Health noted that the literature supported the theory that Hepatitis C transmission occurs in health care settings as a result of mishandling of multi-dose injectable medications.

The use of multi-dose injectables, while common, presents greater risk when used in a high volume, rapid turnover environment.

Toronto Public Health concluded that it was possible that a multi-dose vial of medication, most likely lidocaine, became contaminated with blood from Patient A, and was used during the subsequent procedures on that day. It noted that lidocaine was the one vial used for all patient procedures that day, while the propofol vial would not have provided enough doses for all patient procedures subsequent to Patient A.

Clinical Care Issues Identified College by College Experts

The College retained two medical inspectors to conduct an investigation into Dr. Young's practice. The College's experts reviewed the charts of the patients who had been provided with anesthesia by Dr. Young during their procedures at the Ontario Endoscopy Clinic on the day in question, interviewed Dr. Young and observed his practice providing anaesthesia for endoscopy procedures at the Hospital.

The first College expert opined that:

- Dr. Young failed to properly review Patient A's chart, including the pre-anesthesia questionnaire, to determine whether there were any anaesthesia associated risks;
- Dr. Young did not see that the patient had checked off "hepatitis" in the questionnaire and may have taken additional precautions based on this information;
- This failure created a significant risk to patient safety;
- Dr. Young should have been aware of the risks of using a multi-dose vial regardless of time or cost pressures that might have been in play at the Ontario Endoscopy Clinic level;
- Despite Dr. Young's statement that he never re-enters a multi-dose vial with a used syringe, this is the most plausible explanation for the sequence of Hepatitis C cases that occurred on March 15, 2013;
- Dr. Young should have been aware of the importance of reviewing a patient's medical history;
- Dr. Young's care did display a lack of judgment, but did not display a lack of skill or knowledge;
- Despite the fact that he could not control what the Ontario Endoscopy Clinic ordered in terms of stack vial size, he could have exercised increased caution when using large multi-dose vials.

The first expert concluded that transmission of Hepatitis C likely occurred as a result of contamination of a multi-dose vial, likely of propofol, by Dr. Young. The expert concluded that the degree of deficit in this case was mild and that Dr. Young appeared to have learned from the experience at the Ontario Endoscopy Clinic and concluded that Dr. Young's current clinical practice, behaviour or conduct does not expose and is not likely to expose patients to harm or injury.

The second College expert opined that the documentation in the anaesthetic record completed by Dr. Young for Patient A and the 6 patients who followed her was deficient and below standards of practice in one or more of the following areas:

- No pre-operative vitals (in two out of seven cases);
- No post-operative vitals or level of consciousness;
- No discharge orders;
- No pre-operative airway assessment.

The second expert opined that with respect to Patient A, the anaesthetic record was deficient in having no pre-operative blood glucose despite her history of diabetes and insulin use, no notation of the patient's history of Hepatitis C, and no documentation of her history of chest pain.

The second expert concluded that Dr. Young did not meet standards of practice in that he was not aware that Patient A was Hepatitis C positive although the patient questionnaire indicated a history of Hepatitis C. There was an increased potential for harm in not being aware that the patient was Hepatitis C positive. Dr. Young did not meet the standards of practice regarding infection control procedures. It is extremely likely that the 5 patients were infected with Hepatitis C from contaminated intravenous medication administered by Dr. Young, In addition, there were poor infection control practices observed both in medication preparation (e.g., not cleaning the tops of vials before re-entering) as well as failure to change gloves frequently enough and disposal of contaminated syringes in a bio-medical waste bin.

The second College expert reported that Dr. Young displayed a lack of knowledge regarding appropriate infection control techniques with respect to multi-dose vials and that Dr. Young's clinical practice exposed five patients to harm as they were infected with Hepatitis C.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Young's certificate of registration for a period of three (3) months commencing immediately.
- The Registrar impose the following terms, conditions and limitations on Dr. Young's certificate of registration:
    - (ii) Dr. Young shall take a course on infection control as approved by the College within six (6) months of the date of this Order and provide proof of completion of same to the College;
    - (iii) Dr. Young shall be subject to an assessment of his practice, including but not limited to an observation of his sterile technique, his preoperative process and his record keeping within six (6) months of his return to practice after the end of the suspension referred to above; and
    - (iv) Dr. Young shall be solely responsible for payment of all fees, costs charges and expenses, arising from the implementation of this order.
- Dr. Young appear before the panel to be reprimanded.
- Dr. Young pay costs to the College in the amount of $10,000.00 within sixty (60) days of the date of this order.

Disgraceful, Dishonourable, or Unprofessional Conduct - 2 cases

1. Dr. R.C. Maranda

Name:	Dr. Robert Claude Maranda
Practice:	Cardiology
Practice Location:	Ottawa
Hearing:	Agreed Facts and Joined Submission on Penalty
Penalty Decision Date:	June 15, 2017
Written Decision Date:	July 13, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Conduct unbecoming a physician – **withdrawn**

Summary

Dr. Maranda is a cardiologist practising in Ottawa. He received his certificate of registration authorizing independent practice in Ontario in 2005 and his specialist qualification in cardiology in 2007. In the relevant years, Dr. Maranda held privileges at The Ottawa Hospital.

