CPSO

Meeting of Council

September 22 & 23, 2022

NOTICE

OF

MEETING OF COUNCIL

A meeting of the Council of the College of Physicians and Surgeons of Ontario (CPSO) will take place in-person on September 22 and 23, 2022 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The Council meeting will be open to staff and members of the public who wish to attend in-person. The meeting will also be live streamed. Members of the public who wish to observe the meeting in-person or view the live stream will be required to register online at least 48 hours prior to the meeting. Details on this process will be available on the CPSO's website in due course.

The meeting will convene at 10:30 am on Thursday, September 22, 2022.

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

August 29, 2022

Council Meeting Agenda

September 22-23, 2022

CPSO

THURSDAY, SEPTEMBER 22, 2022

Item	Time	Topic and Objective(s)	Purpose	Page No.
1	**10:30 am** (10 mins)	**Call to Order and Welcoming Remarks** (J. van Vlymen) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
2	**10:40 am** (5 mins)	**Consent Agenda** (J. van Vlymen) 2.1 Approve Council meeting agenda 2.2 Approve draft minutes from Council meeting held on June 16-17, 2022	Approval (with motion)	1-64
3	**10:45 am**	**Items for information:** 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Policy Report 3.5 Medical Learners Report 3.6 Update on Council Action Items 3.7 2023 Council Meeting Dates	Information	 65 66-71 72-74 75-80 81-84 85-92 93
4	**10:45 am** (60 mins)	**CEO/Registrar's Report** (N. Whitmore)	Discussion	N/A
5	**11:45 am** (15 mins)	**President's Report** (J. van Vlymen)	Discussion	N/A
*	**12:00 pm** (60 mins)	**LUNCH (Lunch available in the Dining Room)**		
6	**1:00 pm** (60 mins)	**Human Rights in the Provision of Health Services – Draft Policy for Consultation** (C. Roxborough) • Consider approving the draft Human Rights in the Provision of Health Services policy for external consultation	Decision (with motion)	94-116
7	**2:00 pm** (25 mins)	**Amendments to Declaration of Adherence and Council Code of Conduct (regarding Social Media)** (L. Rinke-Vanderwoude, M. Cooper, C. Allan) • Consider approving the amendments to the Declaration of Adherence and Council Code of Conduct regarding changes made to address social media use	Decision (with motion)	117-135

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**2:25 pm** (30 mins)	**NUTRITION BREAK**		
8	**2:55 pm** (45 mins)	**Medical Assistance in Dying – Draft Policy for Consultation** (M. Cabrero Gauley) • Consider approving the draft Medical Assistance in Dying policy for external consultation	Decision (with motion)	136-165
9	**3:40 pm** (30 mins)	**Council Self-Assessment** (C. Allan) • Consider approving the revised Council Self-Assessment	Decision (with motion)	166-172
10	**4:10 pm**	**Adjournment Day 1** (J. van Vlymen)	N/A	N/A

FRIDAY, SEPTEMBER 23, 2022

Item	Time	Topic and Objective(s)	Purpose	Page No.
*	**8:30 am**	**INFORMAL NETWORKING (Breakfast available in the Dining Room)**		
11	**9:00 am** (10 mins)	**Call to Order** (J. van Vlymen) • Participate in roll call and declare any conflicts of interest	Discussion	N/A
12	**9:10 am** (60 mins)	**Governance Committee Report** (J. Plante) 12.1 Executive Committee Elections 12.2 Governance Committee Elections 12.3 Committee Appointments and Re-appointments	 Decision Decision Decision	 173-181 182-186 187-193
13	**10:10 am** (20 mins)	**Premises Inspection Committee Public Member Update** (L. Reid, C. Allan, N. Novak, L. Rinke-Vanderwoude) • Consider approving the changes to the composition of the Premises Inspection Committee to remove the Public Member requirement as well as by-law amendments	Decision (with motion)	194-201
*	**10:30 am** (30 mins)	**NUTRITION BREAK (Refreshments available in the Dining Room)**		
14	**11:00 am** (20 mins)	**Education Advisory Group Dissolution** (L. Rinke-Vanderwoude, M. Cooper, C. Allan) • Consider approving the dissolution of the Education Advisory Group	Decision (with motion)	202-210
15	**11:20 am** (25 mins)	**Specialist Recognition Criteria in Ontario** (S. Tulipano) • Consider approving the amendments to the Specialist Recognition Criteria in Ontario	Decision (with motion)	211-220
New item		**Regulatory Proposal – Temporary Class of Licensure** (C. Roxborough, S. Tulipano) • Consider approving the proposed regulation for submission to create a temporary class of registration designed to support mobility within Canada • Consider proposed By-law amendments to the Fees and Remuneration By-law for circulation	Decisions (with motions)	
16	**11:45 am** (15 mins)	**COUNCIL AWARD PRESENTATION** (Dr. Anne Walsh) Celebrate the achievements of Dr. Georgina Wilcock, Scarborough		
17	**12:00 pm**	**Motion to move In-Camera** (J. van Vlymen)	Decision (with Motion)	221
*	**12:00 pm** (60 mins)	**LUNCH (Lunch available in the Dining Room)**		
18	**1:00 pm** (50 mins)	**In-Camera Session**		

Item	Time	Topic and Objective(s)	Purpose	Page No.
19	**1:50 pm** (10 mins)	**Filling Vacancies on Council – By-law Amendment** (L. Brownstone, M. Cooper) • Consider approving the By-law Amendment for filling Council vacancies • Consider approving recommendation to leave seat in District 5 vacant until next year's Council election	Decisions (with motions)	222-227
20	**2:00 pm** (60 mins)	**Out-of-Hospital Premises Inspection Program (OHPIP) – Draft Standards for Consultation** (C. Brown, T. Terzis, C. Roxborough, L. Reid, R. Halko) • Consider approving the OHPIP draft standards for external consultation	Decision (with motion)	228-288
21	**3:00 pm** (10 mins)	**Adjournment Day 2** (J. van Vlymen) • Reminder that the next meeting is scheduled on December 8-9, 2022	N/A	N/A
*	**3:10 pm**	**Meeting Reflection** (J. van Vlymen)		

DRAFT PROCEEDINGS OF THE MEETING OF COUNCIL
June 16 & 17, 2022

Location: Council Chamber, 80 College Street, Toronto, Ontario

June 16, 2022

Attendees

Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Shahid Chaudhry
Dr. Brenda Copps
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton
Dr. Paul Hendry
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Ms. Lydia Miljan
Dr. Rupa Patel
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Janet van Vlymen
Dr. Anne Walsh
Ms. Shannon Weber

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Andrea Lum
Dr. Karen Saperson

Regrets:

Mr. Jose Cordeiro
Dr. Deborah Hellyer
Mr. Rob Payne

1. Call to Order and Welcoming Remarks

J. van Vlymen, President of Council and Chair, called the meeting to order at 9:00am. J. van Vlymen welcomed members of Council and staff to the Council meeting.

She also welcomed members of the public tuning in via YouTube and reminded the meeting of the College's mission, vision, and values. There were no conflicts of interest declared.

A. Walsh provided the land acknowledgement as a demonstration of recognition and respect for Indigenous peoples of Canada.

J. van Vlymen conducted a roll call and noted regrets. She mentioned that both K. Pirzada and P. Giroux have resigned from Council. She recognized their outstanding contributions to Council and wished them well on their future endeavors.

2. Consent Agenda

J. van Vlymen provided an overview of the items listed on the Consent Agenda for approval. She noted that there will be a few amendments to the order of agenda items on day 2 to facilitate flow.

01-C-06-2022

The following motion was moved by P. Pielsticker, seconded by J. Goyal and carried, that:

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

- The Council meeting agenda for June 16 and 17, 2022, as amended; and
- The minutes from the Council meeting held on March 3 and 4, 2022, as distributed.

CARRIED

3. For Information

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

3.1 Executive Committee Report
3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases
3.3 Government Relations Report (sent out under separate cover on June 10, 2022)
3.4 Finance and Audit Committee Report
3.5 Policy Report
3.6 Medical Learners Reports – Ontario Medical Students Association (OMSA) and Professional Association of Residents of Ontario (PARO)
3.7 Update on Council Decisions

4. Chief Executive Officer / Registrar's Report

N. Whitmore, Chief Executive Officer and Registrar presented her report to Council. She provided an overview on the targets for the Key Performance Indicators. A status update was provided on the Annual Renewal process.

An overview was provided on the following department programs:

- Registration and Membership Services;
- Quality Improvement program including an update on the the number of hospitals collaborating in the Quality Improvement partnership;
- Out of Hospital Premises Inspection Program;
- Patient & Public Help Centre;
- Ontario Physicians and Surgeons Discipline Tribunal (OPSDT)

An update was provided on policy and government relations items, noting that there are a number of policies coming forward to Council at this meeting and reviews launching following the meeting. An update was provided on the upcoming provincial election noting that health care continues to be a priority for all political parties and that continued interest in the modernization of the *Regulated Health Professions Act* is expected following the election.

The Annual Meeting of Federation of Medical Regulatory Authorities of Canada (FMRAC) was held in June. The was the first in-person since 2019. The conference focus was on indigenous healthcare and safety. S. Sharda, Equity, Diversity and Inclusion (EDI) Lead was recognized in providing a two-hour interactive session at the Conference. N. Whitmore was appointed as President of FMRAC.

Updates were provided on the June issue of Dialogue which has an article on Allyship and the recent launch of In Dialogue podcast featuring J. van Vlymen. K. Saperson and S. Reid will be featured on upcoming podcasts.

May 1, 2022 was Doctor's Day, and a message was sent out to the profession with a 64 percent open rate.

The following updates were provided on engagement, collaboration, and operations:

- Launch of the 2023 Council Award nominations
- Release of the Annual Report
- Pride Month is celebrated, Rainbow Health program offered to staff
- N. Novak recognized for her work in fully digitalizing operations
- N. Novak appointed as Chief Operating Officer
- D. Finkelstein appointed as Physician Engagement Lead
- S. Sharda awarded The Dr. Pauline Alakija Trailblazer Award for Equity in Medicine
- Launch of the new Intranet

An update was provided on staff returning to the office on a limited basis to facilitate face to face interactions as well as cross functional work. Key priorities for 2023 were highlighted including migrating the HR platform into the Finance system (data link) and rebuilding the external facing register. An update will be provided to Council in September on the modernization to workspace. Council congratulated N. Whitmore and team on all the hard work to date and efforts underway.

5. President's Report

J. van Vlymen presented her report to Council highlighting the importance of completing the Council meeting evaluation form in order to inform future Council meetings. She shared general themes from the March meeting evaluation including the power of storytelling as an effective tool as well as having more interactive sessions and breakout sessions.

The topic of physician wellness was brought forward, and questions were raised as to what we could do as a regulator in promoting physician wellness. Various initiatives are underway to address this important topic, including enhancing and streamlining the annual renewal process and having a tone of kindness and commitment to improving members' experiences. D. Finkelstein's new role as Physician Engagement Lead will facilitate communication and outreach opportunities with the profession.

J. van Vlymen and J. Plante will be conducting one to one meetings with Council Members in early fall to connect and reflect on Council Members' experience on Council.

An update was provided on a number of meetings that have taken place over the last few months including the Chair / Vice Chair training workshop and J. van Vlymen's first ever In Dialogue podcast.

Highlights from the FMRAC Conference were provided, attendees were able to connect with peers in provinces and territories across Canada.

It was noted that there have been recent correspondence and communications containing threatening and concerning language directed to some Council Members. This is a concern that is being taken very seriously.

6. Dispensing Drugs – Draft Policy for Consultation

C. Roxborough, Director, Policy provided an overview of the draft Dispensing Drugs policy. The draft policy is being brought forward to Council for approval to release the draft policy for a shortened 45 day external consultation and engagement process. Council discussed elements of the draft policy.

Feedback will be sought from relevant physicians in this niche area. The consultation will be promoted on social media and Dialogue. Following discussion, Council expressed support for releasing the draft policy for an abridged external consultation process.

02-C-06-2022

The following motion was moved by I. Preyra, seconded by L. Becker and carried, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy “Dispensing Drugs”, (a copy of which forms Appendix “A“ to the minutes of this meeting).

CARRIED

7. Governance Committee Report

J. Plante, Chair of Governance provided the Governance Committee Report. She reported on the status of the Council district elections noting that Districts 2 and 3 will be acclaimed. An overview was provided on Districts 1 and 4 noting that the voting period is now open and closes on June 21st.

The Executive Committee elections will take place at the September meeting in order to avoid any overlap with the Council district elections. Nominations for the Executive Committee will take place over the summer.

An update was provided on the committee recruitment process which has moved onto a web based application in an effort to increase interest. The interview process for committee work will commence over the summer. The Governance Office has developed enhanced eligibility screening processes and is working on revising interview scripts.

In addition, staff are working on exploring other options for the Council self-assessment tool.

There was discussion on filling the vacancy resulting from K. Pirzada’s resignation from Council and whether a by-election will be held in district 5. It was noted that this item will come back to Council at its September meeting in order to give staff an opportunity to look at the by-election timing and determine options and next steps. It was confirmed that Council is required to have between 15 to 16 Council Members and that Council currently meets this minimum requirement.

8. Register By-Law Amendments

M. Cooper, Senior Corporate Counsel & Privacy Officer brought the proposed Register By-law amendments back to Council for final approval, noting that no feedback was received from the external consultation.

03-C-06-2022

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

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 148:

By-law No. 148

(1) Paragraphs 12, 13, 14, 17, and 17.1 of subsection 49(1) of the General By-law are revoked and substituted with the following:

Content of Register Entries

49. (1) In addition to the information required under subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following information with respect to each member:

…

12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations and relinquishments of the member's privileges or practice, and rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect.

13. If an allegation of professional misconduct or incompetence against the member has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided,

    i. a summary of the allegation if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to September 10, 2013,
    ii. a summary of the allegation and/or the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal after September 10, 2013,
    iii. an indication that the matter has been referred to the Ontario Physicians and Surgeons Discipline Tribunal,
    iv. the anticipated date of the hearing, if the date has been set,
    v. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of the adjournment, and
    vi. if the decision is under reserve, that fact.

14. If the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register,
    i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding,
    ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty, and
    iii. if the finding is appealed, the status of the appeal and the disposition of the appeal.

…

17. If an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal,

    i. that fact,
    ii. the dates on which the application is scheduled to be heard,

iii. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of that adjournment, and
iv. if the decision is under reserve, that fact.

17.1. If an application to the Ontario Physicians and Surgeons Discipline Tribunal for reinstatement has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

(2) Subsection 49(1) of the General By-law is amended by adding the following as paragraphs 17.3 and 17.4:

17.3. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed,

i. that fact,

ii. the dates on which the application is scheduled to be heard,

iii. if the hearing has been adjourned and no future date has been set, the fact of that adjournment, and

iv. if the decision is under reserve, that fact.

17.4. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal.

(3) Paragraph (g) of subsection 50.1(1) of the General By-law is amended by deleting the reference to "discipline committee" and substituting it with "Ontario Physicians and Surgeons Discipline Tribunal".

CARRIED

9. Council Award Presentation

D. Robertson, Council Member presented the Council Award to Dr. Sinziana Avramescu of Toronto for her leadership, passion for education, research and problem-solving. Dr. Avramescu was recognized for her leadership at Humber River Hospital (HRH) in creating and implementing an ICU Care plan during the pandemic. She recognized her colleagues at HRH for their support. Dr. Avramescu expressed appreciation to the CPSO for recognition of her outstanding contributions to the profession.

10. The Power of Teamwork

J. van Vlymen introduced Council's guest speaker, Dr. Brian Goldman. Dr. Goldman is an emergency physician, author, public speaker, and radio personality. He delivered an informative presentation to Council on the topic of The Power of Teamwork sharing his personal experiences and insights.

11. Finance and Audit Committee Update

T. Bertoia, Chair of the Finance and Audit Committee and N. Novak, Chief Operating Officer presented the Finance and Audit Committee update providing highlights from the audited financial statements noting a $4.5M surplus. N. Novak presented the financial road map that highlighted changes from 2018 through to 2021 including operational savings during this period, a detailed overview of the restructuring of departments to align with the new strategy and lean methodology and projects such as the build of Solis, Vault and Finance and Operations (F&O) among others.

An overview of the next four year road map was shared which includes migrating the HR platform into F&O, development of a data lake house and rebuilding the external facing physician register. Next steps and timelines were provided. It was confirmed that there will not be any increase to membership fees for 2023.

11.1 Audited Financial Statements for the 2021 Year

T. Bertoia, Chair of the Finance and Audit Committee, provided the Finance and Audit Committee Report to Council.

P. Brocklesby from Tinkham LLP, provided an overview of the audit process. The auditors met with the Finance and Audit Committee in April 2022 and noted that there were no matters of non-compliance and that multiple controls are in place. The auditors highlighted details from the Independent Auditor's Report noting that the financial statements presented fairly and that the audit was conducted in accordance with Canadian generally accepted auditing standards. The auditors thanked staff for facilitating the audit process.

11.2 Approval of the Audited Financial Statements for the 2021 Fiscal Year

04-C-06-2022

The following motion was moved by P. Malette, seconded by P. Pielsticker and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2021 as presented (a copy of which forms Appendix "B" to the minutes of this meeting).

CARRIED

11.3 Appointment of the Auditors

05-C-06-2022

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

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

CARRIED

11.4 Fees By-Law Update

T. Bertoia, Chair of the Finance and Audit Committee provided an overview of the proposed changes to the Fees and Remuneration By-Law highlighting following key changes:

- To allow physician members to charge for either actual time spent, or time scheduled for meetings, whichever is longer.
- To allow physician members to charge for actual time spent travelling to the meeting.
- To change the travel time rate to 100% of the current hourly rate for meeting attendance.

It was confirmed that the changes apply to physician Council members only. The effective date of such amendments will be effective as of June 16, 2022, following approval by Council.

06-C-06-2022

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

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 149:

By-law No. 149

(1) Subsections 20(3), (4) and (6) of By-law No. 2 (the Fees and Remuneration By-law) are revoked and substituted with the following:

Council and Committee Remuneration

> 20. … (3) The amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour.
>
> (4) The amount payable to members of the council and a committee for travel to or from home, or both, in connection with the conduct of council or committee business is the hourly rate set out in subsection 20(3).
>
> (6) The amount payable to members of the council and a committee in reimbursement of expenses incurred in the conduct of the council's or committee's business is,
>
> (a) for travel by common carrier, the member's actual cost for economy air fare or VIA 1 train fare,
>
> (b) the member's actual cost of transportation to and from airports, stations or other terminals, if applicable,
>
> (c) for travel by automobile, the member's reasonable automobile expenses, consistent with applicable Canada Revenue Agency rules and guidelines in effect from time to time, and
>
> (d) for overnight accommodation and related meals away from home, the actual amount reasonably spent up to such maximum amount set by the College from time to time, for each day away from home for both accommodation and meals.

(2) Subsection 20(8) is amended by deleting the reference to "subsection 20(3)(a)" and substituting it with "subsection 20(3)".

CARRIED

12 Decision-Making for End-of-Life Care – Draft Policy for Consultation

C. Roxborough, Director, Policy provided an overview of the draft Decision-Making for End-of-Life Care policy, including addressing issues regarding withdrawing life sustaining treatment and withholding life sustaining treatment to align the current policy with recent case law. Following an overview of the policy, Council engaged in a small group exercise to explore and consider the draft policy expectations.

Following questions and discussion, approval was sought from Council to release the draft policy for external consultation.

07-C-06-2022

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

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Decision-Making for End-of-Life Care," (a copy of which forms Appendix "C" to the minutes of this meeting).

CARRIED

13 Proposed Amendments to Medical Records Management Policy

T. Terzis, Senior Policy Analyst provided an overview of proposed minor amendments to the Medical Records Management policy intended to address challenges CPSO has been experiencing accessing electronic medical records (EMRs) during the course of College regulatory activities. In particular, the proposed amendments clarify physicians' obligations to only engage with EMR service providers who are willing and able to make medical records accessible, where required, for the purposes of regulatory processes and to ensure that EMR service providers are aware of these obligations. Given the minor nature of the amendments, they were presented for final approval.

08-C-06-2022

The following motion was moved by D. Robertson, seconded by G. Bandiera and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Medical Records Management", (a copy of which forms Appendix "D" to the minutes of this meeting) as a policy of the College.

CARRIED

14 Adjournment Day 1

J. van Vlymen adjourned day 1 of the Council meeting at 4:10 pm.

Draft Proceedings of Council – June 17, 2022

Attendees

Attendees

Dr. Madhu Azad
Dr. Glen Bandiera
Ms. Lucy Becker
Mr. Shahid Chaudhry
Dr. Brenda Copps
Ms. Joan Fisk
Mr. Murthy Ghandikota
Ms. Julia Goyal
Dr. Robert Gratton
Dr. Paul Hendry
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Dr. Camille Lemieux
Mr. Paul Malette
Dr. Lionel Marks de Chabris
Ms. Lydia Miljan
Dr. Rupa Patel
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Ian Preyra
Dr. Sarah Reid
Ms. Linda Robbins
Dr. Deborah Robertson
Dr. Jerry Rosenblum
Dr. Patrick Safieh
Mr. Fred Sherman
Dr. Janet van Vlymen
Dr. Anne Walsh

Non-Voting Academic Representatives on Council Present:

Dr. Mary Bell
Dr. Andrea Lum
Dr. Karen Saperson

Regrets:

Mr. Jose Cordeiro
Dr. Deborah Hellyer
Mr. Rob Payne
Ms. Shannon Weber

15 Call to Order

J. van Vlymen, Chair and President, called the meeting to order at 9:00 am and welcomed everyone back to the meeting. A roll call was conducted.

16 Virtual Care – Revised Policy for Final Approval

S. Reid, Council Member and T. Terzis, Senior Policy Analyst presented the revised Virtual Care policy to Council. S. Reid began with an overview of the virtual emergency care program offered by the Children's Hospital of Eastern Ontario (CHEO) and shared her experience in providing virtual care via this program.

Discussion ensued on virtual care. It was noted that virtual care provides for efficiencies by reducing unnecessary visits and providing patients easier access to care. Other issues were discussed including ensuring that the standard of care is met as well as ensuring that in-person care is offered when necessary.

It was noted that many of the College's policies would benefit by having a patient guidance document available, virtual care being one of them. The policy team will look into putting a patient guidance document together for virtual care. Following questions and discussion, Council expressed approval of the revised Virtual Care Policy.

09-C-06-2022

The following motion was moved by D. Robertson, seconded by J. Rosenblum and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Virtual Care", formerly titled "Telemedicine", (a copy of which forms Appendix "E" to the minutes of this meeting) as a policy of the College.

CARRIED

17 Social Media – Revised Policy for Final Approval

K. Saperson, Academic Representative and A. Wong, Policy Analyst, presented the revised draft Social Media policy to Council. Council was engaged in an interactive polling session to provide their views on social media outlets.

In June 2021, Council approved the draft policy for external consultation. An overview of key revisions made in response to consultation feedback was provided. It was noted that this is an evolving space, and updates to guidance offered in the companion advice document may be needed. Following discussion, Council expressed their support to approve the revised Social Media policy and rescind the *Social Media – Appropriate Use by Physicians* statement.