Also, in the relevant years, Dr. Maranda was an assistant professor and an “ePorfolio” group leader at the Faculty of Medicine at a University.

Disgraceful, dishonourable or unprofessional conduct

Ms A was a student in Dr. Maranda’s ePortfolio group. Dr. Maranda’s role as group leader involved meeting with the group of students approximately twice a year to discuss issues associated with the process of completing medical school and preparing their e-portfolios.

Each student in the group had to submit a draft final ePortfolio posting by the required deadline. The ePortfolio class was to be graded by Dr. Maranda on a pass-fail basis. A student would receive a “pass” so long as the student submitted the required postings.

Ms A requested an extension of time for submitting her draft posting. She explained to Dr. Maranda that she was experiencing personal difficulties following the end of a relationship. Dr. Maranda granted the extension. Later, Dr. Maranda offered to meet with Ms A to offer supportive advice.

Dr. Maranda and Ms A went for drinks and food and discussed Ms A’s personal issues as well as her progress in obtaining a residency placement. Following their meeting, Ms

A texted Dr. Maranda to thank him. Their communications became more frequent and personal after that time.

Dr. Maranda and Ms A arranged to meet at a pub again a few weeks later. Following their meeting, they returned to Ms A's apartment and a sexual encounter took place. The next day, Dr. Maranda and Ms A texted back and forth. After several days, Ms A stopped communicating with Dr. Maranda, who continued to send her messages for a few days.

Subsequently, Ms A submitted a complaint about Dr. Maranda to the University.

Dr. Maranda was advised that he was to have no contact with learners, pending review of Ms A's complaint by the University's Professionalism Investigation Committee (the "PIC"). The PIC concluded that Dr. Maranda engaged in a personal relationship with a student and that the relationship constituted a breach in professionalism. Although the PIC recommended a supervised reintegration into the learning environment over the course of three years, Dr. Maranda's academic appointment at the University was terminated.

Dr. Maranda subsequently resigned his privileges at the Ottawa Hospital.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar impose the following terms, conditions and limitations on Dr. Maranda's Certificate of Registration:
  a) At his own expense, Dr. Maranda shall successfully complete the next available course in Understanding Boundaries at Western University within 6 months of the date of this Order
- Dr. Maranda appear before the panel to be reprimanded.
- Dr. Maranda pay costs to the College for a one day hearing in the amount of $5,500.00 within 30 days of the date of this Order.

2. Dr. J. A. Zadra

Name:	Dr. Joseph Antonio Zadra
Practice:	Urology
Practice Location:	Barrie
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	April 17, 2017
Written Decision Date:	June 12, 2017

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Failure to maintain standard of practice **– withdrawn**
- Incompetence **– withdrawn**

Summary

Dr. Zadra is a staff urologist at the Royal Victoria Regional Health Centre (RVH) in Barrie, Ontario. Dr. Zadra received his certificate of registration authorizing independent practice in Ontario in 1984 and his specialist qualification in urology in 1988. Dr. Zadra has maintained his privileges at the RVH throughout the College investigation, described below, to the present.

In March 2014, the College received a complaint indicating that Dr. Zadra had been dictating operative reports that did not accurately reflect the work he had done. No patient harm was reported as a result of this practice.

RVH Investigation

RVH conducted a review of a portion of Dr. Zadra's work, which revealed that Dr. Zadra inaccurately recorded the names of certain procedures that he performed.

Specifically, Dr. Zadra indicated that he performed a procedure named "cystometrogram" or "water cystometrogram", while RVH had not had a functioning cystometrogram machine for at least several years. In addition, Dr. Zadra dictated that he performed a "urethrotomy" in three cases, when RVH did not have a pediatric urethrotome and this procedure should have been recorded as a "meatotomy". Furthermore, in one case, Dr. Zadra dictated that he performed a procedure using a urethrotome under local anesthetic, which is considered to be an unusual practice as the urethrotome is only used in the operating room at RVH. Also, the operating room nursing staff indicated that Dr. Zadra's dictation of the particular size of sutures he used while performing hernia repair on a patient were not in fact used according to the surgical count.

College Investigation

The College retained an expert in urology and oncology, who opined that while Dr. Zadra's practice did not expose patients to harm, there were some planned or proposed procedures that could have exposed patients to potential harm if they had been carried out.

In addition, similarly to the results of the RVH investigation, the expert reported concerns with Dr. Zadra's record keeping, documentation and description of the procedures performed, including the "semantics and labeling of the procedures actually performed."