10-C-06-2022

The following motion was moved by P. Safieh, seconded by J. Goyal and carried, that:

The Council of the College of Physicians and Surgeons of Ontario approves the policy "Social Media" (a copy of which forms Appendix "F" to the minutes of this meeting) as a policy of the

College, and rescinds the statement “Social Media – Appropriate Use by Physicians”, (a copy of which forms Appendix “G“ to the minutes of this meeting).

CARRIED

18 Motion to Go in Camera

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

11-C-06-2022

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

Exclusion of public

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

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

(e) instructions will be given to or opinions received from the solicitors for the College.

CARRIED

19 In-Camera Session

The Council of the College of Physicians and Surgeons of Ontario entered into an in-camera session at 10:55 am and returned to the open session at 12:17 pm.

20 Presidential Compensation

J. van Vlymen and R. Gratton declared a conflict of interest and abstained from discussion and voting. J. Plante stepped in as Chair for the Presidential Compensation item. N. Novak, Chief Operating Officer provided an overview of the amendments to the Fees and Remuneration By-law to reflect changes to the presidential compensation. Following discussion, Council requested that reference to conference attendance in subsection 20(b) of the proposed By-law amendments be removed.

Council considered a motion to amend the motion for By-law No. 150 in this regard.

12-C-06-2022

The following motion was moved by J. Fisk, seconded by I. Preyra (J. van Vlymen and R. Gratton abstaining) and carried, that:

The Council of the College of Physicians and Surgeons of Ontario amends the motion for By-law No. 150 to remove the reference to “such as conference attendance” in the proposed amendment to subsection 20(b) of By-law No. 2 (the Fees and Remuneration By-law).

CARRIED

13-C-06-2022

The following motion was moved by P. Pielsticker, seconded by J. Rosenblum (J. van Vlymen and R. Gratton abstaining) and carried, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 150:

By-law No. 150

(1) Subsection 20(3) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

Council and Committee Remuneration

20. … (3) Except as provided in subsection (8), the amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour.

(2) Subsection 20(8) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following:

Council and Committee Remuneration

20. … (8) For all College business conducted by the president that is part of or related to the role of the president (for greater certainty, including but not limited to, external stakeholder meetings coordinated by the College), subsection 20(3) does not apply and the College shall pay the president a stipend in the annual amount authorized in the College budget, or if the president is unable or unwilling to serve any part of the term as president, a pro rata amount for the time served.

For College business conducted by the president that is not part of or related to the role of the president, including, without limitation:

(a) attendance at and preparation for meetings of, and work resulting from, CPSO advisory or working groups or CPSO committees other than the Executive Committee, the Governance Committee and the Finance and Audit Committee; and

(b) authorized optional activities,

the amount payable to the president is as set out under subsection 20(3).

For greater certainty, subsection (4) applies to the president, and amounts payable under subsection (4) are not included in the stipend or in amounts payable to the president as set out in subsection 20(3).

CARRIED

21 Adjournment Day 2

J. van Vlymen adjourned day 2 of the meeting at 12:20 pm. The next Council meeting is scheduled on September 22-23, 2022.

Chair

Recording Secretary

Dispensing Drugs

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

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

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

Definitions

Dispensing: refers to the process of preparing and providing a prescription drug to a patient for subsequent administration or use.[1] Dispensing involves both technical and cognitive components.[2]

Policy

1. Physicians who dispense drugs **must** meet the same dispensing standards as pharmacists[3] and comply with the requirements set out in this policy, in any other relevant College policies,[4] and provincial and federal legislation.[5]

2. Physicians **must** dispense drugs only for their own patients.

3. Physicians **must:**

[1] The policy does not apply to the distribution of drug samples. Relevant expectations relating to drug samples can be found in other College policies, including *Medical Records Documentation*, *Prescribing Drugs*, and *Physicians Relationships' with Industry: Practice, Education and Research*. For more information, see the *Advice to the Profession.*

[2] Technical components may include drug selection, verification, and quantity determination, applying appropriate labelling, and documentation. Cognitive components may include assessing the appropriateness of drug therapy, considering drug interactions and contraindications, providing patient communication and counselling, and offering follow-up advice. For more information see the *Advice to the Profession.*

[3] For example, see the Ontario College of Pharmacists' (OCP) Standards of Practice.

[4] Including, but not limited to, the *Prescribing Drugs* policy and the *Medical Records Documentation* policy.

[5] Including, but not limited to, the *Controlled Drugs and Substances Act*, the *Narcotics Safety and Awareness Act, 2010*, the *Drug and Pharmacies Regulation Act* (*DPRA*), the *Drug Interchangeability and Dispensing Fee Act*, and the *Food and Drugs Act*. These acts and their regulations set out requirements for the sale and dispensing of drugs, including labelling, record keeping, and record retention.

a. provide appropriate packaging and labelling for the drugs dispensed;[6] and
b. provide patient counselling, including discussing instructions for proper drug use.

4. Physicians **must not** sell drugs to a patient at a profit, except when permitted by legislation.[7]

5. Physicians **must** be transparent and inform the patient of the option to purchase the drug(s) from a pharmacy of their choice, if this option is available.

6. Physicians **must not** charge a dispensing fee that is excessive.[8]

7. Physicians **must not** dispense drugs that are past their expiry date or that will expire before the patient completes their normal course of therapy.[9]

8. Physicians **must**:
   a. use proper methods of procurement in order to confirm the origin and chain of custody of drugs being dispensed;
   b. have an audit system in place in order to identify possible drug loss;
   c. store drugs securely;
   d. store drugs appropriately to prevent spoilage (for example, temperature control where necessary);
   e. monitor recalled drugs[10] and have a process for contacting patients whose dispensed drugs are affected; and
   f. dispose of drugs that are unfit to be dispensed (for example, expired or damaged) safely and securely and in accordance with any environmental requirements.[11]

9. Physicians **must** keep records:
   a. of the purchase and sale of drugs; and
   b. which allow for the retrieval and/or inspection of prescriptions.

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[6] Subsection 156(3) of the *DPRA* sets out the information to be recorded on the container of a dispensed drug. The *Food and Drug Regulations* sets out specific requirements for physicians dispensing Class A opioids. For more information, see the *Advice to the Profession*.
[7] It is not a conflict of interest to sell or otherwise supply a drug to a patient at a profit where the drug is necessary for the immediate treatment of the patient, in an emergency, or where the services of a pharmacist are not reasonably readily available (Section 16 (d), O. Reg. 114/94 under the *Medicine Act*).
[8] It is an act of professional misconduct to charge a fee that is excessive in relation to the services provided (Subsection 1(1) paragraph 21, O. Reg. 856/93 under the *Medicine Act*).
[9] This requirement does not apply to *pro re nata* (PRN) medications, when physicians may not know whether patients will finish the medication before their expiry date.
[10] For instance, through Health Canada's Recalls and Safety Alerts Database or subscribing to MedEffect Canada notices of recalls.
[11] For more information about the safe disposal of drugs, please see the College's *Advice to the Profession: Prescribing Drugs*.

Financial statements of the

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2021

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

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INDEPENDENT AUDITOR'S REPORT

To the Members of the
College of Physicians and Surgeons of Ontario

We have audited the accompanying financial statements of the College of Physicians and Surgeons of Ontario ("College"), which comprise the statement of financial position as at December 31, 2021 and the statements of operations and changes in unrestricted net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2021, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the College's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the College’s financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the College's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast doubt on the College's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

TORONTO, Ontario
June 16, 2022

Licensed Public Accountants

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Financial Position

As at December 31	**2021**	2020
Assets		
Current		
Cash	**$ 58,578,305**	$ 57,723,392
Accounts receivable	**1,903,588**	1,626,007
Prepaid expenses	**1,573,129**	1,143,913
	62,055,022	60,493,312
Investments (note 3)	**50,331,712**	50,000,000
Capital assets (note 4)	**16,828,346**	14,976,974
	$129,215,080	$125,470,286
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 9,208,460**	$ 9,222,798
Current portion of obligations under capital leases (note 7)	**689,167**	837,439
	9,897,627	10,060,237
Deferred revenue (note 5)	**33,240,949**	33,250,440
	43,138,576	43,310,677
Accrued pension cost (note 6)	**5,256,150**	5,319,798
Obligations under capital leases (note 7)	**316,093**	786,489
	48,710,819	49,416,964
Net assets		
Internally restricted (note 8)		
Invested in capital assets	**15,823,086**	13,353,046
Building Fund	**60,700,276**	60,700,276
Intangible Asset Fund	**3,980,899**	2,000,000
Pension remeasurements	**(1,284,280)**	(1,173,107)
Unrestricted	**1,284,280**	1,173,107
	80,504,261	76,053,322
	$129,215,080	$125,470,286

Commitments and contingencies (notes 9 and 10, respectively)

Approved on behalf of the Council

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See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Unrestricted Net Assets

Year ended December 31	2021	2020 (note 12)
Revenue		
Membership fees		
General and educational (note 5)	**$ 67,443,326**	$ 66,676,837
Penalty fee	**563,126**	1,026
	68,006,452	66,677,863
Application fees	**8,837,479**	7,933,273
OHPIP annual and assessment fees (note 5)	**1,440,239**	939,982
IHF annual and assessment fees (note 5)	**1,431,792**	1,243,292
OHPIP, IHF application fees and penalties	**62,525**	39,914
Cost recoveries and other income	**2,290,504**	1,913,672
Interest income	**553,628**	680,745
	82,622,619	79,428,741
Expenses		
Staffing costs (schedule I)	**51,707,598**	47,358,543
Per diems (schedule II)	**7,869,158**	7,086,960
Other costs (schedule III)	**7,805,729**	6,824,997
Professional fees (schedule IV)	**4,886,444**	3,649,353
Depreciation of capital assets	**3,503,959**	1,874,590
Occupancy (schedule V)	**2,629,811**	2,373,431
	78,402,699	69,167,874
Excess of revenue over expenses before undernoted items	**4,219,920**	10,260,867
Investment income	**342,192**	2,059,268
Excess of revenue over expenses for the year	**4,562,112**	12,320,135
Unrestricted net assets, beginning of year	**1,173,107**	689,281
Less: Invested in capital assets (net)	**(2,470,040)**	(5,382,680)
Less: Transfer to Building Fund	**-**	(4,453,629)
Less: Transfer to Intangible Asset Fund	**(1,980,899)**	(2,000,000)
Unrestricted net assets, end of year	**$ 1,284,280**	$ 1,173,107

See accompanying notes to the financial statements.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Statement of Cash Flows

Year ended December 31	2021	2020
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 4,562,112**	$ 12,320,135
Depreciation of capital assets	**3,503,959**	1,874,590
	8,066,071	14,194,725
Net change in non-cash working capital items:		
Accounts receivable	**(277,581)**	(365,916)
Prepaid expenses	**(429,216)**	688,507
Accrued interest receivable	**(331,712)**	1,375,478
Accounts payable and accrued liabilities	**(14,338)**	(1,251,026)
Deferred revenue	**(9,491)**	391,793 //
Pension cost	**(174,821)**	(140,796)
Cash provided by operating activities	**6,828,912**	14,892,765
Cash flows used by investing activities:		
Purchase of capital assets	**(5,137,442)**	(6,381,823)
Cash flows used by financing activities:		
Payment of capital lease obligations	**(836,557)**	(875,447)
Net increase in cash	**854,913**	7,635,495
Cash, beginning of year	**57,723,392**	50,087,897
Cash, end of year	**$ 58,578,305**	$ 57,723,392

See accompanying notes to the financial statements. 6

1 Organization

College of Physicians and Surgeons of Ontario ("College") was incorporated without share capital as a not-for-profit organization under the laws of Ontario for the purpose of regulating the practice of medicine to protect and serve the public interest. Its authority under provincial law is set out in the Regulated Health Professions Act (RHPA), the Health Professions Procedural Code under RHPA and the Medicine Act.

The College is exempt from income taxes.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

(a) Cash

Cash includes cash deposits held in an interest bearing account at a major financial institution.

(b) Investments

Guaranteed investment certificates are carried at amortized cost.

(c) Capital assets

The cost of a capital asset includes its purchase price and any directly attributable cost of preparing the asset for its intended use.

When conditions indicate a capital asset no longer contributes to the College's ability to provide services or that the value of future economic benefits or service potential associated with the capital asset is less than its net carrying amount, its net carrying amount is written down to its fair value or replacement costs. As at December 31, 2021, no such impairment exists.

(i) Tangible assets

Tangible assets are measured at cost less accumulated amortization and accumulated.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated lives as follows:

Building	10 - 25 years	Computer and other equipment	3 - 5 years
Furniture and fixtures	10 years	Computer equipment under capital lease	2 - 4 years

(ii) Intangible assets

Intangible assets, consisting of separately acquired computer application software, are measured at cost less accumulated amortization.

Amortization is provided for, upon the commencement of the utilization of the assets, on a straight-line basis over their estimated useful lives of four years.

2 Significant accounting policies (continued)

(d) Pension plans

(i) Healthcare of Ontario Pension Plan

Healthcare of Ontario Pension Plan ("HOOPP") is a multi employer best five consecutive year average pay defined benefit pension plan.

Defined contribution accounting is applied to HOOPP and contributions are expensed when due.

(ii) CPSO Retirement Savings Plan 2019

CPSO Retirement Savings Plan 2019 is a defined contribution plan. Contributions are expensed when due.

(iii) Designated Employees' Retirement Plan for the College of Physicians and Surgeons on Ontario

The College maintains a closed (1998) defined benefit pension plan and supplementary arrangements for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

The College recognizes its defined benefit obligations as the employees render services giving them right to earn the pension benefit. The defined benefit obligation at the statement of financial position date is determined using the most recent actuarial valuation report prepared for accounting purposes. The measurement date of the plan assets and the defined benefit obligation is the College's statement of financial position date.

In its year-end statement of financial position, the College recognizes the defined benefit obligation, less the fair value of plan assets, adjusted for any valuation allowance in the case of a net defined benefit asset. The plan cost for the year is recognized in the excess of revenues over expenses for the year. Past service costs resulting from changes in the plan are recognized immediately in the excess of revenue over expenses for the year at the date of the changes.

Remeasurements and other items comprise the aggregate of the following: the difference between the actual return on plan assets and the return calculated using the discount rate; actuarial gains and losses; the effect of any valuation allowance in the case of a net defined pension asset; past service costs; and gains and losses arising from settlements or curtailments. Remeasurements are recognized as a direct charge (credit) to net assets.

(e) Revenue recognition

(i) Members' fees and application fees

These fees are set annually by Council and are recognized as revenue proportionately over the fiscal year to which they relate. Fees received in advance are recorded as deferred revenue.

(ii) Independent Health Facility (IHF) and Out of Hospital Premises Inspection Program (OHPIP) fees

IHF and OHPIP annual and assessment fees are recognized at the same rate as the related costs are expensed.

(iii) Cost recoveries

Cost recoveries are recognized at the same rate as the related costs are expensed.

(iv) Other income

Other income is recognized as the services are provided, the amount is known and collection is reasonably assured.

2 Significant accounting policies (continued)

(e) Revenue recognition (continued)

(v) Interest and investment income

Interest income is comprised of interest on cash deposits held in an interest bearing account at a major financial institution. Investment income is comprised of income on guaranteed investment certificates.

Interest and investment income are recognized when earned. Income on guaranteed growth investment certificates is determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest is accrued at the minimum guaranteed rates.

(f) Financial instruments

(i) Measurement

The College initially measures its financial assets and financial liabilities at fair value, adjusted by, in the case of a financial instrument that will not be measured subsequently at fair value, the amount of transaction costs directly attributable to the instrument.

The College subsequently measures its financial assets and liabilities at amortized cost. Transaction costs are recognized in income in the period incurred.

(ii) Impairment

At the end of each reporting period, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the period in the expected timing or amount of future cash flows from the financial asset.

(g) Management estimates

In preparing the College's financial statements, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and reported amounts of revenue and expenses during the period. Actual results may differ from these estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

(h) Internally restricted reserves

Council has established the following internally restricted reserves:

(i) Invested in capital assets which comprises the net book value of capital assets less the related obligations under capital leases;

(ii) Building Fund which comprises assets restricted for future building requirements; and

(iii) Intangible Asset Fund which comprises assets restricted for future information technology infrastructure development and improvements.

3 Investments

As at December 31	**2021**	2020
Guaranteed Investment Certificates (GIC)		
Bank of Montreal (BMO) Extendible GIC	**$ 25,000,000**	$ -
National Bank of Canada (NBC) Canadian Banks Portfolio Flex GIC	**25,000,000**	-
Accrued interest	**331,712**	-
Cash	**-**	50,000,000
	$ 50,331,712	$ 50,000,000

The BMO Extendible GIC earns interest at 1.45% and has an initial maturity date of February 1, 2022. The issuer has the option to extend the maturity date in six month increments on the initial maturity date and on each extended maturity date thereafter extending to August 1, 2027.

The NBC Canadian Bank Portfolio Flex GIC matures on January 29, 2026 and earns a return determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. At maturity the principal amount of $25,000,000 is guaranteed. The fair market value of the GIC as at December 31, 2021 is $24,212,500.

4 Capital assets

As at December 31	**2021**		2020	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Tangible assets				
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**21,101,419**	**16,639,886**	21,089,134	16,136,035
Furniture and fixtures	**4,571,754**	**4,155,683**	4,493,281	4,014,251
Computer and other equipment	**1,984,487**	**1,951,546**	1,943,244	1,936,762
Computer equipment under capital lease	**4,038,383**	**3,033,123**	3,839,472	2,215,544
Intangible assets				
Computer application software	**11,122,247**	**2,352,609**	6,116,805	345,273
	44,961,193	**28,132,847**	39,624,839	24,647,865
Net book value		**$ 16,828,346**		$ 14,976,974

5 Deferred revenue

Deferred revenue consists of membership fees received in advance for the next year as well as unearned fees related to the Independent Health Facility program (IHF) and Out of Hospital Premises Inspection Program (OHPIP). The change in the deferred revenue accounts for the year is as follows:

	Membership Fees	IHF	OHPIP	2021 Total	2020 Total
Balance, beginning of year	**$ 28,267,320**	**$ 3,421,627**	**$ 1,561,493**	**$ 33,250,440**	$ 32,858,647
Amounts billed during the year	**67,821,299**	**1,403,006**	**1,081,561**	**70,305,866**	69,251,904
Less: Recognized as revenue	**(67,443,326)**	**(1,431,792)**	**(1,440,239)**	**(70,315,357)**	(68,860,111)
Balance, end of year	**$ 28,645,293**	**$ 3,392,841**	**$ 1,202,815**	**$ 33,240,949**	$ 33,250,440

The IHF and OHPIP Programs are budgeted and billed on a cost recovery basis.

6 Employee future benefits

(a) Designated Employees' Retirement Plan and Supplementary Arrangements

(i) Reconciliation of funded status of the defined benefit pension plan to the amount recorded in the statement of financial position

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Plan assets at fair value	**$ 2,698,132**	**$ -**	**$ 2,698,132**	$ 2,845,069
Accrued pension obligations	**(3,689,691)**	**(4,264,591)**	**(7,954,282)**	(8,164,867)
Funded status - deficit	**$ (991,559)**	**$ (4,264,591)**	**$ (5,256,150)**	$ (5,319,798)

(ii) Pension plan assets

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Fair value, beginning of year	**$ 2,845,069**	**$ -**	**$ 2,845,069**	$ 2,951,102
Interest income	**62,592**	**-**	**62,592**	88,533
Return on plan assets (excluding interest)	**112,592**	**-**	**112,592**	125,409
Employer contributions	**-**	**291,856**	**291,856**	290,099
Benefits paid	**(322,121)**	**(291,856)**	**(613,977)**	(610,074)
Fair value, end of year	**$ 2,698,132**	**$ -**	**$ 2,698,132**	$ 2,845,069

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(iii) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Balance, beginning of year	$ 3,790,392	$ 4,374,475	$ 8,164,867	$ 7,927,870
Interest cost on accrued pension obligations	83,389	96,238	179,627	237,836
Benefits paid	(322,121)	(291,856)	(613,977)	(610,074)
Actuarial losses	138,031	85,734	223,765	609,235
	$ 3,689,691	$ 4,264,591	$ 7,954,282	$ 8,164,867

The most recent actuarial valuation of the pension plan for funding purposes was made effective December 31, 2018. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2021. The valuation of the pension plan for funding purposes as at December 31, 2021 is in progress as of the date of the statements.

(iv) The net expense for the College's pension plans is as follows:

	2021	2020
Funded defined benefit plan	$ 20,797	$ 22,718
Unfunded supplementary defined benefit plan	96,238	126,585
Defined contribution plan	708,993	966,883
Healthcare of Ontario Pension Plan	3,019,898	2,514,591
	$ 3,845,926	$ 3,630,777

(v) The elements of the defined benefit pension expense recognized in the year are as follows:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Interest cost on accrued pension obligations	$ 83,389	$ 96,238	$ 179,627	$ 237,836
Interest income on pension assets	(62,592)	-	(62,592)	(88,533)
Pension expense recognized	$ 20,797	$ 96,238	$ 117,035	$ 149,303

(vi) Remeasurements and other items recognized as a direct charge (credit) to net assets are as follows:

Defined Benefit Plan	Funded Plan	Unfunded Plan	2021 Total	2020 Total
Actuarial losses	$ 138,031	$ 85,734	$ 223,765	$ 609,235
Return on plan assets (excluding interest)	(112,592)	-	(112,592)	(125,409)
Charge to net assets	$ 25,439	$ 85,734	$ 111,173	$ 483,826

6 Employee future benefits (continued)

(a) Designated Employees' Retirement Plan and Supplementary Arrangements (continued)

(vii) Actuarial assumptions

The significant actuarial assumptions adopted in measuring the accrued pension obligations as at December 31 are as follows:

	2021	2020
Discount rate	**2.70 %**	2.20 %

(b) Healthcare of Ontario Pension Plan

Employer contributions made to the plans during the year by the Institute total $3,019,898 (2020 - $2,514,591). These amounts are included in staffing costs in the statement of operations.

Each year an independent actuary determines the funding status of HOOPP by comparing the actuarial value of invested assets to the estimated present value of all pension benefits that members have earned to date. The most recent actuarial valuation of the Plan as at December 31, 2021 indicates the Plan is 120% funded. HOOPP's statement of financial position as at December 31, 2021 disclosed total pension obligations of $85.9 billion with net assets at that date of $144.4 billion indicating a surplus of $28.5 billion.

(c) Restructuring benefits

The College restructured its affairs during the year for the purpose of achieving long-term savings, which resulted in severance benefits to employees in the amount of $2,006,829 (2020 - $2,266,872), which has been included in staffing costs.

7 Obligations under capital leases

The College has entered into capital leases for computer equipment. The following is a schedule of the future minimum lease payments over the term of the leases:

2022	$	688,733
2023		278,356
2024		38,171
		1,005,260
Less: current portion		689,167
	$	316,093

8 Internally restricted net assets

2021	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	**$ 13,353,046**	**$ 2,000,000**	**$ 60,700,276**	**$ (1,173,107)**
Excess (deficiency) of revenue over expenses for the year	**(3,503,959)**	**-**	**-**	**-**
Transfer to Intangible Asset Fund	**-**	**1,980,899**	**-**	**-**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(111,173)**
Transfer to Invested in Capital Assets	**5,973,999**	**-**	**-**	**-**
Balance, December 31	**$ 15,823,086**	**$ 3,980,899**	**$ 60,700,276**	**$ (1,284,280)**

2020	Invested in Capital Assets	Intangible Asset Fund	Building Fund	Pension Re-measurement
Balance, January 1	$ 7,970,366	$ -	$ 56,246,647	$ (689,281)
Excess (deficiency) of revenue over expenses for the year	(1,874,590)	-	2,059,268	-
Transfer to Intangible Asset Fund	**-**	8,116,805	-	-
Actuarial remeasurement for pension	-	-	-	(483,826)
Transfer to Invested in Capital Assets	7,257,270	(6,116,805)	-	-
Transfer to Building Fund	-	-	2,394,361	-
Balance, December 31	$ 13,353,046	$ 2,000,000	$ 60,700,276	$ (1,173,107)

The College has transferred $nil (2020 - $2,394,361) to the building fund and $1,980,899 (2020 - $2,000,000) to the Intangible Asset Fund from unrestricted net assets.

Net assets invested in capital assets is calculated as follows:

As at December 31	2021	2020
Net book value of capital assets	**$ 16,828,346**	$ 14,976,974
Less: obligations under capital leases	**(1,005,260)**	(1,623,928)
	$ 15,823,086	$ 13,353,046

9 Commitments

The College has a lease for additional office space which extends to February 28, 2023 with two options to renew for additional five year terms subsequent. Minimum payments for base rent and estimated maintenance, taxes and insurance in aggregate and for each year of the current term are estimated as follows:

2022	$ 717,083
2023	464,875
Total	$ 1,181,958

10 Contingencies

The College has been named as a defendant in lawsuits with respect to certain of its members or former members. The College denies any liability with respect to these actions and no amounts have been accrued in the financial statements. Should the College be unsuccessful in defending these claims, it is not anticipated that they will exceed the limits of the College's liability insurance coverage.

11 Financial instruments

General objectives, policies and processes

Council has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash, accounts receivable and investments.

Credit risk associated with cash and investments is mitigated by ensuring that these assets are invested in financial obligations of major financial institutions.

Accounts receivable are generally unsecured. This risk is mitigated by the College's requirement for members to pay their fees in order to renew their annual license to practice medicine. The College also has collection policies in place.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows and holding assets that can be readily converted into cash, so as to meet all cash outflow obligations as they fall due.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and equity risk.

(i) Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College is not exposed to foreign exchange risk.

(ii) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investments and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested, provides for a high degree of liquidity, and achieves a satisfactory investment return giving consideration to risk. The College has mitigated exposure to interest rate risk.

(iii) Equity risk

Equity risk is the uncertainty associated with the valuation of assets arising from changes in equity markets. The College is not exposed to this risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

12 Comparative figures

Certain comparative figures have been reclassified to conform to the presentation adopted in the current year.

Schedule I - Staffing costs

Year ended December 31	**2021**	2020
Salaries	**$ 41,679,796**	$ 37,932,316
Employee benefits	**4,741,440**	5,162,553
Pension (note 6)	**3,845,926**	3,630,777
Training, conferences and employee engagement	**1,297,111**	479,431
Professional association fees	**143,325**	153,466
	$ 51,707,598	$ 47,358,543

Schedule II - Per diem

Year ended December 31	**2021**	2020
Attendance	**$ 2,270,282**	$ 1,878,678
Preparation time	**2,895,023**	2,722,037
Decision writing	**1,208,111**	1,030,050
Teleconference	**658,763**	642,998
HST on per diems	**425,620**	378,951
Travel time	**411,359**	434,246
	$ 7,869,158	$ 7,086,960

Schedule III - Other costs

Year ended December 31	**2021**	2020
Credit card service charges	**$ 1,628,051**	$ 1,540,401
Software	**2,382,274**	1,445,462
Equipment leasing	**104,998**	89,030
Equipment maintenance	**33,104**	5,378
Miscellaneous	**753,716**	522,978
Photocopying	**131,200**	221,515
Printing	**6,641**	2,962
Postage	**94,050**	98,159
Members dialogue	**360,445**	296,598
Courier	**26,200**	24,789
Telephone	**408,998**	269,185
Office supplies	**115,203**	514,652
Reporting and transcripts	**461,481**	263,872
FMRAC membership fee	**454,578**	454,528
Publications and subscriptions	**164,444**	185,741
Meals and accommodations	**195,328**	348,616
Travel	**169,542**	208,921
Grants	**74,000**	38,244
Survivors fund	**241,476**	293,966
	$ 7,805,729	$ 6,824,997

Schedule IV - Professional fees

Year ended December 31	**2021**	2020
Consultant	**$ 3,723,378**	$ 2,109,316
Legal	**916,475**	1,471,356
Audit	**77,061**	53,901
Recruiting	**169,530**	14,780
	$ 4,886,444	$ 3,649,353

Schedule V - Occupancy

Year ended December 31	**2021**	2020
Building maintenance and repairs	**$ 878,364**	$ 871,572
Insurance	**723,127**	592,234
Realty taxes	**112,793**	108,101
Utilities	**167,515**	159,937
Rent	**748,012**	641,587
	$ 2,629,811	$ 2,373,431

Decision-Making for End-of-Life Care

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

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

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

Definitions

Advance care planning discussions: Conversations that take place between health-care providers and capable patients, and where possible, substitute decision-makers, which enable patients to reflect on and communicate their personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, including which treatment(s) they may want at the end of life. The aim of these discussions is to prepare patients and/or substitute decision-makers for future decision-making.

Do Not Resuscitate (DNR) order: A written order in a patient's medical record that provides instructions to the health-care team regarding which resuscitative measures should not be performed if the patient experiences a cardiac or respiratory arrest. DNR orders can be all-encompassing, i.e., "no resuscitative measures," and may be referred to by other names, such as "do not attempt resuscitation" (DNAR) orders, "no-cardiopulmonary resuscitation" (no-CPR) orders, and "do not intubate" orders.[1]

Goals of care discussions: Conversations that take place between health-care providers, patients and/or substitute decision-makers, in the context of a serious illness when there are treatment or care decisions that need to be made in the foreseeable future. The aim of these discussions is to educate patients and/or substitute decision-makers about available treatment options; help define obtainable goals of care by identifying the patient's personal, cultural, and religious/spiritual values and beliefs, as well as their wishes, if they can be ascertained; and align treatment options accordingly through the process of shared decision-making.

[1] Although DNR orders may also include limiting what life-sustaining measures are offered, for the purposes of this policy, DNR orders pertain to resuscitative measures only.

Life-sustaining treatment: Any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or replace a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, vasopressors and inotropes, etc.).

Medical futility: A term used to describe treatment that would not achieve its physiologic goal (e.g., with respect to resuscitative measures, treatment that would not provide oxygenated blood flow to the heart and brain).

Resuscitative measures: A suite of medical interventions, including chest compressions, artificial ventilation, intubation and/or defibrillation, that may be provided following cardiac or respiratory arrest in an attempt to restore or maintain cardiac, pulmonary, and circulatory function. Not all interventions in the suite will necessarily be provided or required in all cases.

Substitute decision-maker (SDM): A person, or persons, who may give or refuse consent to a treatment on behalf of an incapable person.[2]

Policy

Advance Care Planning and Goals of Care Discussions

1. Physicians who provide care as part of a sustained physician-patient relationship **must** determine whether, based on the patient's illness or medical condition, it is appropriate to initiate an advance care planning discussion, and if so:
    a. raise end-of-life care issues with the patient; and
    b. encourage the patient to discuss those issues with their SDM.

2. Physicians who provide care to patients who are palliative, receiving non-curative treatment, or at risk of clinical deterioration in the foreseeable future **must**, where possible:
    a. initiate a timely goals of care discussion (particularly when the risk of a cardiac or respiratory arrest is foreseeable), which involves:
        i. describing the underlying illness or medical condition and prognosis;
        ii. educating the patient and/or SDM about the available treatment options, which may include resuscitative measures, and explaining the outcomes that can and cannot be achieved; and
        iii. defining the patient's goals of care by helping the patient and/or SDM identify the patient's wishes, values and beliefs, or if they cannot be ascertained, identifying what would be in the patient's best interests;

[2] For more information on substitute decision-makers, please see the College's *Consent to Treatment* policy.

b. facilitate the goals of care discussion to help build consensus about what treatment decision(s) need to be made; and
c. review the goals of care discussion with the patient and/or SDM whenever it is appropriate to do so (e.g., when there is a significant change in the patient's medical condition or when the patient and/or SDM indicate that the patient's wishes, values, and/or beliefs have changed).

End-of-Life Care

3. Physicians **must** seek to balance medical expertise and patient wishes, values, and beliefs when making decisions about end-of-life care.

Withdrawing Potentially Life-Sustaining Treatment

4. Physicians **must** obtain consent from patients and/or SDMs before withdrawing life-sustaining treatment.[3]
    a. As part of the consent process, physicians **must**:
        i. explain why they are proposing to withdraw life-sustaining treatment; and
        ii. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

Managing Disagreements

5. Where consent cannot be obtained and the physician is of the view that life-sustaining treatment should be withdrawn, the physician **must** try to resolve the disagreement with the patient and/or SDM in a timely manner by:
    a. communicating information regarding the patient's diagnosis and/or prognosis, treatment options, and assessments of those options;
    b. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
    c. reassuring the patient and/or SDM that the patient will continue to receive all other clinically appropriate care or treatment(s);
    d. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering supportive services (e.g., social work, spiritual care, etc.) and consultation with the patient's family physician, where appropriate and available;
    e. offering to make a referral to another health-care provider and facilitating obtaining a second opinion, where appropriate and available;
    f. offering consultation with an ethicist or ethics committee, where appropriate and available; and

[3] The Supreme Court of Canada determined in *Cuthbertson v. Rasouli, 2013 SCC 53* (hereinafter *Rasouli*) that consent must be obtained prior to withdrawing life-sustaining treatment.

g. taking reasonable steps to transfer care of the patient to another facility or health-care provider, if possible, and only when all appropriate and available methods of resolving disagreements have been exhausted.[4]

6. Physicians **must** determine whether to apply to the Consent and Capacity Board when:[5]
   a. in relation to treatment decisions, disagreements arise with an SDM over an interpretation of a wish, or assessment of the applicability of a wish, or if no wish can be ascertained, what is in the best interests of the patient; or
   b. they are of the view that an SDM is not acting in accordance with their legislative requirements.[6]

Withholding Resuscitative Measures

A physician's decision to withhold resuscitative measures is not "treatment" and therefore does not require the patient or SDM's consent.[7]

A physician may decide that providing resuscitative measures is not appropriate for a patient in situations where they determine that:

- providing resuscitative measures would be medically futile (i.e., no intervention can successfully resuscitate the patient)[8]; or
- the risks of providing resuscitative measures outweigh the potential benefits (i.e., even if the patient could be resuscitated in the immediate term, it would cause them more harm than good).[9]

7. When a physician determines that providing resuscitative measures to a patient would be medically futile, the physician can write a DNR order in the patient's medical record but **must**, at the earliest opportunity (and, if possible, before the DNR order is written):

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[4] In following such a course, physicians must comply with the College's *Ending the Physician-Patient Relationship* policy.

[5] In *Rasouli,* the Supreme Court of Canada determined that when SDMs refuse to provide consent to withdraw life-support that, in the physician's opinion, is not in the patient's best interests, physicians must apply to the Consent and Capacity Board for a determination of whether the SDM has met the substitute decision-making requirements of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (hereinafter *HCCA*) and whether the refused consent is valid. See in particular paragraph 119 of *Rasouli*.

[6] Please see footnote 2.

[7] In *Wawrzyniak v. Livingstone*, 2019 ONSC 4900, the Court concluded that the writing of a DNR order and withholding of cardiopulmonary resuscitation (CPR) do not fall within the meaning of "treatment" in the *HCCA*. Accordingly, consent is not required prior to writing a DNR order and withholding resuscitative measures, such as CPR, and physicians are only required to provide resuscitative measures in accordance with the standard of care.

[8] The concept of medical futility is as close as possible to a value free, "objective," view of futility.

[9] This risk-benefit calculation involves subjective value judgments.

a. inform the patient and/or SDM that an order will be or has been written;
b. explain to the patient and/or SDM why resuscitative measures are not appropriate; and
c. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

8. Before determining that resuscitative measures will not be provided because the risks of providing those interventions would outweigh the potential benefits, the physician **must** consider the patient's wishes, as well as their personal, cultural, and religious/spiritual values and beliefs, if they can be ascertained and/or the physician is aware of them.

9. When a physician determines that the risks of providing resuscitative measures would outweigh the potential benefits, the physician can write a DNR order in the patient's medical record but **must**, before writing the order:
   a. inform the patient and/or SDM that the order will be written;
   b. explain to the patient and/or SDM why resuscitative measures are not appropriate, including the risks of providing those interventions and the likely clinical outcomes if the patient is resuscitated; and
   c. provide details regarding all other clinically appropriate care or treatment(s) they propose to provide.

10. When a patient's condition is deteriorating rapidly and there is an imminent need for an order to be written (e.g., actual or impending cardiac or respiratory arrest), the physician can write a DNR order in the patient's record but **must** comply with the expectations set out in provision 9 at the earliest opportunity.

11. When a physician is not able to determine whether the risks of providing resuscitative measures would outweigh the potential benefits, the physician **must not** write a DNR order in the patient's medical record unless the patient and/or SDM requests or agrees to it.

Providing Support if Disagreements Arise

12. If the patient and/or SDM disagree with the writing of a DNR order, the physician can write the order, but **must**, at the earliest opportunity after learning of the disagreement, make reasonable efforts to provide support to the patient and/or SDM by:
   a. identifying the basis for the disagreement, taking reasonable steps to clarify any misunderstandings, and answering questions;
   b. reassuring the patient and/or SDM that the patient will continue to receive all other clinically appropriate care or treatment(s);
   c. making reasonable efforts to support the patient's physical comfort, as well as their emotional, psychological, and spiritual well-being, by offering

supportive services (e.g., social work, spiritual care, etc.), where appropriate and available; and

d. taking reasonable steps to transfer care of the patient to another facility or health-care provider, if possible and requested by the patient and/or SDM.[10]

[10] Please see footnote 4.

Medical Records Management

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

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

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

Policy

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

Establishing Custodianship and Accountabilities

2. Physicians **must** have a written agreement that establishes custodianship and clear accountabilities regarding medical records if they:

    a. practise in a setting where there are multiple contributors to a record-keeping system (e.g., a group or interdisciplinary practice, settings with a shared electronic medical record (EMR)); or
    b. are not the owner of the practice and/or of the EMR licence.[2,3]

3. Physicians **must** ensure their agreements:

[1] *Personal Health Information Protection Act*, *2004*, S.O. 2004, c.3, Sched. A (hereinafter *PHIPA*); Part V of the General, Ontario Regulation 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act*, General Regulation); General, Ontario Regulation 57/92, enacted under the *Independent Health Facilities Act*, R.S.O.1990, c.1.3 (hereinafter *IHFA,* General Regulation); Hospital Management, Regulation 965, enacted under the *Public Hospitals Act*, R.S.O. 1990, c.P.40 (*Public Hospitals Act,* Hospital Management Regulation); *Personal Information Protection and Electronic Documents Act of Canada*, S.C. 2000, c. 5 (hereinafter *PIPEDA*).

[2] Section 14(1) of the *Public Hospitals Act* sets out that patient medical records compiled in a hospital are the property of the hospital. For the purposes of this policy, the provisions set out in the *Public Hospitals Act*, along with the terms of a physician's hospital privileges can serve as the official agreement for physicians who work in hospitals.

[3] Additional advice for establishing such agreements can be found in the Canadian Medical Protective Association's (CMPA) *Electronic Records Handbook*. In particular, the CMPA's Data Sharing Principles and the template titled *Contractual Provisions for Data Sharing* can be reviewed and serve as a model. The OMA can also provide assistance establishing contracts.

a. are in place prior to the establishment of the group practice, business arrangement, or employment, or as soon as possible afterward;
b. comply with the *Personal Health Information Protection Act, 2004* (*PHIPA*) and with the expectations set out in this policy; and
c. address:
    i. custody and control of medical records, including upon termination of employment or the practice arrangement;
    ii. privacy, security, storage, retention, and destruction of records; and
    iii. enduring access for themselves[4] and their patients.

4. Physicians with custody or control of medical records **must** give all former partners and associates reasonable access to their patient medical records to allow them to prepare medico-legal reports, defend legal actions, or respond to an investigation, when necessary.[5]

5. Physicians moving to a new practice who do not have custody or control of the medical records of patients who choose to follow them to the new practice, **must** obtain patient consent to transfer copies of the records to the new location.

6. Physicians **must** take all reasonable steps within their control to prevent a conflict about medical records from compromising patient care.

Access and Transfer of Medical Records

Providing Access to Medical Records

7. Physicians **must** provide patients and authorized parties[6] with access to, or copies of, all the medical records in their custody or control upon request, unless an exception applies.[7,8]

8. Where an exception applies and access is refused, physicians **must** inform the individual in writing of the following:

    a. the fact of the refusal;
    b. the reason for the refusal; and

[4] See *PHIPA*, s. 41(1) for the specific circumstances where physicians are permitted access to the personal health information of their former patients.
[5] See *PHIPA*, s. 41(1) for the specific circumstances where access can be provided to former partners and associates.
[6] Authorized parties include substitute decision-makers and estate trustees/executors of the estate where applicable, and third parties where consent has been obtained.
[7] *PHIPA*, s. 52; Section 52 of *PHIPA* contains a comprehensive list of the exceptions.
[8] There are exceptions that may limit the information a physician is required to produce in the context of an independent medical examination. For more information, please refer to *PIPEDA*. The CMPA's article, *Providing access to independent medical examinations* also sets out advice on this issue.

c. the right of the patient to make a complaint to the Information and Privacy Commissioner of Ontario (IPC).[9]

9. Physicians **must** provide patients and authorized parties with explanations of any term, code, or abbreviation used in the medical record, upon request.[10]

Transferring Copies of Medical Records

10. Physicians **must** retain original medical records for the time period required by the Regulation[11] (see Medical Records Retention below) and only transfer copies to others.

11. Physicians **must** only transfer copies of medical records where they have consent or are permitted or required by law to do so.[12]

12. Physicians **must** transfer copies of medical records in a timely manner, urgently if necessary, but no later than 30 days after a request.[13] What is timely will depend on whether there is any risk to the patient if there is a delay in transferring the records (e.g., exposure to any adverse clinical outcomes).

13. Physicians **must** transfer copies of the entire medical record, unless providing a summary or a partial copy of the medical record is acceptable to the receiving physician and/or the patient.

14. Physicians **must** transfer copies of medical records in a secure manner[14] and document the date and method of transfer in the medical record.[15]

Fees for Copies and Transfer of Medical Records[16]

Fulfilling a request for copying and transferring medical records is an uninsured service. As such, physicians are entitled to charge patients or third parties a fee for obtaining a copy or summary of their medical record.

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[9] *PHIPA,* s. 54(1)(c). When access is refused on certain grounds, there are exceptions to the type of information that must be provided to patients. See *PHIPA,* s.54(1.1) for more information.
[10] *PHIPA*, s. 54(1)(a).
[11] *Medicine Act*, General Regulation, s. 19(1).
[12] For more information regarding disclosure, please refer to the College's *Protecting Personal Health Information* policy.
[13] *PHIPA*, s. 54(2). Physicians are required under *PHIPA* to respond to requests of records transfer as soon as possible, but no later than 30 days of the request. Sections 54(3) and 54(5) of *PHIPA* set out provisions for circumstances requiring expedited access and an extension.
[14] *PHIPA,* s. 13(1).
[15] For more information on transferring records, please see the *Advice to the Profession: Medical Records Management* document.
[16] These requirements apply regardless of whether access is provided directly by a physician or an agent of the physician, such as a records storage company.

15. When charging for copying and transferring medical records, physicians **must**:

    a. provide a fee estimate prior to providing copies or summaries;[17]
    b. provide an itemized bill that provides a breakdown of the cost, upon request (e.g., cost per page, cost for transfer, etc.);[18] and
    c. only charge fees that are reasonable.

16. When determining what is reasonable to charge, physicians **must** ensure that fees:

    a. do not exceed the amount of "reasonable cost recovery";[19] and
    b. are commensurate with the nature of the service provided and their professional costs (i.e., reflect the cost of the materials used, the time required to prepare the material and the direct cost of sending the material to the requesting individual).[20]

17. When determining a reasonable fee, physicians must consider the recommended fees set out in the Ontario Medical Association's *Physician's Guide to Uninsured Services* ("the OMA Guide")[21,22] and the applicable orders of the IPC[23].

18. When determining a reasonable fee, physicians **must** additionally consider the patient's ability to pay.[24] In particular, physicians **must** consider the financial burden that these fees might place on the patient and consider whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds.[25]

[17] *PHIPA*, s. 54(10).
[18] It is an act of professional misconduct to fail to provide an itemized invoice when asked (See s. 1(1) paragraph 24 of Ontario Regulation 856/93 *Professional Misconduct*, enacted under the *Medicine Act, 1991* S.O. 1991. C.30 (hereinafter *Professional Misconduct Regulation*).
[19] *PHIPA*, s. 54(11).
[20] In accordance with s. 1(1), paragraph 21 of the *Professional Misconduct Regulation* it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided.
[21] The OMA Guide is typically updated annually, and so physicians must ensure they have reviewed the most recent edition.
[22] While physicians are not obliged to adopt the recommended fees set out in the OMA Guide, in accordance with s. 1(1) paragraph 22 of the *Professional Misconduct Regulation*, it is an act of professional misconduct to charge more than the current recommended fees in the OMA Guide without first notifying the patient of the excess amount that will be charged.
[23] See IPC Orders HO-009 and HO-14.
[24] The Canadian Medical Association's *Code of Ethics and Professionalism* (#26) states that physicians have an ethical and professional responsibility to "Discuss professional fees for non-insured services with the patient and consider their ability to pay in determining fees."
[25] For more information on how to determine a patient's ability to pay, please refer to the *Advice to the Profession: Medical Records Management* document.

19. Physicians may request pre-payment for records or take action to collect any fees owed to them but **must not** put a patient's health and safety at risk by delaying the transfer of records until payment has been received.[26]

Retention and Destruction

Medical Records Retention[27]

20. Physicians **must** ensure medical records are retained for a minimum of the following time periods[28]:

    a. *Adult patients:* 10 years from the date of the last entry in the record.
    b. *Patients who are children:* 10 years after the day on which the patient reached or would have reached 18 years of age.[29,30]

Destruction of Medical Records

21. Physicians **must** only destroy medical records once their obligation to retain the record has come to an end.

22. When destroying medical records, physicians **must** do so in a secure and confidential manner[31] and in such a way that they cannot be reconstructed or retrieved. As such, physicians **must**, where applicable:

    a. cross-shred all paper medical records;
    b. permanently delete electronic records by physically destroying the storage media or overwriting the information stored on the media; and

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[26] For additional guidance on fees please refer to the College's *Uninsured Services: Billing and Block Fees* policy.