The expert noted that for five patients, Dr. Zadra dictated that he performed a "water cystomerogram", while he later admitted in his interview with the expert that the Ambulatory Care Unit at RVH did not have a functioning cystometrogram machine. It was noted, that in one case of a circumcision of an 8-year old boy, Dr. Zadra failed to dictate issues that should have been documented, such as pre- and post-operative urine stream. In another case, Dr. Zadra dictated a procedure of "hernia repair with multiple 2-0 and 3-0 Vicryl sutures" that did not correspond to the operating room nurses' suture count. The discrepancy was that 3-0 sutures were in fact used. In two other cases, Dr. Zadra dictated that he performed a "urethrotomy", when he should have dictated it as a "meatotomy". It was also revealed that in two cases, Dr. Zadra amended his dictated note to different procedures than he had initially recorded.

The expert further opined that in a number of patient charts, the description of the procedures actually performed was inaccurate, leading to inaccurate and/or questionable claims submissions to OHIP. Although the amounts were small, a number of fee codes were billed in error due to the inaccurate description of procedures performed.

For example, for several patients, Dr. Zadra had billed the OHIP code, which covers "pelvis limited study other than pregnancy" done by ultra-sound and was paid at $21.95. In his interview with the expert, Dr. Zadra stated that in fact he had carried out a "post-void residual urine measurement", which should have been billed at the rate of $12.70. Another example was billing an OHIP Code for what was dictated as a "water cystometrogram", when the procedure was not in fact performed on several patients.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Zadra's certificate of registration for a period of three (3) months;
- The Registrar impose the following terms, conditions and limitations on Dr. Zadra's Certificate of Registration:

  Instruction in medical ethics

  (i) At his own expense and within twelve (12) months of the date of this Order, Dr. Zadra shall participate in and successfully complete individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Zadra.

  Medical record-keeping

  (ii) At his own expense and within twelve (12) months of the date of this Order, Dr. Zadra shall participate in and successfully complete a record-keeping course acceptable to the College, and provide proof of completion thereof to the College;

Clinical Supervision

(iii) At his own expense and within thirty (30) days of this Order, Dr. Zadra shall retain a Clinical Supervisor approved by the College, who will sign an undertaking in the form attached to this Order as Schedule "A";

(iv) For a period of six (6) months commencing from the date Dr. Zadra resumes practice following the suspension of his certificate of registration described in paragraph 2, Dr. Zadra may practise only under the supervision of the Clinical Supervisor ("Clinical Supervision");

(v) Clinical Supervision of Dr. Zadra's practice shall contain the following elements:

  (a) Review, on a monthly basis, operating room dictations and notes in a minimum of twenty-five (25) patient charts, to be selected at the sole discretion of the Clinical Supervisor, along with the corresponding OHIP claims submissions;

  (b) Discuss with Dr. Zadra any concerns the Clinical Supervisor may have arising from the chart reviews;

  (c) make recommendations to Dr. Zadra for practice improvements and ongoing professional development, and inquire into Dr. Zadra's compliance with the recommendations;

  (d) the Clinical Supervisor will keep a log of all patient charts reviewed along with patient identifiers; and

  (e) the Clinical Supervisor will provide reports to the College on a bi-monthly basis for the six (6) month period of practice monitoring, or more frequently if the Clinical Supervisor has concerns about Dr. Zadra's standard of practice or conduct.

(vi) Throughout the period of Clinical Supervision, Dr. Zadra shall abide by the recommendations of the Clinical Supervisor;

(vii) If a clinical supervisor who has given an undertaking as set out in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Zadra shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time;

(viii) If Dr. Zadra is unable to obtain a clinical supervisor in accordance with paragraph (vii) of this Order, he shall cease to practice until such time as he has done so;

(ix) Dr. Zadra shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Zadra's compliance with this Order;

(x) Dr. Zadra shall inform the College of each and every location where he practices including but not limited to hospital, clinics and offices, in any jurisdiction (collectively his "Practice Location(s)), within fifteen (15) days of this order and shall inform the College of any new Practice Locations

within fifteen (15) days of commencing practice at that location, for the purposes of monitoring his compliance with this Order;

(xi) Dr. Zadra shall submit to, and not interfere with, unannounced inspections of his Practice Locations(s) and patient records by a College representative, for the purposes of monitoring his compliance with this Order;

(xii) Dr. Zadra shall consent to the monitoring of his OHIP billings and cooperate with inspections of his practice, his patient charts and his OHIP billings by his Clinical Supervisor and College representatives for the purpose of monitoring his compliance with the terms of this Order;

(xiii) Dr. Zadra shall provide consent to the College to make appropriate enquiries of OHIP, for a period of one (1) year after he resumes practice following the suspension of his certificate of registration described in paragraph 2, for the purpose of monitoring his compliance with the terms of this Order; and

(xiv) Dr. Zadra shall be responsible for any and all costs associated with implementing this Order.

- Dr. Zadra attend before the Committee to be reprimanded;
- Dr. Zadra pay costs to the College in the amount of $5,000.00 within thirty (30) days of the date this Order becomes final.