[27] There are separate provisions for the retention of certain records, including the following:

- Physicians who cease to practise family medicine or primary care have specific retention requirements under s. 19(1)(2) of the *Medicine Act*, General Regulation; see the College's *Closing a Medical Practice* policy for more information.
- Hospitals have separate retention schedules for diagnostic imaging records; see s. 20(4) of the *Public Hospitals Act*, Hospital Management Regulation for more information.
- Independent health facilities have separate retention schedules for patient health records; see s. 11(1) of the *IHFA,* General Regulation for more information.

[28] Retention requirements apply equally to the medical records of patients who are living and deceased.

[29] *Medicine Act,* General Regulation, s. 19(1).

[30] When a request for access to personal health information is made before the retention period ends, physicians are obligated under section 13(2) of *PHIPA* to retain the personal health information for as long as necessary to allow for an individual to take any recourse that is available to them under *PHIPA*. This may require physicians to retain records longer than the above time periods, in some instances. Furthermore, s. 15(2) of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B allows for some legal proceedings to be brought forward 15 years after the act or omission on which the claim is based took place and thus physicians may wish to retain records for longer than the 10 year requirement.

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

c. destroy any back-up copies of records.[32]

Storage and Security

Storage

23. Physicians **must** ensure medical records in their custody or control are stored in a safe and secure environment[33] and in a way that ensures their integrity and confidentiality, including:

    a. taking reasonable steps to protect records from theft, loss and unauthorized access, use or disclosure, including copying, modification or disposal;[34]
    b. keeping all medical records in restricted access areas or in locked filing cabinets to protect against unauthorized access, loss of information and damage;
    c. backing-up electronic records on a routine basis[35] and storing back-up copies in a secure environment separate from where the original data is stored.

24. Where physicians choose to store medical records content that is no longer relevant to a patient's current care separately from the rest of the medical record, physicians **must** include a notation in the record indicating that documents have been removed from the chart and the location where they have been stored.

25. Physicians **must** ensure medical records are readily available and producible when access is required.[36]

Security[37]

26. Physicians with custody or control of medical records **must** ensure that:

    a. all individuals who have access to medical records are bound by appropriate confidentiality agreements; and

[32] For further information, see s. 13(1) of *PHIPA* and the IPC's Fact Sheets on *Secure Destruction of Personal Information* and *Disposing of Your Electronic Media*.
[33] *PHIPA*, s. 13(1).
[34] *PHIPA*, s. 12(1). What is reasonable in terms of records management protocols will depend on the threats and risks to which the information is exposed, the sensitivity of the information, and the extent to which it can be linked to an identifiable individual.
[35] The CMPA suggests daily or weekly back-ups be considered. The CMPA provides risk management advice regarding back-up and recovery practices for EMR systems in its *Electronic Records Handbook*.
[36] This includes where physicians rely on an external facility or organization, such as a commercial storage provider, diagnostic facility, or clinic to retain records.
[37] For expectations related to privacy breaches please refer to the College's *Mandatory and Permissive Reporting* policy.

b. agreements that address data sharing are established for all health care providers, organizations or service providers who will have access to or who will be sharing patient health information with the physician.[38]

27. Physicians with custody or control of medical records **must** have records management protocols that regulate who may gain access to the medical records in their custody or control and what they may do according to their role, responsibilities, and the authority they have.[39]

28. Accordingly, physicians with custody or control of electronic records **must**:

a. ensure each authorized user has a unique ID and password; and
b. maintain an audit trail for all accesses (views) of personal health information, even where no changes are made to the record.

29. When using an electronic record-keeping system, physicians **must** not share their credentials or passwords.

Electronic Records – System Requirements

30. Physicians **must** use due diligence when selecting an EMR system and/or engaging EMR service providers and **must** only use electronic record-keeping systems that:

a. comply with privacy standards set out in *PHIPA,*
b. comply with the standards set out in the Regulation[40], and
c. can fulfill the requirements set out in this policy and *the Medical Records Documentation* policy (e.g., capturing all pertinent personal health information).[41]

31. Physicians **must** only engage with EMR service providers who are willing and able to make medical records accessible, where required, for the purposes of regulatory processes (e.g., College investigations and assessments) and **must** ensure that EMR service providers are aware of their obligations in this regard (e.g., through written agreements).

[38] The CMPA's *Electronic Records Handbook* contains advice for creating data sharing agreements.
[39] Records management protocols include both physical and logical access controls. Physical access controls are physical safeguards intended to limit persons from entering or observing areas of the physician's office that contain confidential health information or elements of an EMR system. Logical access controls are system features that limit the information users can access, modifications they can make, and applications they can run. Examples of the latter include the use of "lockboxes" and "masking" options to restrict access to personal health information at a patient's request.
[40] *Medicine Act*, General Regulation, s. 20.
[41] Use of EMRs that are certified by OntarioMD can help ensure compliance with this expectation. Please see the *Advice to the Profession: Medical Records Management* document for more information on the benefits of using EMRs that are certified by OntarioMD.

32. In particular, the Regulation[42] requires that physicians **must** only use electronic systems that:

    a. Provide a visual display of the recorded information;
    b. Provide a means of access to the record of each patient by the patient's name and Ontario health number, where applicable;
    c. Are capable of printing the recorded information promptly;
    d. Are capable of visually displaying and printing the recorded information for each patient in chronological order;
    e. Include a password or otherwise provide reasonable protection against unauthorized access;
    f. Maintain an audit trail (a record of who has accessed the electronic record) that:
        i. records the date and time of each entry of information for each patient,
        ii. indicates any changes in the recorded information,
        iii. preserves the original content of the recorded information when changed or updated, and
        iv. is capable of being printed separately from the recorded information for each patient;
    g. Automatically back up files and allow the recovery of backed-up files or otherwise provide reasonable protection against loss of, damage to, and inaccessibility of, information.[43]

33. Physicians **must** be proficient with their electronic record-keeping system in order to:

    a. meet the requirements for record-keeping set out in relevant legislation and this policy; and
    b. participate in all regulatory processes (e.g., College investigations and assessments).

Transitioning Records Management Systems[44]

34. When transitioning from one record-keeping system to another (i.e., a paper-based to electronic system, or from one electronic system to another), physicians **must**:

    a. maintain continuity and quality of patient care;
    b. continue appropriate record-keeping practices without interruption;
    c. protect the privacy of patients' personal health information; and

[42] *Medicine Act*, General Regulation, s. 20.
[43] *Medicine Act*, General Regulation, s. 20.
[44] For additional guidance related to transitioning record-keeping systems please refer to the companion *Advice to the Profession: Medical Records Management* document.

d. maintain the integrity of the data in the medical record.

35. To ensure the integrity of the medical record is maintained, physicians who are transitioning from one record-keeping system to another **must** have a quality assurance process in place that includes:

    a. written procedures that are consistently followed; and
    b. verification that the entire medical record has remained intact upon conversion (e.g., comparing scanned copies to originals to ensure that they have been properly scanned or converted).

36. Physicians who wish to destroy original paper medical records following conversion into a digital format **must**:

    a. use appropriate safeguards to ensure reliability of digital copies;
    b. save scanned copies in “read-only” format; and
    c. destroy medical records in accordance with the expectations set out in this policy.

37. Physicians who use voice recognition software or Optical Character Recognition (OCR) technology to convert records into searchable, editable files **must** retain either the original record or a scanned copy for the retention periods set out above.

38. So that complete and up to date information is contained in one central location, physicians with custody or control of records **must:**

    a. set a date whereby the new (electronic) system becomes the official record; and
    b. inform all health care professionals who would reasonably be expected to contribute or rely on the record of this date.

39. Physicians **must** only document in the new system from the official date onward.

Virtual Care

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

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

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

Definitions

Virtual Care: Any interaction between patients and/or members of their circle of care[1] that occurs remotely[2], using any form of communication or information technology, including telephone, video conferencing, and digital messaging (e.g., secure messaging, emails, and text messaging) with the aim of facilitating or providing patient care.[3]

Policy

Virtual care is the practice of medicine

1. When providing virtual care, physicians **must** continue to meet the standard of care and the existing legal and professional obligations that apply to care that is provided in person, including those pertaining to prescribing drugs, medical record-keeping, protecting personal health information, consent to treatment, continuity of care, and charging for insured and uninsured services.[4]

[1] For more information about who is included in the circle of care, please see CPSO's *Protecting Personal Health Information* policy.
[2] Remotely means without physical contact and does not necessarily involve long distances. Patients, patient information and/or physicians may be separated by space (e.g. not in the same physical location) and/or time (e.g. not in real time).
[3] This definition was adapted from Shaw, J., Jamieson, T., Agarwal, P., Griffin, B., Wong, I., & Bhatia, R.S. (2018). Virtual care policy recommendation for patient-centred primary care: findings of a consensus policy dialogue using a nominal group technique. *Journal of Telemedicine and Telecare, 24*(9), 608-615.
[4] Relevant legal obligations include privacy and confidentiality requirements as set out in the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A (hereinafter *PHIPA*), and General, Ontario Regulation 329/04, enacted under *PHIPA*, consent requirements in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, and mandatory liability coverage in s. 50.2 of the General By-Law. Professional obligations are set out in CPSO's *Practice Guide* and policies.

a. For example, physicians providing virtual care **must** conduct any assessments, tests, or investigations that are required in order for them to appropriately provide treatment and **must** provide or arrange for appropriate follow-up care.[5]

2. Physicians **must** ensure they have the competence to provide care virtually, including to effectively use the relevant technology.

Virtual Care and Patients' Best Interests

Virtual care is not appropriate in every instance as not all conditions can be effectively treated virtually and not every patient has access to or will be comfortable using virtual care technology.

3. Physicians **must:**

    a. use their professional judgment to determine whether virtual care is appropriate in each instance its use is contemplated; and
    b. only provide virtual care if it is in the patient's best interest to do so. This means only providing virtual care when:

        i. the quality of care will not be compromised; or
        ii. the potential benefits of providing virtual care outweigh the risks to the patient (e.g., during contagious disease outbreaks or for a patient whose access might be otherwise limited to the point of risking patient harm).[6]

4. When determining whether virtual care is appropriate and in the patient's best interest (i.e., can meet the conditions set out in 3(b) above), physicians **must** consider and ensure their decisions reflect the following factors:

    a. the nature of the presenting complaint and care required, including whether a physical examination is required in order to meet the standard of care;
    b. the patient's existing health status and specific health-care needs;

[5] For more information on what it means to meet the standard of care when delivering care virtually, please see the *Advice to the Profession: Virtual Care* document.

[6] In some exceptional circumstances it may be appropriate to provide virtual care even when in-person care would generally be required to meet the standard of care. These circumstances are generally limited to instances where virtual care promotes patient or public safety. In these circumstances the potential benefits of patient or public safety override the potential risk to quality of care.

c. the patient's specific circumstances and preferences (e.g., financial hardship, mobility limitations, distance required to travel to an in-person appointment, ability to take time off from work, or any language and/or communication barriers); and
d. the technology available to the patient and their ability to effectively utilize the technology.

5. Where clinically appropriate and available, physicians **must** prioritize patient preference for in-person or virtual care.

Establishing a physician-patient relationship

6. Physicians providing virtual care **must** ensure the following is disclosed to all new patients:

    a. the physician's identity,
    b. the physician's contact information, and
    c. the physician's licensure status (i.e., where they hold a medical licence).

Limitations of Virtual Care and Appropriate Action

7. Physicians **must:**

    a. be mindful of the limitations of virtual care; and
    b. take appropriate action if, during the course of a virtual encounter it is determined that a patient requires in-person care, including:
        i. informing patients of the need for in-person care and the urgency with which it should be sought; and
        ii. providing or assisting patients in accessing appropriate in-person care in a timely manner (e.g., through a coverage arrangement or by directing patients to local in-person options).

8. Physicians **must** take appropriate action if, during the course of a virtual encounter the quality of the encounter becomes compromised (e.g., technology fails or security is compromised) and the patient's best interests will no longer be served by continuing with the virtual encounter, including:

    a. ensuring the patient is followed-up with in a timely manner; and/or
    b. rescheduling the appointment, where necessary.

Appropriate Setting and Technology

9. Where the virtual encounter is synchronous (i.e., involves real-time interaction with the patient), physicians **must** confirm the physical setting where the patient is receiving virtual care is appropriate and safe in the circumstances (i.e., taking into account the nature and purpose of the intended interaction).

    a. Physicians **must** take appropriate action if they determine that it is not appropriate or safe to proceed, such as explaining that they will be unable to proceed at that time and re-scheduling the appointment in a timely manner.

10. Physicians providing virtual care **must** use technology that is fit for purpose, can facilitate a quality encounter, and enables the standard of care to be met, including technology that:

    a. allows physicians to gather the information needed to provide the care; and
    b. supports the sharing of high quality and reliable patient health information (e.g., diagnostic or other images that are of sufficient quality).

Maintaining Privacy, Security, and Confidentiality

The legal obligations to protect the privacy and confidentiality of patients' personal health information (PHI) also exist when delivering virtual care.

11. All physicians **must** take reasonable steps to protect PHI, including protection against theft, loss, and unauthorized access, use, and disclosure of PHI.[7] When providing virtual care, physicians **must**:

    a. take reasonable steps to accurately identify the patient (e.g., verify their name and date of birth);[8]
    b. conduct the encounter in a private setting, where applicable;
    c. disclose the identities of all participants that will be present during the encounter;
    d. ask the patient whether they are in a reasonably private setting and are comfortable discussing or sharing their PHI at that time; and
    e. use secure information and communication technology (e.g., platforms that are protected by encryption), unless it is in the patient's best interest to do otherwise, taking into account:

[7] *PHIPA*, s. 12 (1).
[8] What is reasonable will differ if the encounter takes place within the context of an existing physician-patient relationship compared with a new patient.

- the nature and purpose of the encounter, including the degree of sensitivity of the PHI being shared;
- the availability (or lack thereof) of alternative technology;
- the volume of information and frequency of use;
- patient expectations; and
- any emergency or other urgent circumstances.[9]

12. If using less secure technology (e.g., unencrypted platforms), physicians **must** obtain and document the patient's express (i.e., verbal or written) consent to do so.[10]

Obtaining Informed Consent for Virtual Care

13. Physicians **must** ensure informed consent is obtained from the patient or their substitute decision maker (SDM) for the delivery of care using a virtual modality, which will require informing patients or their SDM of the benefits, limitations, and potential risks of a virtual encounter, including:

    a. those related to privacy (e.g., potential for privacy breaches); and
    b. any clinical limitations to providing virtual care and the potential requirement for in-person follow-up.[11]

14. Physicians **must** obtain informed consent during the initial virtual encounter and each time the benefits, limitations, and potential risks change (e.g., if the virtual modality used changes, or if the nature of the care significantly changes).

CPSO Members Providing Virtual Care Across Borders[12]

15. When providing or assisting in the provision of virtual care to a patient in another province, territory, or country, physicians **must:**

    a. comply with the licensing requirements of that jurisdiction;[13] and
    b. ensure they have appropriate liability protection.[14]

[9] For more information on privacy and security safeguards see the *Advice to the Profession: Virtual Care* document.
[10] For the purposes of this policy, the telephone is considered secure technology.
[11] For more information about obtaining informed consent see the *Advice to the Profession: Virtual Care* document.
[12] CPSO maintains jurisdiction over its members regardless of where (i.e., physical location) or how (i.e., in-person or virtually) they practise medicine, and will investigate any complaints made about a member, regardless of whether the member or patient is physically located in Ontario.
[13] The medical regulatory authority of the jurisdiction where the physician and/or patient are physically located may also require that physicians hold an appropriate medical licence in that jurisdiction.
[14] Physicians can consult the Canadian Medical Protective Association (CMPA) and the Ministry of Health for more information on liability protection and billing in these circumstances.

Licensing Requirements when Providing Virtual Care to Ontario Patients

16. Physicians providing virtual care to Ontario patients located in Ontario[15] **must** hold a valid and active certificate of registration with the CPSO, unless the provision of virtual care from a physician licensed elsewhere is in the patient's best interest;[16] for example, the care sought is:

    a. not readily available in Ontario (e.g., specialty care);
    b. provided within an existing physician-patient relationship and intended to bridge a gap in care; or
    c. for urgent or emergency assessment or treatment of a patient.[17]

[15] For guidance related to treating Ontario patients who are temporarily out of the province, please see the *Advice to the Profession: Virtual Care* document.
[16] This provision does not permit physicians licensed in other jurisdictions to circumvent Ontario licensing requirements and primarily practise in Ontario. It is intended to allow the provision of limited virtual care by physicians licensed in other jurisdictions in circumstances where it will serve a patient's best interests.
[17] CPSO reserves the right to take action against physicians who are providing virtual care to Ontario patients in accordance with Provision #16 if they are not meeting the standard of practice. If CPSO becomes aware of concerns about virtual care provided to an Ontario patient by a physician who is not licensed in Ontario it may share that information with the regulatory authority that has jurisdiction over the member, so that appropriate action can be taken by that regulatory authority.

Social Media

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

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

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

Definitions

Social media[1]**:** Online platforms, technologies, and practices that people use to share content, opinions, insights, experiences, and perspectives. Examples of social media include, but are not limited to, Twitter, Facebook, YouTube, Instagram, LinkedIn, and discussion forums.

Disruptive behaviour: Inappropriate words, actions, or inactions by a physician that interfere with (or may interfere with) the physician's ability to collaborate, the delivery of quality health care, or the safety or perceived safety of others. Disruptive behaviour may be demonstrated through a single act, but will more commonly be identified through a pattern of events. Disruptive behaviour may include, for example, bullying, attacking, or harassing others and making discriminatory comments.[2] An example of behaviour that is not likely to be considered disruptive behaviour includes constructive criticism offered in good faith with the intention of improving patient care or the health-care system.[3]

[1] For the purposes of this policy, the term "social media" may also refer to other electronic or digital communications such as email, websites, and text messaging, depending on the context in which it is used and its impact. For more information, see the *Advice to the Profession*.

[2] Discriminatory comments can take various forms, but may involve the expression of negative attitudes, stereotypes, and biases on the basis of protected grounds in the Ontario *Human Rights Code* (e.g., race, ethnic origin, creed, ancestry, colour, sexual orientation, gender identity, sex, disability, etc.) as well as other categories (e.g. socioeconomic status, education, weight, etc.).

[3] For more information on disruptive behaviour see the *Advice to the Profession*. The *Physician Behavior in the Professional Environment* policy and the *Guidebook for Managing Disruptive Physician Behaviour* contain further information on disruptive behaviour in the workplace environment.

Policy

This policy sets out expectations to help physicians navigate the online environment and prevent conduct that could harm the public's trust in individual physicians and the profession as a whole. The focus of this policy is on a physician's professional use of social media, but it can also apply to personal use depending on several factors, for example, the connection between the physician's conduct and their professional role.[4]

The College recognises that physicians have rights and freedoms under the *Canadian Charter of Rights and Freedoms*, including the freedom of expression, subject to reasonable limits. Physicians hold a respected position in society. Professional conduct and communication are important to preserve the reputation of the profession, foster a culture of respect, not adversely impact patient care, and avoid harm to the public while using social media.

1. Physicians **must** comply with the expectations set out in this policy, other College policies,[5] and other relevant legislative and regulatory requirements[6] when using social media.

Professionalism

2. Physicians **must** uphold the standards of medical professionalism, conduct themselves in a professional manner, and **not** engage in disruptive behaviour while using social media.

3. Physicians **must** consider the potential impact of their conduct on the reputation of the profession and the public trust.

4. Advocacy for patients and for an improved health care system is an important component of the physician's role. While advocacy may sometimes lead to disagreement or conflict with others, physicians **must** continue to conduct themselves in a professional manner while using social media for advocacy.

[4] For more information, see the *Advice to the Profession*.
[5] Including *Advertising*, *Boundary Violations*, *Physician Behaviour in the Professional Environment*, *Professional Obligations and Human Rights*, *Protecting Personal Health Information*, *Virtual Care*, and *Physicians' Relationships With Industry: Practice, Education and Research*.
[6] Including the *Personal Health Information Protection Act, 2004*, S.O. 2004, the *Medicine Act, 1991*, the *Libel and Slander Act,* R.S.O. 1990, the *Copyright Act*, and the *Criminal Code* (e.g., hatred offences under sections 318 – 320.1), and their regulations.

Health-related information and clinical advice

5. When disseminating general health information on social media for educational or information-sharing purposes, physicians **must:**
    a. disseminate information that is:
        i. verifiable and supported by available evidence and science, if making statistical, scientific, or clinical claims; and
        ii. **not** false, misleading, or deceptive.
    b. be aware of and transparent about the limits of their knowledge and expertise; and
    c. **not** misrepresent their qualifications.

6. When disseminating information on social media, physicians **must** be mindful of the risks of creating a physician-patient relationship or creating the reasonable perception that a physician-patient relationship exists.[7]
    a. Physicians **must not** provide specific clinical advice to others on social media unless they are able and willing to meet the professional obligations that apply to a physician-patient relationship and the requirements in the *Virtual Care* policy and the *Personal Health Information Protection Act, 2004* (*PHIPA*).[8]

Professional Relationships and Boundaries

7. Physicians **must** maintain professional and respectful relationships and boundaries with patients, persons closely associated with patients, and medical students and/or postgraduate trainees over whom they have responsibilities while using social media.[9]

8. While using social media, physicians **must** consider the impact on and **must not** exploit the power imbalance inherent in:
    a. the physician-patient relationship when engaging with a patient or persons closely associated with them; and

[7] For example, by providing information in a manner that would lead a reasonable person to rely on it as clinical advice. If asked a medical question, physicians can direct individuals to the appropriate channels to obtain care. See the *Advice to the Profession* for more information.
[8] The provision of clinical advice through information and communication technologies is considered providing virtual care. Physicians must continue to meet the standard of care, which can include performing a comprehensive assessment, considering risks and benefits of treatment options, obtaining consent, etc.
[9] Boundaries can be sexual, financial/business, social, or other. For the definition of a "patient", see the *Boundary Violations* policy. For more information on maintaining appropriate boundaries, see the *Advice*.

b. any relationship with a medical student and/or postgraduate trainee while responsible for mentoring, teaching, supervising or evaluating a medical student and/or trainee.[10]

Privacy and Confidentiality

9. Physicians **must** comply with the requirements set out in *PHIPA* and its regulations and the expectations set out in the College's *Protecting Personal Health Information* policy while using social media.

Posting patient health information

10. If a physician is posting original content on social media containing health information about a patient, physicians **must**:
    a. de-identify the patient information;[11] and/or
    b. obtain and document express and valid consent from the patient or substitute decision-maker (SDM) for the publication of the content on social media, including when there is any doubt that the anonymity of a patient can be maintained.[12]

11. In fulfilling the requirement to obtain express and valid consent from the patient or SDM, physicians **must**:
    a. show them the content to be published;
    b. inform them that consent to publication can be withdrawn at any point;
    c. inform them about the risks of publication of the content (for example, that once posted on social media it may be unable to be completely withdrawn);
    d. engage in a dialogue with them about the publication of the content, such as the purposes of posting the content, where it will be posted, and any other relevant information, regardless of whether supporting documents (such as consent forms, patient education materials or pamphlets) are used; and
    e. consider how the power imbalance inherent in the physician-patient relationship could cause patients to feel pressured to consent and take

[10] For more information on professional relationships with students and trainees, see the *Professional Responsibilities in Medical Education* policy.
[11] A privacy breach can occur if the sum of the information available is sufficient for the patient to be identified, even if only by themselves. For more information on de-identification see the *Advice to the Profession*.
[12] If relying on consent, physicians must only post a patient's personal health information, to the best of their knowledge, for a lawful purpose (in accordance with s.29(a) of *PHIPA*). For content posted for the purposes of advertising, physicians must comply with the General Regulation under the *Medicine Act, 1991*, S.O. 1991 and the *Advertising* policy.

reasonable steps to mitigate this potential effect (for example, by informing the patient that if they do not consent, it will not impact their care).

Seeking out patient health information

12. Physicians **must** refrain from seeking out a patient's health information online[13] without a patient's consent unless:
    a. the information is necessary for providing health care;
    b. there is an appropriate clinical rationale related to safety concerns;[14]
    c. the information cannot be obtained from the patient and relied on as accurate and complete, or cannot be obtained from the patient in a timely manner;
    d. they have considered whether it is appropriate to ask the patient for consent to seek out the information online; and
    e. they have considered how the search may impact the physician-patient relationship (for example, whether it would lead to a breakdown in trust).

13. Physicians **must** document the rationale for conducting the search, the limitations (if any) on the accuracy, completeness or up-to-date character of the information, and any other relevant information (for example, search findings and the nature of search) in the patient's record.

14. Physicians relying on patient health information found online for clinical decision-making **must**:
    a. take reasonable steps to confirm the information is accurate, complete, and up-to-date, as is necessary for its purposes, prior to using the information; and
    b. if it is safe and appropriate to do so, disclose to the patient the source of the information, the clinical rationale for obtaining the information, and any other relevant information.

[13] This excludes authorized use of electronic health tools, such as patient databases, for the delivery of health care.
[14] For more information on what may be considered a clinical rationale related to safety concerns, see the *Advice to the Profession*.

SOCIAL MEDIA — APPROPRIATE USE BY PHYSICIANS

The term ‘social media’ refers to web and mobile technologies and practices that people use to share content, opinions, insights, experiences, and perspectives online. There are many prominent examples of social media platforms, including Facebook, Twitter, YouTube, LinkedIn, and blogging sites, among many others.

Social media can be used for both personal and professional purposes. Many physicians are now using social media in their practices to interact with colleagues and patients, to seek out medical information online, and to share content with a broad audience.

Whether engaging in social media for personal or professional use, the nature of these platforms, which are highly accessible, informal, and public, raise important questions about the steps physicians should take to uphold their important professional obligations while online.

Purpose

This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.

This document is not a policy, nor does it establish any new expectations for physicians that are unique to social media. Rather, this document clarifies how existing professional expectations can be met in the social media sphere.

College position on social media

The College’s position is that physicians are expected to comply with all of their existing professional expectations, including those set out in relevant legislation, codes of ethics, and College policies, when engaging in the use of social media platforms and technologies.

If physicians do so, the College recognizes that social media platforms may present important opportunities to enhance patient care, medical education, professional competence, and collegiality, among other potential benefits.

Relevant professional expectations

Legal and professional expectations that govern medical practice are set out in the College’s Practice Guide, policies, and relevant legislation. A number of these obligations are relevant to the use of social media by physicians, and are articulated below. These obligations are not unique to social media, but apply to medical practice in general, and must be met by all physicians.

They are as follows:

- Comply with all legal and professional obligations to maintain patient privacy and confidentiality.[1]
- Maintain appropriate professional boundaries with patients and those close to them.[2]
- Maintain professional and respectful relationships with patients, colleagues, and other members of the health-care team.[3]
- Comply with relevant legislation with respect to physician advertising.[4]
- Comply with the law related to defamation, copyright, and plagiarism when posting content online.[5]
- Avoid conflicts of interest.[6]

Guidelines

In order to satisfy the above professional expectations while engaging in social media, it is recommended that physicians:

1. Assume that all content on the Internet is public and accessible to all.
2. Exercise caution when posting information online that relates to an actual patient, in order to ensure compliance with legal and professional obligations to maintain privacy and confidentiality. Bear in mind that an unnamed patient may still be identified through a range of other information, such as a description of their clinical condition, or area of residence.[7]

3. Refrain from providing clinical advice to specific patients through social media.[8] It is acceptable, however, to use social media to disseminate generic medical or health information for educational or information sharing purposes.
4. Protect their own reputation, the reputation of the profession, and the public trust by not posting content that could be viewed as unprofessional.
5. Be mindful of their Internet presence, and be proactive in removing content posted by themselves or others which may be viewed as unprofessional.[9]
6. Refrain from establishing personal connections with patients or persons closely associated with them online, as this may not allow physicians to maintain appropriate professional boundaries and may compromise physicians' objectivity.[10] It is acceptable to create an online connection with patients for professional purposes only.
7. Refrain from seeking out patient information that may be available online without prior consent.[11]
8. Read, understand, and apply the strictest privacy settings necessary to maintain control over access to their personal information, and social media presence undertaken for personal purposes only.
9. Remember that social media platforms are constantly evolving, and be proactive in considering how professional expectations apply in any given set of circumstances.

Endnotes

1. *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A (hereinafter PHIPA), the CPSO's Confidentiality of Personal Health Information policy.

2. For more information please see the CPSO's Maintaining Appropriate Boundaries and Preventing Sexual Abuse and Treating Self and Family Members policies.

3. The duty of physicians to maintain professional and respectful relationships is set out in the CPSO's Physician Behaviour in the Professional Environment policy, and the Practice Guide.

4. For more information on physician advertising, please see Part II of O.Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30.

5. For example, *Copyright Act*, R.S.C. 1985, c. C-42.

6. For more information on conflicts of interest, please see Part IV of the General, O. Reg., 114/94, and the CPSO's Practice Guide.

7. A breach of confidentiality may be deemed to have occurred if the facts available are sufficient for the patient to be identified, even if only by themselves. This is consistent with the definition of "identifying information" in section (4)2 of PHIPA.

8. Clinical advice is defined as advice of a clinical nature that is directed toward a specific individual to address a medical concern. It is distinct from general health information that is not patient-specific, but disseminated to a general audience for education or information sharing purposes.

9. Be mindful that once information has been posted online, it may be difficult or impossible to remove. Reasonable steps should be taken to remove information that has been posted by one's self or others.

10. Some physicians may find it preferable to maintain a separate online presence for their personal and professional networks. For more information on maintaining appropriate professional boundaries, please see the CPSO's Maintaining Professional Boundaries and Preventing Sexual Abuse policy, Treating Self and Family Members policy, and *Dialogue* article "Maintaining Boundaries."

11. Patients are entitled to a reasonable expectation of privacy. While physicians are expected to adhere to all of their relevant legal obligations under PHIPA with respect to the collection of personal health information, they should also refrain from seeking out other types of non-protected information online without prior consent.

Related Links

Social Media FAQ

This document provides guidance to physicians about

how to engage in social media while continuing to meet relevant legal and professional expectations.

Council Motion

Motion Title	Council Meeting Consent Agenda
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the items outlined in the consent agenda, which include in their entirety:

- The Council meeting agenda for September 22 and 23, 2022; and
- The minutes from the meeting of Council held June 16 and 17, 2022

Council Briefing Note

September 2022

Topic:	Executive Committee Report
Purpose:	For Information
Main Contact:	Lisa Brownstone, Chief Legal Officer
Attachment:	N/A

02-EX-May-2022 **Correction to Committee Appointment for Mr. Shahab Khan**

Upon a motion moved by J. Fisk, seconded by I. Preyra and carried, that the Executive Committee approve the correction to the appointment term for the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practice Committee term to conclude at the Annual General Meeting of Council in 2024.

Contact: Janet van Vlymen, President
Lisa Brownstone, Chief Legal Officer

Date: September 7, 2022

Council Briefing Note

September 2022

Topic:	**Ontario Physicians and Surgeons Discipline Tribunal Report of Completed Cases | May 31, 2022 – September 2, 2022**
Purpose:	For Information
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	**Accountability:** Holding physicians accountable to their patients/clients, the public, and their regulatory body. **Protection:** Fulfilling the College's mandate to ensure public protection.
Main Contacts:	Dionne Woodward, Tribunal Counsel
Attachments:	None

Issue

- This report summarizes reasons for decision released between May 31, 2022 and September 2, 2022 by the Ontario Physicians and Surgeons Discipline Tribunal.
- It includes reasons on discipline hearings (liability and/or penalty), motions and case management issues brought before the Tribunal.
- This report is for information.

Current Status and Analysis

In the period reported, the Tribunal released 11 reasons for decision:

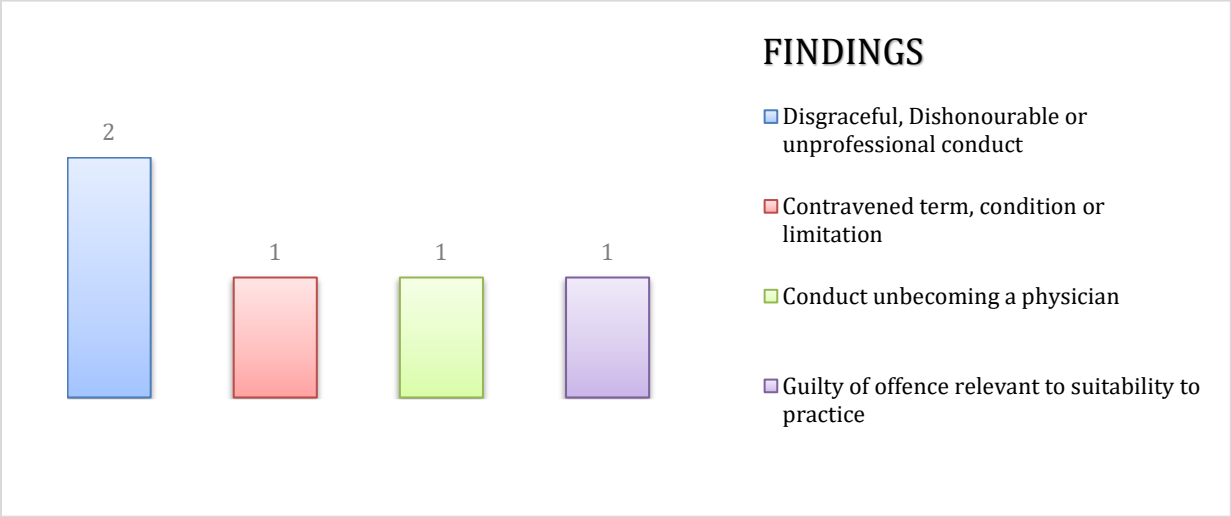
- 2 reasons on findings (liability) and penalty
- 2 reasons on penalty only
- 7 reasons on motions/case management

Findings

Liability findings included:

- 2 findings of disgraceful, dishonorable or unprofessional conduct
- 1 finding of contravening a term, condition or limitation on a certificate of registration
- 1 finding of conduct unbecoming a physician
- 1 finding of guilty of an offence relevant to suitability to practise

Figure 1: Types of Findings Issued During Reporting Period
**Note: Some cases had more than one finding*



Penalty

Penalty orders included:

- 4 reprimands
- 1 suspension
- 3 revocations
- 1 imposition of terms, conditions or limitations on the physician's Certificate of Registration
- 1 fine payable to the Minister of Finance

Costs

The Tribunal imposed a costs order on the physician in all penalty reasons. The maximum costs ordered were $197,030 and the minimum costs ordered were $6,000.

Motions and case management decisions

For the period reported, the Tribunal released five orders and reasons for decisions on motions and two case management decisions.

TABLE 1: TRIBUNAL DECISIONS – FINDINGS (May 31, 2022 to September 2, 2022)

Citation and hyperlink to published reasons	Physician	Date of Reasons	Disgraceful, Dishonourable, Unprofessional	Failed to maintain standard of practice	Incompetence	Conduct Unbecoming a Physician	Other
2022 ONPSDT 25	Verma	Jul. 6, 2022	X			X	Guilty of offence relevant to suitability to practice
2022 ONPSDT 27	Matheson	July 26, 2022	X				Contravened a term, condition or limitation on Certificate of Registration

TABLE 2: TRIBUNAL DECISIONS - PENALTIES (May 31, 2022 to September 2, 2022)

Citation and hyperlink to published reasons	Physician	Date of reasons	Penalty (TCL = Term, Condition or Limitation)	Length of suspension in months	Costs
2022 ONPSDT 22	Fagbemigun	June 9, 2022	Reprimand; revocation; $35,000 fine to Minister of Finance		$72,590
2022 ONPSDT 25	Verma	Jul. 6, 2022	Reprimand; revocation		$6000
2022 ONPSDT 26	Khan	July 15, 2022	Reprimand; revocation		$197,030
2022 ONPSDT 27	Matheson	July 26, 2022	Reprimand; suspension; TCL	9 months	$6000

TABLE 3: TRIBUNAL DECISIONS - MOTIONS AND CASE MANAGEMENT (May 31, 2022 to September 2, 2022)

Citation and hyperlink to published reasons	Physician	Date of reasons	Motion/Case management outcome	Nature of motion/case management issue
2022 ONPSDT 21	Gerber	June 1, 2022	Member's motion for statement of particulars in proper form granted.	Panel found that it was inappropriate for the College to rely on disclosure and 'Pre-Hearing Conference Memorandum' as sources of the particulars of the allegations.
2022 ONPSDT 23	Khan	June 13, 2022	Motions for the Chair's recusal; removal of College counsel; and disclosure of a document, all dismissed.	Dr. Khan brought three motions before the Tribunal as follows: 1) Motion for the Chair's recusal due to an alleged reasonable apprehension of bias flowing from the Chair's role on College's leadership team; 2) Motion for removal of College Counsel for allegedly committing prosecutorial misconduct in prior case where false expert evidence was put forward against him; and 3) Motion for the disclosure of documentation indicating that a requested document did not exist. All three motions were dismissed.
2022 ONPSDT 24	Fagbemigun	June 30, 2022	Motion under Rule 12.03 of the Tribunal Rules of Procedure granted.	CTV reporter sought and was granted access to exhibits (photographs) filed at the merits hearing.
2022 ONPSDT 28	McInnis	August 10, 2022	Case Management – Request for continued adjournment denied.	Member was denied continued adjournment. Earlier hearing to be scheduled given nature of case (e.g. serious misconduct of a sexual nature) and delay that had already occurred.

2022 ONPSDT 29	Benjamin	August 15, 2022	Motion to stay the allegations or, in the alternative, quash the referral, was dismissed.	Member argued that loss or destruction of investigator notes; biased investigation process; and raising of allegations that were already successfully remediated by the College were an abuse of process warranting a stay of proceedings. The motion was dismissed in its entirety.
2022 ONPSDT 30	Kadri	August 25, 2022	Motion for Tribunal to address certain issues at the merits hearing and order the production of third-party records dismissed due to irrelevance.	Member brought motion for Tribunal to consider, at merits hearing, issues pertaining to College processes and the model of care adopted by Windsor Regional Hospital (WRH) for renal patients. Further, the Member sought a production order for third-party records, namely patient records and emails sent and received by multiple individuals associated with WRH. The panel found that the issues the member sought to add to the hearing and the third-party documents were not relevant to the allegations of misconduct or incompetence before the Tribunal.
2022 ONPSDT 31	Gerber	August 26 2022	Case Management - Member's amendment to Notice of Third-Party Motion not permitted due to inadequate notice.	The Member brought motion for the production of records (i.e. electronic communications) held by third parties, including the complainants. The Member filed an amended Notice of Motion broadening the scope of the records sought to include communications between the complainants and 12 added persons. These added individuals were not provided notice of the amended motion. The panel held that the 12 individuals were entitled to notice of the motion and the harm of adjourning the motion to permit notice outweighed the physician's interest in broadening the initial motion and records sought. The Member was not permitted to amend the original Notice of Motion.

Council Briefing Note

September 2022

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

Ontario Political Update

- On August 8th, the government recalled the legislature and commenced the 1st session of the 43rd Parliament. The legislature is scheduled to sit until December 8th, with a possible recess at the end of the summer.

- Since returning to Queen's Park, government has delivered a Throne Speech, tabled a budget bill and "strong-mayor" legislation, released a health system recovery plan, and passed amendments to long-term care legislation.

- On August 18th, government released their *Plan to Stay Open: Health System Stability and Recovery*. This four-part plan outlines recent and upcoming actions government is taking to preserve hospital capacity; provide the right care in the right place; reduce surgical waitlists; ease pressure on emergency departments; and expand Ontario's health workforce.
    - Most relevant to CPSO, government indicated that would work with us to "expedite the registration of doctors, including those from out-of-province and who may want to work in rural and northern emergency departments, so they can start working and caring for patients sooner". Additional details on this topic are shared below.
    - The plan also makes commitments to reduce surgical wait times and government indicated that they will "consider options for further increasing surgical capacity by increasing the number of OHIP-covered surgical procedures performed at independent health facilities." At the time of drafting this briefing note, no further details on this plan were known.

- Further to the commitment to preserve hospital capacity, outlined in the *Plan to Stay Open* the Minister of Long-Term Care, Paul Calandra, introduced Bill 7, More Beds, Better Care Act.
    - Among other things, the bill will authorize physicians and other providers to initiate a process of assessing and selecting a long-term care home for "alternate level of care" patients without the consent of the patient (or family). While government has indicated that these actions are needed in order to support hospitals, critics have called it a violation of patient rights.
    - The bill bypassed committee hearings and swiftly passed through the House—receiving Royal Assent on August 31. Minister Calandra has said that the bill's regulations will be finalized a week after it passes.

- Following the resignation of both NDP and Liberal party leaders on election night, both parties now have interim leaders in place. Veteran MPPs Peter Tabuns and John Fraser have taken on the role for the NDP and the Liberals, respectively.

Issues of Interest

a) Red-Tape Reduction

- As part of CPSO's ongoing commitment to reduce red tape and implement a right-touch approach to regulation, we have made numerous requests to government over the years for legislative and regulatory changes.

- This summer, staff sought opportunities with government to highlight the top priority issues that would allow us to be a more effective and efficient regulator, mitigate risk, reduce red tape, and lay the groundwork for broader reform. These priorities were to:
    - Eliminate the requirement for a physician member of Council on every Tribunal hearing (but maintain the requirement for a professional member); and
    - Provide CPSO with greater discretion to investigate complaints and streamline the handling of frivolous and vexatious complaints at the ICRC.

- While we understand that red tape reduction remains a priority for government, at the time this briefing note was written, CPSO had not yet received indication that government would move forward with these requested changes.

b) Letter from Minister of Health on increasing Physician Supply

- On August 4, the new Minister of Health, Sylvia Jones wrote to CPSO asking that we "make every effort to register out of province and internationally educated physicians to the College as expeditiously as possible". The Minister asked that we provide our response within two weeks' time. CPSO's response to the Minister was sent on August 18th.

- In the letter, we highlighted the existing tools which have been leveraged throughout the pandemic to support the health system and outlined a variety of short and longer term options that could address these pressing issues. This included outreach to recently retired physicians (which has now been done), potential regulatory or policy changes, initiating a Practice Ready Assessment program and increasing the supply of residency positions.

- Conversations with government are ongoing regarding implementation.

Interactions with Government

a) Letters of Congratulations to MPPs

- As part of the government relations activities following the June election, the President and Registrar/CEO sent letters of congratulations to all newly elected MPPs and select returning MPPs.

- These letters provided us with an opportunity to educate MPPs about our role, ensure they have a contact within CPSO should they have questions or concerns, open the door for future meetings with these MPPs, and/or strengthen existing relationships.

- As a result of our outreach, we received numerous letters and emails of appreciation for this correspondence as well as expressions of interest in meeting.

b) Meetings with the Minister of Health

- Since the new Health Minister's appointment, the Registrar/CEO has met with her a number of times. These meetings have been positive and collegial and provided CPSO with the opportunity to establish a relationship with the Minister, brief her on our priorities, and demonstrate our alignment with the government's commitment to red tape reduction and health system improvement.

- Staff will continue to strengthen the relationship with the Minister of Health and key staff in her office.

c) Looking Forward

- We anticipate an extremely busy legislative session as government contends with ongoing health system challenges and seeks ways to effectively manage then.

- MPP meetings with the President will resume in the fall and staff will continue to build relationships with political/Ministry staff.

Council Briefing Note

September 2022

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

Issue

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

Current Status

1. Policy Consultation Update

- Four policy consultations launched following June Council and closed in August 2022. Notice of the consultation was sent to the membership and external stakeholders and was promoted through CPSO's website and social media platforms.

- An overview of the key themes that emerged in the feedback is provided below. All feedback received during these consultations will be analyzed to help inform the policy reviews. Council will be provided with further detail about these reviews at future meetings.

General Consultation: *Dispensing Drugs*

- Council approved the draft *Dispensing Drugs* policy and companion *Advice to the Profession: Dispensing Drugs* document for an expedited public consultation in June 2022.

- This consultation received 33 responses: seven through written feedback and 26 via the online survey. The vast majority of respondents were physicians and feedback was also received from three organizational respondents.[1]

- There was overall broad support for the draft policy, with a strong majority of survey respondents agreeing that the draft is clearly written, easy to understand, and reasonable.

    - The majority of respondents agreed that the draft definition of "dispensing" is clear and comprehensive and also supported the proposed expectations around patient counselling, transparency in pharmacy choice, and monitoring of recalled drugs.

- The vast majority of survey respondents agreed that the distribution of drug samples to patients is different from the dispensing of other drugs. However, they were somewhat split on the potential application of the draft policy to drug samples with roughly one-third feeling this could be beneficial and one-half indicating it would have a negative or burdensome impact (including some respondents indicating they would stop the practice).

- Suggestions on how to improve the draft policy's clarity and comprehensiveness included:

    - Provide guidance on determining dispensing fees and billing for dispensing;
    - Clarify the expectations around informing patients about other available options for obtaining a drug and dispensing only to physicians' own patients; and
    - Outline which drugs under what circumstances can be dispensed by physicians.

General Consultation: *Decision-Making for End-of-Life Care*

- Council approved the draft *Decision-Making for End-of-Life Care* policy and companion *Advice to the Profession: End-of-Life Care* document for public consultation in June 2022.

- This consultation received 130 responses: 20 through written feedback and 110 via the online survey. The vast majority of respondents were physicians and feedback was also received from eight organizational respondents.[2]

- Both the quantitative feedback and open-ended comments were supportive of the new expectations related to both advance care planning (ACP) and goals of care (GOC) discussions, with the majority of survey respondents agreeing that the expectations are

[1] Organizational respondents included: Canadian Ophthalmological Society; Ontario Medical Association (OMA); and OMA Section on Plastic Surgery.

[2] Organizational respondents included: Canadian Critical Care Society (CCCS); Canadian Medical Protective Association (CMPA); Department of Critical Care Medicine, the Hospital for Sick Children (SickKids); Dying With Dignity Canada (DWDC); Ethics Quality Improvement Lab, William Osler Health System; Euthanasia Prevention Coalition; OMA; Regional Ethics Program, Trillium Health Partners; and Professional Association of Residents of Ontario (PARO).

clear and reasonable. However, some concerns noted that these discussions are important for *all* patients, the determination for initiating conversations is too subjective, and that the draft GOC expectations are too broad whereas the ACP ones are not specific enough.

- The quantitative feedback was also supportive of the draft provisions regarding withholding resuscitative measures, with a strong majority of survey respondents agreeing that they strike the appropriate balance between supporting physician professional judgment and considering the diversity of patient wishes, values, and beliefs, among other things. However, written feedback from respondents was varied and conflicting:
    - Some indicated that more weight should be given to medical expertise, while others felt that the patient's decision should always prevail;
    - Some agreed that the concept of "futility" is clear and meaningful, whereas others indicated that it should not be used because it is vague and/or problematic;
    - Some said that the "potential benefits" should be defined objectively, while others agreed that they can be defined only in reference to the patient's values and beliefs; and
    - Some felt that physicians should always inform patients and/or their substitute decision-makers *before* writing a "Do Not Resuscitate" order except in emergency cases, while others indicated that the draft provisions set too high a bar.

Preliminary Consultation: *Blood Borne Viruses (BBVs)*

- This consultation received 48 responses: four through written feedback and 44 via the online survey. The vast majority of respondents were physicians and feedback was also received from two organizational respondents.[3]

- Much of the feedback focused on the testing, monitoring, and reporting requirements with many respondents expressing concern or offering a critique of the current policy position.
    - Roughly half of physician survey respondents who specified that they perform or assist in performing exposure-prone procedures (EPPs) agreed that it is important to know their infection or immunity status, but a strong majority felt that testing is not important.

- Constructive suggestions from respondents in order to improve the current policy included:
    - Updating the current definition of EPPs (some physicians indicated it is outdated);
    - Including the actual risk of transmission of BBVs from physicians to patients; and
    - Indicating whether physicians need to disclose their serological status to patients.

[3] Organizational respondents included: CMPA and OMA.

Preliminary Consultation: *Mandatory and Permissive Reporting*

- This consultation received 57 responses: 14 through written feedback and 43 via the online survey. The vast majority of respondents were physicians and feedback was also received from five organizational respondents.[4]

- A strong majority of survey respondents agreed that the current policy is clearly written, easy to understand, and easy to navigate.

- A majority of survey respondents indicated that it is helpful for CPSO to catalogue physicians' reporting obligations even though they are set out in law, although there was some support for exploring different methods or formats to support physician understanding.

- Suggestions on how the current policy might be updated to enhance its use included:

    - Categorizing the obligations differently (e.g., by whether the report needs to be filed with a regulatory college or another organization) and/or organizing the content in a new way (e.g., by using a searchable/filterable table);
    - Providing short, plain language summaries for each reporting obligation; and
    - Creating a companion *Advice to the Profession* document and a fillable form for submitting reports to CPSO.

2. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix A**. This table is updated for each Council meeting.

[4] Organizational respondents included: College of Kinesiologists of Ontario (COKO); Information and Privacy Commissioner of Ontario (IPC); OMA; Ontario Trial Lawyers Association (OTLA); and Retirement Homes Regulatory Authority (RHRA).

Table 1: Current Reviews

Policy	Launch	Stage of Policy Review Cycle						Target Comp.	Notes
		Prelim. Consult	Drafting	Approval to Consult	Consult on Draft Policy	Revising Draft Policy	Final Approval		
Blood Borne Viruses	Jun-22		✓					**2024**	
Mandatory and Permissive Reporting	Jun-22		✓					**2024**	
Physicians' Relationships with Industry: Practice, Education and Research	Dec-21		✓					**2023**	
Dispensing Drugs	Sep-21					✓		**2022**	
Professional Obligations and Human Rights	Dec-20			✓				**2023**	The draft policy has been retitled to *Human Rights in the Provision of Health Services*.
Medical Assistance in Dying	Dec-20			✓				**2023**	
Planning for and Providing Quality End-of-Life Care	Dec-20					✓		**2023**	The draft policy has been retitled to *Decision-Making for End-of-Life Care*.
Statements & Positions Redesign	Jan-20		✓					**2022**	All CPSO Statements & Positions are being evaluated for relevance and currency.

Table 2: Policy Review Schedule

Policy	Target Review	Policy	Target Review
Providing Physician Services During Job Actions	2018/19	*Walk-in Clinics*	2024/25
Cannabis for Medical Purposes	2020/21	*Disclosure of Harm*	2024/25
Consent to Treatment	2020/21	*Prescribing Drugs*	2024/25
Physician Treatment of Self, Family Members, or Others Close to Them	2021/22	*Boundary Violations*	2024/25
Physician Behaviour in the Professional Environment	2021/22	*Medical Records Documentation*	2025/26
Accepting New Patients	2022/23	*Medical Records Management*	2025/26
Ending the Physician-Patient Relationship	2022/23	*Protecting Personal Health Information*	2025/26
Uninsured Services: Billing and Block Fees	2022/23	*Advertising*	2025/26
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/24	*Delegation of Controlled Acts*	2025/26
Public Health Emergencies	2023/24	*Professional Responsibilities in Medical Education*	2025/26
Closing a Medical Practice	2024/25	*Third Party Medical Reports*	2025/26
Availability and Coverage	2024/25	*Complementary and Alternative Medicine*	2026
Managing Tests	2024/25	*Virtual Care*	2027
Transitions in Care	2024/25	*Social Media*	2027

Ontario Medical Students' Association
CPSO Council Update
September 22-23, 2022

Presented by:
Angie Salomon, President
Jeeventh Kaur, President-Elect

Thank you once again to the CPSO for inviting representatives from the Ontario Medical Students Association (OMSA) to observe and participate in your Council meeting. OMSA represents the interests and concerns of Ontario's 4000+ medical students, and is entrusted with advocating for changes in education, health policy, and care delivery that will benefit the future physicians of Canada and the communities that we serve.

The summer months are generally quiet for OMSA, as most medical students step away from academic and clinical responsibilities to pursue research interests, work part-time jobs, explore hobbies, travel, and spend much-deserved time with family and friends.

As the fall term begins, **OMSA is thrilled to welcome all first year students (Class of 2026, and 2025 for McMaster's 3-year program) to our ranks!** We are ramping up our "welcome" activities through various means:

1. **Introduction to OMSA virtual presentations:** conducted by the President and President-Elect to introduce medical students to OMSA, the OMA, and ways to get involved
2. **Clerkship Kits:** small tokens of appreciation for incoming clerks, with useful items such as reusable cutlery kits, water bottles, and clipboards
3. **2022-2023 Incoming Student Handbook:** beginning of school "to-do" list, mental health and wellness advice, preliminary outline of medical specialties

This year, **high-level goals from the President's portfolio for 2022-2023 include:**

- Improving medical student engagement with OMSA
- Optimizing OMSA's internal communication and operations
- Supporting medical student wellness
- Improving transparency and fairness in grant allocation and subcommittee selection
- Enabling OMSA to become a known and influential voice in the sphere of medical education, healthcare, health policy, student affairs, etc.

We look forward to attending, contributing to, and learning from CPSO meetings to help achieve these goals. Thank you as always for welcoming medical students to the table.

Sincerely,

Angie Salomon
President, OMSA
president@omsa.ca

Jeeventh Kaur
President-Elect, OMSA
president_elect@omsa.ca

PARO

Inspired by our love of medicine

CPSO Council August 2022

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

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

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

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

We are pleased to submit this update on some organizational projects, info related to COVID-19 as well as some strategic initiatives at PARO.

Academic Days Best Practices

Residents from across specialties and training programs value Academic Days and the contribution they make to residency education. Over the years, residents have identified that there is a great deal of variation in how this time is structured and how teaching is delivered.

In order to support programs looking to optimize their Academic Days, we asked our members to share what they love about their Academic Days, and the approaches that help them learn best. Based on the feedback from hundreds of residents from across the province, PARO has articulated a vision of success for Academic Days and curated a selection of best practices for programs to consider implementing.

The final *Academic Days Best Practices* guide is now complete.

PARO Framework for In-Person Events

We can all appreciate that in-person events can help to boost morale and energy. They can help us to connect, reduce isolation and burnout.

As there isn't an Ontario Government mandate relative to in person gatherings any longer, the Board created a framework to support the work of our teams so that all Site Chairs, Social Leads, SIT Team and event organizers can plan events that will appeal to as many members to comfortably participate.

The following principles have been crafted for our organization to navigate planning events in the coming months.

PUT SAFETY FIRST

• We must adhere to provincial and local public health guidance - and interpret them in the strictest possible manner.
• Where possible, use outside locations/open-air spaces for general member events.
For indoor events:
  • favour spaces with good ventilation (i.e. covered patios, indoor spaces where doors or windows can be opened);
  • encourage indoor events in larger spaces and/or fewer people to minimize close physical contacts.
  • Ask for all attendees be vaccinated in event promotional messaging.
  • Organize events where attendees are able to wear well-fitting masks and are encouraged to do so.
  • Require or provide guidance to attendees to screen for symptoms prior to attending events and stay home if ill.
  • Continually evaluate the conditions to make best decisions on appropriate of in-person events and where possible have a back-up plan

TRANSPARENT COMMUNICATION

• Be explicit & communicate clearly in promotional messaging what precautions are being put in place at the event, and what assessment of safety has been conducted.
• Get feedback on events related to the experience of attending events to improve future events.

INCLUSIVITY

• Continue to host a mix of events and include options for participation beyond in-person so that all members have opportunities to socialize.

PARO General Council and Site Chairs

Over the month of July, PARO held its annual elections for General Council and we are pleased that all 100 positions have been filled. As with previous years, our GC is approx. 40% returning reps and 60% first-time reps. Following our General Council elections, each site team selected a Site Chair who will be responsible for leading the work of the team locally. We have had the opportunity to begin our training and onboarding process for our Site Chairs, and they are eager to begin work with their local site teams. We are very pleased that both the GC and Site Chairs elections were very competitive, and we are excited to get started with this new team.

PARO Board

In June we elected our PARO Board and we are engaged with the robust training and team-building PARO provides to help us and the PARO Staff develop into a high-performing team. Through a series of sessions, we learn about ourselves, how to work with each other and how to employ critical thinking discussion and decision-making. The access to this training at PARO has become a significant reason for the competitive Board elections we have been fortunate to have.

Government MRRP (Medical Resident Redeployment Program)

Along with other Government Programs, we are very pleased that the Government has again extended the MRRP a fourth time – **through to March 31, 2023.** This program enables residents to provide much-needed additional service resulting from the impact of COVID, and to receive payment at a rate of $50 per hour. Our priority was to ensure that all residents could be eligible to participate in providing service on a voluntary basis, and to ensure that they would receive extra pay for doing so as a tangible way of recognizing their contribution.

We continue to work with our PG Deans, Programs and members to encourage use of MRRP at our hospitals with support from PGME, and we are pleased that the sites have increased

utilization of the program. At this juncture, our PG Deans have identified that it has been a critical factor in meeting the resource challenges. It has also enabled sites to decrease use of university rotation-redeployment and reduce impact to training. Therefore, whether residents have personally participated in the program, it has improved morale broadly amongst members.

If you want more details on the Program, which save for the extension is unchanged, PARO's FAQ remains on the PARO COVID Webpage.

PARO is also in conversation with Government about ways that residents might be able to help with the current HHR challenges. We are very grateful for the partnership that we have with the CPSO in finding solutions to these challenges. The Medical Resident Replacement Program is an excellent example of how the CPSO helped to facilitate and idea that we had to deal with HHR challenges during the pandemic. Another example is our partnership on creating the *Restricted Registration* Program. We look forward to exploring other ideas that can utilize the skills of residents to assist with our current shortages while at the same time providing residents with unique learning opportunities.

PARO-OTH Collective Agreement
We have been watching the success of our PHO counterparts this year in obtaining improvements for their members in their collective bargaining. Our current Collective Agreement term ends June 30, 2023. Within this PARO Board's term we will be preparing for our own next round of negotiations.

Kind Regards,

Zainab Mohamed, MD
PARO Board of Directors

Ariel Gershon, MD
PARO Board of Directors

Council Briefing Note

September 2022

Topic:	Update on Council Action Items
Purpose:	For Information
Relevance to Strategic Plan:	Right Touch Regulation, Quality Care, Meaningful Engagement, System Collaboration, Continuous Improvement
Public Interest Rationale:	Accountability: Holding Council and the College accountable for the decisions made during the Council meetings
Main Contacts:	Lisa Brownstone, Chief Legal Officer Cameo Allan, Manager of Governance Adrianna Bogris, Council Administrator

Issue

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

Current Status

- Council held a meeting on June 16 and 17, 2022. The motions carried and the implementation status of those decisions are outlined in Table 1.

Table 1: Council Decisions from June Meeting

Reference	Motions Carried	Status
01-C-06-2022	**Consent Agenda** The Council approves the items outlined in the consent agenda, which include in their entirety: • The Council meeting agenda for June 16 and 17, 2022, as amended; and • The minutes from Council held March 3 and 4, 2022	Completed.

Reference	Motions Carried	Status
N/A	Items for information: 3.1 Executive Committee Report 3.2 Ontario Physicians and Surgeons Discipline Tribunal Cases 3.3 Government Relations Report 3.4 Finance and Audit Report 3.5 Policy Report 3.6 Medical Learners Report (OMSA) and (PARO) 3.7 Update on Council Action Items	N/A
02-C-06-2022	**Dispensing Drugs – Draft Policy for Consultation** The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy "Dispensing Drugs", (a copy of which forms Appendix "A" to the minutes of this meeting).	Consultation completed. Revising draft policy is underway.
03-C-06-2022	**Register By-law Amendments** The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 148: **By-law No. 148** (1) Paragraphs 12, 13, 14, 17, and 17.1 of subsection 49(1) of the General By-law are revoked and substituted with the following: **Content of Register Entries** **49.** (1) In addition to the information required under subsection 23(2) of the Health Professions Procedural Code, the register shall contain the following information with respect to each member: … 12. The identity of each hospital in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, restrictions, resignations and relinquishments of the member's privileges or practice, and	Completed.

Reference	Motions Carried	Status
	rejections of appointment or reappointment applications, reported to the College by hospitals under section 85.5 of the Health Professions Procedural Code or section 33 of the *Public Hospitals Act*, but excluding voluntary leaves of absence by members, in each case commencing from the date the relevant portion of this by-law goes into effect. 13. If an allegation of professional misconduct or incompetence against the member has been referred to the Ontario Physicians and Surgeons Discipline Tribunal and not yet decided, i. a summary of the allegation if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal prior to September 10, 2013, ii. a summary of the allegation and/or the notice of hearing if it was referred to the Ontario Physicians and Surgeons Discipline Tribunal after September 10, 2013, iii. an indication that the matter has been referred to the Ontario Physicians and Surgeons Discipline Tribunal, iv. the anticipated date of the hearing, if the date has been set, v. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of the adjournment, and vi. if the decision is under reserve, that fact. 14. If the result of a disciplinary proceeding in which a finding was made by the Ontario Physicians and Surgeons Discipline Tribunal in respect of the member is in the register, i. the date on which the Ontario Physicians and Surgeons Discipline Tribunal made the finding,	

Reference	Motions Carried	Status
	ii. the date on which the Ontario Physicians and Surgeons Discipline Tribunal ordered any penalty, and iii. if the finding is appealed, the status of the appeal and the disposition of the appeal. … 17. If an application for reinstatement has been referred to the Ontario Physicians and Surgeons Discipline Tribunal, i. that fact, ii. the dates on which the application is scheduled to be heard, iii. if the hearing has been adjourned after September 10, 2013 and no future date has been set, the fact of that adjournment, and iv. if the decision is under reserve, that fact. 17.1. If an application to the Ontario Physicians and Surgeons Discipline Tribunal for reinstatement has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal. (2) Subsection 49(1) of the General By-law is amended by adding the following as paragraphs 17.3 and 17.4: 17.3. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been filed, i. that fact, ii. the dates on which the application is scheduled to be heard, iii. if the hearing has been adjourned and no future date has been set, the fact of that adjournment, and iv. if the decision is under reserve, that fact.	

Reference	Motions Carried	Status
	17.4. If an application to vary, suspend or cancel an order of the Ontario Physicians and Surgeons Discipline Tribunal has been decided, the decision of the Ontario Physicians and Surgeons Discipline Tribunal. (3) Paragraph (g) of subsection 50.1(1) of the General By-law is amended by deleting the reference to "discipline committee" and substituting it with "Ontario Physicians and Surgeons Discipline Tribunal".	
04-C-06-2022	**Approval of the Audited Financial Statements for the 2021 Fiscal Year** The Council of the College of Physicians and Surgeons of Ontario approves the audited financial statements for the fiscal year ended December 31, 2021 as presented (a copy of which forms Appendix "B" to the minutes of this meeting).	Completed.
05-C-06-2022	**Appointment of the Auditors** The Council of the College of Physicians and Surgeons of Ontario appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next financial meeting of the Council.	Completed.
06-C-06-2022	**Fees By-law Update** The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 149: **By-law No. 149** (1) Subsections 20(3), (4) and (6) of By-law No. 2 (the Fees and Remuneration By-law) are revoked and substituted with the following: **Council and Committee Remuneration** 20. … (3) The amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic means, is, subject to subsections (4) and (8), $178 per hour.	Completed.

Reference	Motions Carried	Status
	(4) The amount payable to members of the council and a committee for travel to or from home, or both, in connection with the conduct of council or committee business is the hourly rate set out in subsection 20(3). (6) The amount payable to members of the council and a committee in reimbursement of expenses incurred in the conduct of the council's or committee's business is, (a) for travel by common carrier, the member's actual cost for economy air fare or VIA 1 train fare, (b) the member's actual cost of transportation to and from airports, stations or other terminals, if applicable, (c) for travel by automobile, the member's reasonable automobile expenses, consistent with applicable Canada Revenue Agency rules and guidelines in effect from time to time, and (d) for overnight accommodation and related meals away from home, the actual amount reasonably spent up to such maximum amount set by the College from time to time, for each day away from home for both accommodation and meals. (2) Subsection 20(8) is amended by deleting the reference to "subsection 20(3)(a)" and substituting it with "subsection 20(3)".	
07-C-06-2022	**Decision-Making for End-of-Life Care – Draft Policy for Consultation** The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Decision-Making for End-of-Life Care," (a copy of which forms Appendix "C" to the minutes of this meeting).	Consultation completed. Revising draft policy is underway.
08-C-06-2022	**Proposed Amendments to Medical Records Management Policy** The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Medical Records Management", (a copy of which forms Appendix "D" to the	Completed.

Reference	Motions Carried	Status
	minutes of this meeting) as a policy of the College.	
09-C-06-2022	**Virtual Care – Revised Policy for Final Approval** The Council of the College of Physicians and Surgeons of Ontario approves the revised policy "Virtual Care", formerly titled "Telemedicine", (a copy of which forms Appendix "E" to the minutes of this meeting) as a policy of the College.	Completed.
10-C-06-2022	**Social Media – Revised Policy for Final Approval** The Council of the College of Physicians and Surgeons of Ontario approves the policy "Social Media" (a copy of which forms Appendix "F" to the minutes of this meeting) as a policy of the College, and rescinds the statement "Social Media – Appropriate Use by Physicians", (a copy of which forms Appendix "G" to the minutes of this meeting).	Completed.
12-C-06-2022	**Presidential Compensation** The Council of the College of Physicians and Surgeons of Ontario amends the motion for By-law No. 150 to remove the reference to "such as conference attendance" in the proposed amendment to subsection 20(b) of By-law No. 2 (the Fees and Remuneration By-law).	Completed.
13-C-06-2022	**Presidential Compensation** The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 150: **By-law No. 150** (1) Subsection 20(3) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following: **Council and Committee Remuneration** 20. … (3) Except as provided in subsection (8), the amount payable to members of the council and a committee for attendance at, and preparation for, meetings to transact College business, whether such meetings are in person, by telephone or by electronic	Completed.

Reference	Motions Carried	Status
	means, is, subject to subsections (4) and (8), $178 per hour. (2) Subsection 20(8) of By-law No. 2 (the Fees and Remuneration By-law) is revoked and substituted with the following: **Council and Committee Remuneration** 20. … (8) For all College business conducted by the president that is part of or related to the role of the president (for greater certainty, including but not limited to, external stakeholder meetings coordinated by the College), subsection 20(3) does not apply and the College shall pay the president a stipend in the annual amount authorized in the College budget, or if the president is unable or unwilling to serve any part of the term as president, a pro rata amount for the time served. For College business conducted by the president that is not part of or related to the role of the president, including, without limitation: (a) attendance at and preparation for meetings of, and work resulting from, CPSO advisory or working groups or CPSO committees other than the Executive Committee, the Governance Committee and the Finance and Audit Committee; and (b) authorized optional activities, the amount payable to the president is as set out under subsection 20(3). For greater certainty, subsection (4) applies to the president, and amounts payable under subsection (4) are not included in the stipend or in amounts payable to the president as set out in subsection 20(3).	

2023 MEETING DATES

Jan-2023

M	T	W	T	F
2 New Year's Day	3	4	5	6
9	10 EC-V	11	12	13
16	17	18	19	20
23	24 GC	25	26	27
30	31			

Feb-2023

M	T	W	T	F
		1	2	3
6	7 EC	8	9	10
13	14	15	16	17
20 Family Day	21	22	23	24
27	28			

Mar-2023

M	T	W	T	F
		1	2 C	3 C
6	7	8	9 GSM	10
13	14	15	16	17
March Break				
20	21 GC	22	23	24
27	28	29	30	31

Apr-2023

M	T	W	T	F
3	4 EC	5	6	7 Good Fri
10 Easter Mon	11	12	13	14
		ICAM (Quebec City)		
17	18	19	20	21
ICAM (Quebec City)			Eid al-Fitr	
24	25 GC	26	27	28

May-2023

M	T	W	T	F
1	2	3	4	5
		CLEAR (Dublin) / FSMB (Minneapolis)		
8	9	10	11	12
15	16 EC	17	18	19
22 Victoria Day	23	24	25	26 CCPL (Van)
29	30	31		
eHealth (Toronto)				

Jun-2023

M	T	W	T	F
			1	2
5	6	7	8 C	9 FMRAC C
12 FMRAC (NS)	13	14	15 GSM	16
19	20	21	22	23
26	27	28	29	30 Registration

Jul-2023

M	T	W	T	F
3 Cda Day	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

Aug-2023

M	T	W	T	F
	1 GC	2	3	4
7 Civic Holiday	8	9	10	11
14 CMPA (Mtl)	15	16	17	18
21	22 EC	23	24	25
28	29	30	31	
	ISQua (Seoul)			

Sep-2023

M	T	W	T	F
				1
4 Labour Day	5	6	7	8
			TIFF	
11	12 GC	13	14	15
TIFF				Rosh Hashanah
18	19	20	21 C	22 C
25 Yom Kippur	26	27	28	29 Truth Day
		CLEAR Ed Conf (Salt Lake City)		

Oct-2023

M	T	W	T	F
2	3 GSM	4	5	6
9 Thanksgiving	10 EC-V	11	12	13
16	17	18	19	20
CNAR (Vancouver)				
23	24	25	26	27
30	31			

Nov-2023

M	T	W	T	F
		1	2	3
6	7 GC	8	9	10 Rem Day
IAMRA (Bali)				
13	14 EC	15 Diwali (Nov 12-16)	16	17
20	21	22	23	24
27	28	29	30	

Dec-2023

M	T	W	T	F
				1
4	5	6	7 C	8 C
11	12	13 GSM	14	15
Hanukkah (Dec 7-15)				
18	19	20	21	22
25 Christmas	26	27	28	29
	CSPO Closure			

C	Council
EC	Executive
EC-V	Executive-Virtual
GC	Governance-Virtual
GSM	General Staff Meeting
FC	Finance & Audit
SMT O-S	SMT On-site
	Stat Holidays
	Conference/AGM

Council Briefing Note

September 2022

Topic:	*Human Rights in the Provision of Health Services* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement System Collaboration
Public Interest Rationale:	Setting clear expectations and guidance for physicians regarding the provision of health services in a safe, inclusive, and accessible environment, in accordance with accessibility and human rights legislation. Ensuring patient access to health services that conflict with physicians' conscience or religious beliefs.
Main Contact(s):	Craig Roxborough, Director, Policy
Attachment(s):	Appendix A: *Human Rights in the Provision of Health Services* Policy Appendix B: *Human Rights in the Provision of Health Services: Advice to the Profession*

Issue

- CPSO's *Professional Obligations and Human Rights* policy is currently under review. A newly titled draft *Human Rights in the Provision of Health Services* policy and companion *Advice to the Profession* (*Advice*) document have been developed.

- Council is asked whether the draft policy can be forwarded to Council for approval to release it for external consultation and engagement.

Background

- The *Professional Obligations and Human Rights* policy was approved by Council in September 2008 and updated in March 2015.

- The constitutional validity of the policy's "effective referral" requirement[1] was challenged by some individual physicians and organizations[2] and CPSO defended the policy on behalf of Council, who has always maintained that the requirement strikes a reasonable balance between physicians' right to practise in accordance with their beliefs and patients' right to access to health services. The Courts concurred with CPSO in their 2018 and 2019 decisions and the policy was maintained as is.

- Council was briefed on the policy review at its December 2020 Council Meeting (see pages 102-111 for the Policy Review Kick-Off) and at its June 2021 Council Meeting (see pages 46-47 for the Consultation Report).

- Additional consultation and engagement activities that were undertaken as part of the policy review included: public opinion polling, a Stakeholder Roundtable Discussion (see page 14 of the 2021 Equity, Diversity, and Inclusion Report), and a Citizen Advisory Group discussion.

Current Status and Analysis

- The draft *Human Rights in the Provision of Health Services* policy (**Appendix A**) retains the majority of the core professional expectations in the current *Professional Obligations and Human Rights* policy, but some important updates have been made to enhance the overall clarity of the existing expectations and to better serve the public interest with the addition of new expectations.

- The draft *Advice* (**Appendix B**) has also been updated to provide guidance on the new expectations.

- An overview of the key updates made in both draft documents is set out below.

Creating and fostering an ideal environment where patients' needs are met

- The draft policy has new positive obligations for physicians to take reasonable steps to create and foster a safe, inclusive, and accessible environment where patients' needs are met by incorporating cultural humility, cultural safety, anti-racism, and anti-oppression into their practices (Provision 1b). New guidance and resources regarding how to do this have been added to the *Advice* (Lines 47-75 and 366-385).[3]

[1] Making an effective referral requires that physicians take positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, other health-care professional, or agency.
[2] The Christian Medical and Dental Society of Canada, The Canadian Federation of Catholic Physicians' Societies, and Canadian Physicians for Life.
[3] A new glossary was also created that defines key terms/concepts related to this policy. It is posted on the Equity, Diversity, and Inclusion section of CPSO's website and can be added as a companion resource to the *Human Rights in the Provision of Health Services* policy once the policy has been finalized and approved by Council.

- The Working Group thought that moving from "what not to do" (e.g., do not discriminate) to "what to do" (e.g., how to create and foster an ideal environment where patients' needs are met) would better serve patients and is consistent with: CPSO's commitment to bring EDI to our policies; the direction other medical organizations and regulators[4] are going in; the literature; the public polling results; and the feedback received.

- The draft policy expectations regarding what physicians must *not* do in the context of providing health services (not express personal moral judgments about patients, not refuse or delay the provision of health services because the physician believes the patient's own actions have contributed to their condition, and not promote their own spiritual, secular, or religious beliefs) (Provision 2) have been broadened and now apply to all physicians, not just those with conscience or religious beliefs as in the current policy.

    - The Working Group agreed with the feedback that suggested these expectations should apply more broadly to all physicians.

Patient requests

- The draft policy has new expectations for physicians in circumstances where patients request to receive care from a physician with a particular social identity (Provision 4) and the *Advice* includes new guidance on how to manage these requests (Lines 158-212).

    - The Working Group acknowledged that this was a complex issue for CPSO to address but felt it was important to do so given the research and feedback.

Limiting health services for clinical competence/scope of practice reasons

- The draft policy now sets out the factors physicians must consider when making decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith (Provision 6a).

    - Recognizing the importance of patient access to a broad range of health services, the Working Group felt it was important to add factors for physicians to consider when making good faith decisions regarding their practice.

- The explicit requirement for physicians to provide a referral to another health-care provider for the elements of care that the physician is unable to manage directly has been removed from the draft policy.

[4] For example, the College of Physicians and Surgeons of British Columbia developed an Indigenous Cultural Safety, Cultural Humility and Anti-racism Practice Standard.

- The Working Group considered how narrow in scope this provision was (i.e., it presumed that a primary care physician was referring to a specialist) and determined that it would be reasonable to assume that physicians generally know what to do when something is outside of their clinical competence/scope of practice. This approach is consistent with right-touch regulation.

Health services that conflict with physicians' conscience or religious beliefs

- This section of the draft policy has been reframed to better reflect which physicians these expectations apply to (e.g., physicians whose beliefs would impact patient access to health services).
    - The Working Group acknowledged that many physicians have conscience or religious beliefs, but CPSO is setting out expectations for those who choose not to provide certain health services and/or object to facilitating patient access to certain health services because of their beliefs.

- The draft policy now clarifies that physicians must provide patients with enough information about all available or appropriate clinical options so that patients are able to make an informed decision (Provision 8).
    - The Working Group thought it would be helpful to tie the provision of information to the concept of valid consent and this decision was supported in the research and consultation feedback.

- The draft policy no longer requires that physicians tell patients that they are providing an effective referral due to their conscience or religious beliefs.
    - The Working Group felt the focus should be on making the effective referral given the research and feedback that suggests patients might feel hurt or judged by their physician if they disclose that their conscience or religious beliefs are the reason why they do not provide the particular health service.

- The draft policy maintains the existing "effective referral" requirement and new safeguards have been added for physicians to take reasonable steps to confirm that a patient was connected and to take further action to provide an effective referral if they learn that the patient was not connected (Provisions 9b ii.-iii.).
    - The Working Group carefully considered all the research and feedback on the "effective referral" requirement, along with the evidence presented in court in defense of this requirement, and determined that the requirement should be maintained with the addition of some new safeguards to help ensure the effective referral is "effective".

- Given these new safeguards, the Working Group added a less onerous example of how to provide an "effective referral" to the *Advice*; namely, providing patients with contact information for a physician, health-care provider, or agency if it's appropriate in the circumstances (Lines 296-299).

Addressing violence, harassment, and discrimination

- The draft policy has new expectations regarding addressing violence, harassment, and discrimination if physicians see it occurring (Provisions 13-14).
    - The Working Group considered the public polling results and other feedback received that indicated there was support for setting out physicians' obligations in these circumstances.

Next Steps

- Pending Council's approval, the draft policy will be released for external consultation and engagement. Feedback received as part of these activities will be shared with Council at a future meeting and used to further refine the drafts.

Question for Council

1. Does Council approve the draft *Human Rights in the Provision of Health Services* policy for external consultation and engagement?

HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

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

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

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

Definitions

Discrimination: an act, communication, or decision that results in the unfair treatment of an individual or group by either imposing a burden on them, or denying them a right, privilege, benefit, or opportunity enjoyed by others. Discrimination may be direct and intentional; it may also be indirect and unintentional, where rules, practices, or procedures appear neutral but have the effect of disadvantaging certain groups of people. Discrimination is best identified by those who experience it given that there is a difference between intent and impact.

Effective referral: taking positive action to ensure the patient is connected to a non-objecting, available, and accessible[1] physician, other health-care professional, or agency.

For more definitions of key terms/concepts related to this policy, see the College's Equity, Diversity, and Inclusion Glossary.

Policy

Providing Health Services

1. Physicians **must** take reasonable steps to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected, and where patients' needs are met, by:

    a. complying with the relevant legal requirements under the *Accessibility for Ontarians with Disabilities Act, 2005*[2] and the *Human Rights Code* (the Code)[3]; and

[1] 'Available and accessible' means that the health-care professional must be operating and/or accepting patients at the time the effective referral is made, and in a physical location the patient can reasonably access, or where appropriate, accessible via virtual care.
[2] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11.
[3] *Human Rights Code*, R.S.O. 1990, c. H.19. See 'The Duty to Accommodate' and 'The Duty to Provide Services Free from Discrimination' sections of this policy for more information.

b. incorporating cultural humility, cultural safety, anti-racism, and anti-oppression into their practices.

2. In discharging provision 1, physicians **must not:**

   a. express personal moral judgments about patients' beliefs, lifestyle, identity, or characteristics or the health services that patients are considering;

   b. refuse or delay the provision of health services because the physician believes the patient's own actions have contributed to their condition;[4] or

   c. promote their own spiritual, secular, or religious beliefs when interacting with patients or impose these beliefs on patients.

The Duty to Accommodate

3. Physicians **must** comply with their duty to accommodate patients' needs arising from a protected ground under the *Code*[5] (e.g., disability[6], gender identity) and make accommodations in a manner that is respectful of the dignity, autonomy, and privacy and confidentiality of the patient, unless the accommodation would:

   a. subject the physician to undue hardship (i.e., excessive cost, lack of outside sources of funding to help offset the cost, or health or safety concerns); or

   b. significantly interfere with the legal rights of others.[7]

4. Where a patient requests to receive care from a physician with a particular social identity (e.g., race, ethnicity, culture, sexual orientation and/or gender identity, spiritual/secular/religious beliefs, etc.), physicians **must:**

   a. with appropriate consent[8], provide any emergent or urgent medical care the patient requires; and

   b. where non-emergent or non-urgent care is required, take reasonable steps to accommodate the patient's request if the physician believes that the request is

[4] See the College's *Ending the Physician-Patient Relationship* policy for circumstances where physicians must not end the physician-patient relationship.
[5] The *Code* articulates the right of every Ontario resident to receive equal treatment with respect to services, goods and facilities – including health services – without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.
[6] "Disability" is defined in s. 10 of the *Code* and includes any degree of physical disability, infirmity, malformation, or disfigurement; a condition of mental impairment or a developmental disability; a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language; a mental disorder; or an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16, Sched. A.
[7] See the Ontario Human Rights Commission's Policy on ableism and discrimination based on disability for more information on "undue hardship" and other limits on the duty to accommodate (e.g., legal rights of others).
[8] See the College's *Consent to Treatment* policy for expectations on obtaining consent during emergencies.

ethically or clinically appropriate (e.g., patient would like to receive care from a physician who speaks the same language to facilitate communication); or

c. tell the patient that their request will not be accommodated if the physician believes that the request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.) and determine whether it is safe and in both parties' best interest to provide any non-emergent or non-urgent care required.[9]

The Duty to Provide Services Free from Discrimination

5. Physicians **must not** discriminate, either directly or indirectly, based on a protected ground under the *Code* when making decisions relating to the provision of health services. This includes when:

   a. accepting or refusing individuals as patients;

   b. providing information to patients;

   c. providing or limiting health services;

   d. providing clinical referrals and effective referrals; and/or

   e. ending the physician-patient relationship.

Limiting Health Services for Clinical Competence/Scope of Practice Reasons

6. Physicians **must** make any decisions to limit the provision of health services for reasons of clinical competence and/or scope of practice in good faith, and in accordance with the *Code*[10] and College expectations.[11]

   a. In making this decision, physicians **must** consider the risks and benefits of limiting the provision of health services and the impact it would have on patients (e.g., if they would have difficulties accessing the services elsewhere in a timely manner due to a lack of resources).

   b. Physicians **must** communicate any decisions to limit the provision of health services for reasons of competence and/or scope of practice to patients in a clear and straightforward manner.

Health Services that Conflict with Physicians' Conscience or Religious Beliefs

7. Where certain health services conflict with physicians' conscience or religious beliefs in a manner that would impact patient access to those health services, physicians **must** fulfill

[9] See the College's *Ending the Physician-Patient Relationship* policy for expectations when ending the physician-patient relationship.
[10] The duty to provide services free from discrimination does not prevent physicians from limiting the health services they provide for legitimate clinical competence and/or scope of practice reasons.
[11] Also see the relevant expectations set out in the College's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*, *Accepting New Patients,* and *Ending the Physician-Patient Relationship* policies.

their professional obligations and fiduciary duty to their patients by putting patients' interests first.[12]

8. Physicians **must** provide patients with enough information about all available or appropriate clinical options to meet their clinical needs or concerns so that patients are able to make an informed decision[13] about exploring a particular option.

9. When a particular service, treatment, or procedure might be a relevant clinical option for a patient and it conflicts with a physician's conscience or religious beliefs in a manner that would impact patient access, physicians **must:**

    a. make any decisions to limit the provision of health services in accordance with the *Code*[14] and inform the patient that they do not provide that service, treatment, or procedure; and

    b. provide the patient with an effective referral.

        i. Physicians **must** provide the effective referral in a timely manner to allow patients to access care.

        ii. Physicians **must** take reasonable steps to confirm that a patient was connected, unless the patient has indicated that they prefer otherwise.

        iii. If physicians learn that the patient was not connected, they **must** take further action to provide an effective referral.

        iv. Physicians **must** have a plan in place on how they will connect patients to the services that would typically be requested in their type of practice, but that conflict with their conscience or religious beliefs.

10. In discharging provisions 8 and 9, physicians **must:**

    a. communicate the necessary information in a clear, straightforward, and neutral manner;

[12] Physicians' freedom of conscience and religion must be balanced against patients' right to access care. The Court of Appeal for Ontario has confirmed that where an irreconcilable conflict arises between a physician's interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails (para. 187 *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2019 ONCA 393).

[13] In accordance with the College's *Consent to Treatment* policy and the *Health Care Consent Act, 1996*, S.O. 1996, c.2, Sched. A, physicians need to obtain valid consent in order to proceed with a particular treatment option. In order for consent to be valid, it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.

[14] Limiting health services on the basis of conscience or religion does not permit physicians to discriminate on the basis of a protected ground under the *Code* and limit to whom they provide services they otherwise offer.

b. comply with the documentation expectations set out in the College's *Medical Records Documentation* policy and where relevant, the College's *Medical Assistance in Dying* policy[15]; and

c. where clinical referrals are provided, comply with the relevant expectations set out in the College's *Transitions in Care* policy.

11. Physicians **must not:**

a. withhold information about the existence of any service, treatment, or procedure because it conflicts with their conscience or religious beliefs;

b. provide false, misleading, confusing, coercive, or incomplete information about available or appropriate clinical options;

c. impede access to information and/or care; or

d. expose patients to adverse clinical outcomes due to a delay in providing the patient with an effective referral.

12. Physicians **must** provide any necessary care in an emergency, even where that care conflicts with their conscience or religious beliefs.[16]

Addressing Violence, Harassment, and Discrimination

13. If physicians see acts of violence, harassment (including intimidation), and discrimination occurring against patients, health-care professionals and/or staff, they **must** take reasonable steps[17] to stop these acts in a manner that does not compromise the safety of the physician.[18]

14. Physicians **must** take any other necessary steps to comply with applicable legislation[19], policies, institutional codes of conduct or by-laws.

[15] Physicians are required to capture, where applicable, all oral and written requests for medical assistance in dying (MAID), the dates they were made, and a copy of the patient's written request in the patient's medical record. This requirement applies to all physicians, including physicians who choose not to assess patients for or provide MAID for reasons of conscience or religion.

[16] For clarity, MAID would never be a treatment option in an emergency and physicians are not required to assess patients for or provide MAID under any circumstances.

[17] There may be times where a patient or individual lacks capacity due to a health condition (e.g., severe mental illness, neurocognitive or neurodevelopmental disorder, etc.) and/or their current health status (e.g., substance intoxication, delirium, etc.) and this will need to be taken into consideration when determining what steps to take to stop the patient or individual.

[18] See the College's *Professional Responsibilities in Medical Education* policy and *Advice to the Profession* document for expectations and guidance in the medical education context, including taking reasonable steps to stop violence, harassment, or discrimination against medical students and/or postgraduate trainees and providing them with support and direction.

[19] For example, the obligations set out in the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 and the *Code*.

ADVICE TO THE PROFESSION:
HUMAN RIGHTS IN THE PROVISION OF HEALTH SERVICES

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

The *Human Rights in the Provision of Health Services* policy articulates physicians' legal and professional obligations regarding the provision of health services, including complying with accessibility and human rights legislation. The policy also sets out physicians' professional obligations where health services are limited for clinical competence/scope of practice reasons and health services conflict with their conscience or religious beliefs. The key values of professionalism articulated in the College's *Practice Guide* — compassion, service, altruism and trustworthiness — and physicians' obligations under the accessibility and human rights legislation form the basis for the expectations in the policy. This *Advice* document is intended to help physicians understand and interpret their obligations, and provide guidance around how these obligations may be effectively discharged.

For definitions of key terms/concepts related to this policy and *Advice*, see the College's Equity, Diversity, and Inclusion Glossary.

Providing Health Services

Why has the College referenced cultural humility, cultural safety, anti-racism, and anti-oppression in the policy?

The College recognizes the vast amount of literature that indicates a patient's racial/ethnic/cultural background, their sexual orientation and/or gender identity, their socio-economic status, and where they live are often the primary determinants of that patient's health. Those who are from racialized or marginalized groups are more likely to have difficulties accessing care and experience poorer health outcomes.[1]

The College has made a commitment to examine how we, as an organization, can better fulfill our mandate by bringing equity, diversity, and inclusion (EDI) to our processes and policies, and to address all forms of discrimination. Many other medical

[1] University of Toronto, Family & Community Medicine. (2020). Family Medicine Report: Caring for Our Diverse Populations. Retrieved from: https://www.dfcm.utoronto.ca/sites/default/files/university_of_toronto_family_medicine_report_-_caring_for_our_diverse_populations.pdf

organizations have also identified EDI and anti-discrimination as priorities, including the following:

- Federation of Medical Regulatory Authorities of Canada;
- Royal College of Physicians and Surgeons of Canada (they have also published resources, including a poster, Examining 'Cultural Safety');
- College of Family Physicians of Canada (they have also published resources, including the CanMEDS–Family Medicine Indigenous Health Supplement); and
- Canadian Medical Protective Association (they have also published a resource on Cultural Safety).

The College believes it is important to set out expectations and guidance for physicians on these fundamental concepts, as creating and fostering a safe, inclusive, and accessible environment for patients will help improve the patient's experience, the quality of the physician-patient relationship, the care provided, and health outcomes. We recognize that these concepts may be new for some physicians and therefore have provided some specific examples and resources for educational purposes below.

What steps can I take to create and foster a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected and where my patients' needs are met?

Some specific examples may include, but are not limited to:

- Being aware of your assumptions, beliefs, and privilege and minimizing any biases[2] when providing care;
- Learning about your patient's lived experience, racial/ethnic/cultural background, values/beliefs/worldview, sexual orientation and/or gender identity, and socioeconomic status and respecting patients for who they are;
- Communicating and collaborating effectively with patients and/or others they wish to involve in their care to help ensure treatment plans address patients' specific needs;
- Incorporating a trauma/violence-informed approach to care;[3] and
- Identifying and addressing any barriers (e.g., communication, physical environment) that may be preventing or limiting patients' access to health services.

[2] For more information, see the College's *eDialogue* article on Implicit Bias in Health Care.
[3] For more information, see EQUIP Health Care's Trauma- and Violence-Informed Care Tool.

A list of resources is provided at the end of this document to help physicians create and foster a safe, inclusive, and accessible environment. Further information and resources can also be found on the College's Equity, Diversity, and Inclusion webpage.

Does the concept of "professionalism" include advocating for a safe, inclusive, and accessible environment in which the rights, autonomy, dignity, and diversity of all patients are respected?

Yes. The College recognizes that the concept of medical professionalism includes adopting the role of health advocate. This may include advocating for individual patient health care needs, advancing policies that promote the health and well-being of the public, and/or promoting a safe health care system.

For example, advocacy can range from helping a specific patient access a service, to challenging the structures (e.g., policies, programs, etc.) that perpetuate inequities in the health care system and actively being anti-racist.

The policy says that physicians must not promote their own spiritual, secular, or religious beliefs when interacting with patients or impose these beliefs on patients. What does this mean? Does this mean that physicians can never discuss spiritual, secular, or religious beliefs with their patients?

No. The College recognizes that patients' spiritual, secular, and religious beliefs can play an important role in the decisions they make about health care, and can offer comfort if patients are faced with difficult news about their health. It is appropriate for physicians to inquire about and/or discuss patients' spiritual, secular, and religious beliefs when those are relevant to patient decision-making, or where it will enable the physician to suggest supports and resources that may assist the patient.

However, as noted in the policy, physicians must not express personal moral judgments about the patient's beliefs, promote their own spiritual, secular, or religious beliefs when interacting with patients, or impose these beliefs on patients. This means, for example, that physicians cannot imply their beliefs are superior to the patient's, attempt to influence the patient's beliefs, or attempt to convert patients to the physician's own beliefs.

When discussing spiritual, secular, or religious beliefs, physicians will need to focus on the patient's beliefs, rather than focusing on their own beliefs, and allow patients to guide the discussion about their beliefs. This may help physicians avoid appearing as though they are attempting to influence the patient's beliefs.

Does the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) apply to physicians, and how does the AODA relate to the Ontario Human Rights Code (the Code)?

Yes. The *AODA* applies to organizations with at least one employee, including organizations that provide health-care services (e.g., physicians' offices, clinics,

hospitals, etc.). Physicians are required to comply with the *AODA* standards[4] regarding accessibility for patients with disabilities that are applicable to their particular office,[5] as well as any policies that have been developed in accordance with *AODA* in their workplace. Physicians are also required to comply with the *Code*.

The human rights principles of the *Code* help to inform and guide how *AODA* standards are to be met. The *AODA* standards do not limit or replace the requirements of the *Code* or any other law. While the *Code* and the *AODA* work together, they have some important differences:

- Under the *Code*, service providers have a duty to accommodate persons with disabilities. Accommodation is a reactive and individualized adaptation or adjustment made to provide a person with a disability with equitable and non-discriminatory opportunities for participation.
- The *AODA* sets general accessibility standards that organizations must meet in a number of different areas, such as information and communication standards and customer service standards. Accessibility is the degree to which persons with disabilities can access a device, service, or environment without barriers. Accessibility is also a process – it is the proactive identification, removal or reduction, and prevention of barriers to persons with disabilities.
- While all organizations with more than one employee are required to comply with the *AODA*, the types of accessibility accommodations that must be provided depend on the number of employees in the organization. On the other hand, the *Code*, requires that organizations comply with their duty to accommodate to the point of undue hardship. Undue hardship is based on excessive cost or health or safety concerns – not the size of the organization.[6]

What is the duty to accommodate set out in the Code and what does this duty look like?

The legal, professional, and ethical obligation to provide services free from discrimination includes a duty to accommodate. The duty to accommodate is fundamental to providing fair treatment to patients and reflects the fact that each person has different needs and requires different solutions to gain equal access to care.

[4] See the Ontario government's website for more information on the accessibility standards.
[5] Physicians can use the Ontario government's Accessibility Standards Checklist to help them identify which requirements apply to their office. For example, requirements under the Information and Communication Standards may include ensuring that the physician's office can communicate with patients in accessible ways (e.g., in accessible formats, provide communication supports upon request, etc.).
[6] For more information, see the Ontario Human Rights Commission's eLearning series, Working Together: The *Code* and the *AODA*.

Examples of accommodation may include, but are not limited to: permitting a service dog to accompany a patient into the examination room, using interpreters to overcome communication barriers, ensuring signage reflects diverse family configurations (e.g., families with two mothers or two fathers), and/or creating forms to accommodate patients' gender identity and expression.[7]

What happens if I cannot accommodate a patient because it would cause undue hardship?

Physicians have a duty to accommodate patients but at times, the accommodation process may result in not being able to meet a patient's needs because it would subject the physician to undue hardship. When this occurs, physicians do not have an obligation to refer the patient to another health-care professional who can accommodate them. However, if physicians are aware of another health-care professional who is available and able to accommodate the patient, they can try connecting the patient to them.

What are "service animals" and "support animals" and are physicians required to allow them?

The *AODA* Customer Service Standards defines an animal as a "service animal" for a person with a disability if:

- the animal can be readily identified as one that is being used by the person for reasons relating to the person's disability, as a result of visual indicators such as the vest or harness worn by the animal; or
- the person provides documentation[8] from a regulated health professional confirming that the person requires the animal for reasons relating to the disability.[9]

A "support animal" (also commonly referred to as an "emotional support animal") is not defined in the *AODA* or the *Code*.

Physicians are required to allow service animals and may be required to allow support animals under the *Code* if support animals are required as a form of accommodation for patients with disabilities, subject to undue hardship.

How do I determine if the reason(s) for a patient's request to receive care from a physician with a particular social identity is discriminatory?

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[7] For more information on accommodation, see the Ontario Human Rights Commission's A policy primer: Guide to developing human rights policies and procedures and the Human Rights Legal Support Centre's Understanding the Duty to Accommodate resources.

[8] See the College's *Third Party Medical Reports* policy for general expectations that would apply to providing third party medical reports, including documentation for a service and/or support animal, and the *Advice to the Profession: Third Party Medical Reports* for guidance on this issue.

[9] See the Ontario government's website for more information about service animals.

Physicians will need to use their professional judgment to determine whether the patient's request is discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.). In order to make this determination, physicians will need to explore the reason(s) for the patient's request.

At times, it may be obvious that the reason(s) for a patient's request is discriminatory because the patient uses disrespectful or derogatory language (e.g., they use a racial slur). Physicians must not be spoken to in this manner as physicians are entitled to a workplace that is free from violence, harassment, and discrimination. Guidance on how to navigate discriminatory requests is provided in the next question and answer below.

In other instances, it may be difficult for physicians to evaluate the patient's reason(s) where the patient is not overtly discriminatory and just does not feel comfortable disclosing the true reason(s) for their request (e.g., a woman may not disclose that they are requesting a woman physician because they were sexually assaulted by a man). In these circumstances, physicians may presume that personal preference requests are likely based on past experiences, cultural norms, etc. and therefore are not discriminatory for the purposes of this policy.

Requests are also not discriminatory when patients are seeking an ethically or clinically appropriate form of concordance (e.g., based on race/ethnicity/culture, language, gender, etc.). For example, patients who are members of racial or ethnic minority groups may request a physician of the same race or ethnicity because of a history of discrimination or other negative experiences with the health care system that have resulted in mistrust. In such cases, the literature recognizes that physician-patient concordance is associated with greater trust, comprehension, and satisfaction and other critical patient-centered outcomes. It is important for physicians to sensitively explore the reason(s) for the patient's request in order determine which requirements apply to the specific circumstances.

How do I navigate patient requests to receive care from a physician with a particular social identity when the reason(s) for their request are perceived to be discriminatory (e.g., racist, sexist, ageist, heterosexist, etc.)?

Physicians do not have to accommodate the patient's discriminatory request. This position supports the right of physicians to be free from violence, harassment, and discrimination in their workplace. As discussed in the College's *eDialogue* article on Treating Patient Bias, physicians do suffer harm (e.g., emotional exhaustion, fear, self-doubt, and increased cynicism) after encounters with patients who are discriminatory towards them and this can lead to physician burnout and negatively impact patient care.

Once a patient's emergent or urgent medical needs are met, one of the factors that physicians will need to consider when determining whether to treat the patient's other needs is safety (of the physician and patient). Some physicians may be harmed and/or

may not feel safe caring for the patient, and it would not be in anyone's best interest for physicians to care for a patient in these circumstances.

When determining whether it is in both parties' best interest to care for the patient, it would also be prudent to take the patient's capacity into account. Patients who are incapable (e.g., due to a severe mental illness, neurocognitive or neurodevelopmental disorder, substance intoxication, delirium, etc.) may not be cognitively aware of what they are saying or doing and therefore physicians may be more willing to care for patients in these circumstances. In fact, professionalism requires physicians to accept a broad range of human behaviour in response to illness or incapacity and physicians will have to use their professional judgment to determine when that behaviour crosses the line and becomes unsafe.

Where physicians determine that it would be unsafe or not in both parties' best interest to care for the patient and they decide to end the physician-patient relationship, they will have to comply with the expectations set out in the College's *Ending the Physician-Patient Relationship* policy.

Health Services that Conflict with Physicians' Conscience or Religious Beliefs

Can physicians practise in accordance with their conscience or religious beliefs?

Yes. However, physicians' freedom of conscience and religion must be balanced against patients' right to access health services.

The *Canadian Charter of Rights and Freedoms* protects the right to freedom of conscience and religion,[10] but this right is not absolute. The right to freedom of conscience and religion can be limited, as necessary, to protect public safety, order, health, morals, or the fundamental rights and freedoms of others.[11]

The balancing of rights must be done in context.[12] In relation to freedom of religion specifically, courts will consider the degree to which the act in question interferes with a sincerely held religious belief and will seek to determine whether the act interferes with the religious belief in a manner that is more than trivial or insubstantial. The less direct the impact on a religious belief, the less likely courts are to find that freedom of religion is infringed, and conduct that would potentially cause harm to and interfere with the rights of others would not automatically be protected.[13] The Court of Appeal for Ontario has confirmed that where an irreconcilable conflict arises between a physician's

[10] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, s 2(a).
[11] *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 at para 95.
[12] Ontario Human Rights Commission, Policy on Competing Human Rights, (Ontario: Jan 26, 2012).
[13] *Syndicat Northcrest v. Amselem*, [2004] 2 S.C.R. 551 at paras 59-61.

interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails.[14]

As such, the College has set out expectations for physicians whose conscience or religious beliefs conflict with certain health services in a manner that would impact patient access to those health services and has done so in such a way that it accommodates the rights of these physicians to the greatest extent possible, while ensuring that patients obtain access to that care.

What does an effective referral involve?

An effective referral involves taking the following steps:

1. **The physician must take positive action to connect a patient with another physician, health-care professional, or agency.** The physician can take these steps themselves or assign the task to someone else (i.e., their designate), so long as this other person complies with the College's expectations.

2. **The effective referral must be made to a non-objecting physician, health-care professional, or agency that is available and accessible to the patient.** The physician, health-care professional, or agency to which the effective referral is made cannot have conscientious or religious beliefs that would impact patient access to the service, treatment, or procedure, must be operating and/or accepting patients, and must be in a location that is reasonably physically accessible to the patient or accessible via virtual care, where appropriate.

3. **The effective referral must be made in a timely manner, so that the patient will not experience an adverse clinical outcome due to a delay in making the effective referral.** A patient would experience an adverse outcome due to a delay if, for example, the patient is no longer able to access the service, treatment, or procedure (e.g., for time sensitive matters such as emergency contraception, an abortion, or where a patient wishes to explore medical assistance in dying); their clinical condition deteriorates; or their untreated pain or suffering is prolonged.

An effective referral *does not:*

- necessarily require that the physician make a clinical referral , unless it is required in order for a patient to access the service, treatment, or procedure;
- require that the physician assess the patient or determine whether the patient is a suitable candidate, or eligible, for the service, treatment, or procedure;

[14] *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2019 ONCA 393 at para. 187.

- guarantee that the patient will receive the service, treatment, or procedure as they may not ultimately choose that particular clinical option or be a suitable candidate, or eligible, for it; or
- require that the physician endorse or support the service, treatment, or procedure.

What are some examples of an effective referral?

Physicians will need to consider the patient's particular circumstances and use their professional judgement to determine what action to take. Some patients may need more assistance than others in accessing the service, treatment, or procedure. Physicians will also need to consider whether the service, treatment, or procedure can be accessed by the patient directly, or whether a clinical referral is required (e.g., to access a specialist). Even where patients can access services directly, many patients will require their physicians' assistance in doing so.

The following are examples of positive actions physicians can take, but these examples are not exhaustive and the action required to confirm a connection is made will depend on the specific circumstances.

- The physician or their designate contacts a non-objecting, available, and accessible physician or other health-care professional and arranges for the patient to be seen.
- The physician or their designate makes a clinical referral to a non-objecting, available, and accessible physician or other health-care professional where a clinical referral is required in order to access the service, treatment, or procedure (e.g., a fertility specialist).
- A physician or their designate partially transfers[15] the patient's care to a non-objecting, available, and accessible physician or other health-care professional with whom the patient can explore all options in which they have expressed an interest. This other physician or health-care professional could make a clinical referral if it is required in order to access the service, treatment, or procedure.
- The physician or their designate connects the patient with an agency charged with facilitating referrals for the service, treatment, or procedure, and arranges for the patient to be seen at that agency. For instance, in the medical assistance in dying (MAID) context, the physician or their designate would contact Ontario's

[15] In this situation, the physician would only transfer the care that they choose not to provide for reasons of conscience or religion. This partial transfer of care is not equivalent to ending the physician-patient relationship. The College's *Ending the Physician-Patient Relationship* policy states that physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that the physician chooses not to provide for conscience or religious reasons.

Care Coordination Service (CCS). The CCS would then connect the patient with a willing provider of MAID-related services.

- In appropriate circumstances (e.g., where the patient does not need assistance), the physician or their designate provides the patient with contact information for a non-objecting, available, and accessible physician, other health-care professional, or agency.
- A practice group in a hospital, clinic, or family practice model identifies patient queries or needs through a triage system. The patient is directly matched with a non-objecting physician in the practice group with whom the patient can explore all options in which they have expressed an interest.
- A practice group in a hospital, clinic, or family practice model identifies a point person who will facilitate an effective referral or who will provide the services, treatment, or procedure to the patient. The physician with conflicting beliefs or their designate connects the patient with that point person.

Regardless of which positive actions were taken, physicians or their designates will have to confirm that they were effective (i.e., the patient was connected).

What steps are involved in meeting the requirement to confirm that the patient was connected?

Given the physician's fiduciary duty to the patient and the professional responsibilities that flow from that duty, the onus falls on the physician or their designate to confirm the patient was connected, unless the patient has indicated that they prefer to reach out to the physician or their designate if they have any issues being connected. To that end, it is important for the physician or their designate to clarify with the patient how the confirmation will be obtained or provided.

Physicians will have to consider the patient's particular circumstances and use their professional judgment to determine what steps are required to confirm that the patient was connected. For example, physicians or their designate could confirm the patient was connected by contacting the patient directly, or the physician, health-care professional, or agency they connected the patient to. It would be prudent for the physician or their designate to obtain the patient's express consent regarding the manner in which they would like the physician or their designate to follow-up.

What further action do I need to take if I learn that the patient was not connected?

If physicians learn that their patient was not connected, they are required to take further action to provide an effective referral. In doing so, physicians may need to take a more active step to connect their patient. For example, if the first action they took was to provide the patient with a contact number for a non-objecting, available, and accessible physician, the next action they may need to take is to directly contact another physician,

health-care professional, or agency on the patient's behalf and arrange for them to be seen.

Does the expectation to provide patients with an effective referral apply in faith-based hospitals and hospices?

Yes. Physicians are required to comply with the expectations set out in the College's policy. This means that physicians would be required to provide patients with access to information and care, including an effective referral, for the services, treatments, and procedures that are not provided in the faith-based hospital or hospice.

Can I end the physician-patient relationship because my patient wishes to explore a care option that conflicts with my conscience or religious beliefs?

No. The College's *Ending the Physician-Patient Relationship* policy states that physicians must not end the physician-patient relationship solely because the patient wishes to explore a care option that conflicts with the physician's conscience or religious beliefs.

I am a primary care provider and my patient is exploring a health service that conflicts with my conscience or religious beliefs. Do I have to continue managing the other elements of their care?

Yes. As noted above, you cannot end the physician-patient relationship solely because the patient is exploring a health service that conflicts with your conscience or religious beliefs. Physicians have an obligation to continue to offer comprehensive and continuous care to meet their patients' other needs and are required to do so in a manner that does not impose their own religious beliefs on patients.

For example, patients who are seeking MAID may still require comprehensive care, including managing the symptoms that have led to their desire to explore MAID, and you have an obligation to ensure the continuity of that care is provided. If the patient's natural death is not reasonably foreseeable, the physician or nurse practitioner who is exploring MAID with the patient may also need your assistance to treat the patient's medical condition by means other than MAID.

Where do I go if I have questions or concerns about whether a physician has complied with their obligations?

You may bring any questions or concerns regarding physicians' compliance with the obligations set out in this policy to the College. You may also raise any concerns regarding physicians' compliance with their legal obligations under the *Code* to the Ontario Human Rights Commission and Tribunal. College processes are separate from the Ontario Human Rights Commission and Tribunal processes.

Resources

- Call it Out: Racism, Racial Discrimination, and Human Rights
- The College of Family Physicians of Canada: Indigenous Health Committee Resources
- Royal College of Physicians and Surgeons of Canada: Indigenous Health
- San'yas Anti-Racism Indigenous Cultural Safety and Training Program
- EQUIP Health Care Trauma- and Violence-Informed Care Resources
- Action Canada for Sexual Health and Rights: A Handbook for health care providers working with clients from diverse communities
- Never in the Room: A Forum Theatre Presentation in Partnership with Ontario Association of Interval and Transition Houses (OAITH) on ending violence against older women in Ontario
- Ontario Association of Interval and Transition Houses (OAITH): Training Portal[16]
- Ontario Association of Interval and Transition Houses (OAITH): Beneath the Iceberg Video Guide
- Rainbow Health Ontario: Education & Training
- Creating An Inclusive Space
- Obesity Guideline Addresses Root Drivers
- Cultural Religious Competence in Clinical Practice
- Religious Diversity: Practical Points for Health Care Providers

[16] These courses are designed for people working in violence against women shelters in Ontario and for all others who work in the violence against women sector or in roles that involve supporting or advocating for women who have experienced violence.

Council Motion

Motion Title	*Human Rights in the Provision of Health Services* – Draft Policy for Consultation
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Human Rights in the Provision of Health Services", (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

September 2022

Topic:	Amendments to Declaration of Adherence and Council Code of Conduct (regarding Social Media)
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Accountability: Ensuring appropriate governance of the CPSO through a current and effective Declaration of Adherence.
Main Contacts:	Laura Rinke-Vanderwoude, Governance Analyst Marcia Cooper, Senior Legal Counsel and Privacy Officer Cameo Allan, Manager of Governance
Attachments:	Appendix A: 2023 Declaration of Adherence

Issue

- Council is asked to consider changes to the Declaration of Adherence and Council and Committee Code of Conduct regarding engagement on social media by Council and committee members.

Background

- In 2020, the Declaration of Adherence was refreshed and approved by Council. This included updates to several components, including a section regarding the use of social media in the Council and Committee Code of Conduct. Since that time, an opportunity was identified to further build on the section about social media.

Current Status and Analysis

- Changes to the social media section of the Council and Committee Code of Conduct have been proposed to clarify and expand it to be aligned with the Social Media policy for physicians and to better reflect the expectations of individuals with a fiduciary duty to the CPSO.
    - The Governance Committee provided recommendations regarding the changes, which have been reflected in Appendix A.

- Page 12 of Appendix A indicates the proposed updates to the social media section of the Council and Committee Code of Conduct. The changes include more specific language about the limitations and restrictions on social media use that apply to Council and Committee members with regards to appropriate online conduct, reputational risks, stakeholder relationships, and the image of the CPSO. The changes include:
    - Elaborating on the list of what behaviour constitutes inappropriate social media conduct;
    - Clarifying what constitutes a risk to the reputation and relationships of the CPSO on social media;
    - Setting expectations regarding cooperation with the CPSO in the event of inappropriate or risky social media conduct; and,
    - Encouraging members to check in with the CPSO prior to engaging with social media.

Next Steps

- The new Declaration of Adherence will be signed by Council and Committee members for 2023.

Question for the Council

1. Does Council approve the proposed changes?

CPSO

Declaration of Adherence Package 2022

CPSO Council and Committee Declaration of Adherence Package

This package contains the Declaration of Adherence and Council and Committee Code of Conduct. For convenience of reference, it also includes links and access to policies and other documents referred to in the Declaration of Adherence and Council and Committee Code of Conduct.

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2021-2022
Declaration of Adherence

CPSO

Members of CPSO Council and Committees

As a member of Council and/or a committee of the College of Physicians and Surgeons of Ontario (CPSO), I acknowledge that:

- the CPSO's duty under the *Regulated Health Professions Act, 1991* (RHPA) and the Health Professions Procedural Code (the Code) (relevant excerpts of which are attached to this document) is to serve and protect the public interest.

- I stand in a fiduciary relationship to the CPSO. This means that I must act in the best interests of the CPSO. As a fiduciary, I must act honestly, in good faith and in the best interests of the CPSO, and must support the interests of the CPSO over the interests of others, including my own interests and the interests of physicians.

- Council and Committee members must avoid conflicts between their self-interest and their duty to the CPSO and conflicts of interest by virtue of having competing fiduciary obligations to the CPSO and to another organization. As part of this Declaration of Adherence, I have identified below any relationship(s) I currently have with any organization that may create a conflict of interest by virtue of having competing fiduciary obligations to the CPSO and the other organization (including, but not limited to, entities of which I am a director or officer).

- I am aware of the confidentiality obligations imposed upon me by Section 36 (1) of the RHPA, a copy of which is attached to this Declaration. All information that I become aware of in the course of or through my CPSO duties is confidential and I am prohibited, both during and after the time I am a Council member or a CPSO committee member, from communicating this information in any form and by any means, except in the limited circumstances set out in Sections 36(1)(a) through 36(1)(k) of the RHPA.

- I have read Section 40 (2) of the RHPA, and understand that it is an offence to contravene subsection 36 (1) of the RHPA. I understand that this means in

Initial

addition to any action the CPSO or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of Section 36 (1) of the RHPA, and if convicted, I may be required to pay a fine of up to $25,000.00 (for a first offence), and a fine of not more than $50,000 for a second or subsequent offence.

- I have read and agree to abide by the Council and Committee Code of Conduct (a copy of which is attached to this Declaration of Adherence).

- I understand that I am subject to the CPSO By-Laws, including the provisions setting out the circumstances in which ~~in~~ I may be disqualified from sitting on Council or on a committee.

- I have read and am familiar with the CPSO's By-laws and governance policies. I am bound to adhere to and respect the CPSO's By-laws and the policies applicable to the Council, including without limitation, the following:

    - Council and Committee Code of Conduct
    - Conflict of Interest Policy
    - Impartiality in Decision Making Policy
    - Confidentiality Policy
    - Use of CPSO Technology Policy
    - Information Breach Protocol
    - E-mail Management Policy
    - Protocol for Access to CPSO Information
    - Safe Disclosure Policy
    - Role Description of a CPSO Council/Committee Member (as applicable)

- I must conduct CPSO work using a CPSO-issued computer or laptop, and that I am not permitted to use a personal computer or laptop for CPSO work.

- I must use **only** my CPSO-provided email address (eg., cpso.on.ca) for any and all communications relating to CPSO work.

- I have completed the attached Conflict of Interest Disclosure Form to the best of my ability, and will notify the CPSO of any changes or additions to the disclosed

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information at the earliest opportunity, in accordance with the Conflict of Interest Policy.

☐ I confirm I have read, considered and understand the Declaration of Adherence including associated documents, and agree to abide by its provisions.

☐ I understand that any breach of this Declaration of Adherence may result in remedial action, censure or removal from office.

Printed Name:	
Signature:	
Date:	

CPSO Council and Committee
Conflict of Interest Declaration Form

As part of your Council or committee work, you are expected to declare any actual or potential conflicts of interest. A conflict of interest is defined in the CPSO General By-law as:

> *A conflict of interest exists where a reasonable person would conclude that a Council or committee member's personal or financial interest may affect his or her judgment or the discharge of his or her duties to the College. A conflict of interest may be real or perceived, actual or potential, direct or indirect.*

Please indicate any financial or personal interests that are or may be perceived to be a conflict of interest with your duties at CPSO, including any positions you hold as an officer or director of any other entity whose interests or mandate could reasonably appear to be in conflict or inconsistent with the CPSO. Please review the *Conflict of Interest* policy for more details and examples of what may constitute a conflict of interest.

Potential conflicts will be investigated by the CPSO to confirm whether a conflict exists, and the extent of the impact of any conflicts on your involvement in work. If you are unsure if something is a conflict, please disclose it below.

I have no conflicts of interest to report ☐

I have the following potential or actual conflicts of interest ☐

1.
2.
3.

Printed Name:

Signature:

Date:

CPSO Council and Committee
Conflict of Interest Declaration Form

Purpose

This Code of Conduct sets out expectations for the conduct of Council and committee members to assist them in:

- carrying out the CPSO's duties under the *Regulated Health Professions Act, 1991* (RHPA) to serve and protect the public interest; and,
- ensuring that in all aspects of its affairs, Council and committees maintain the highest standards of public trust and integrity.

Application

This Code of Conduct applies to all members of Council and to all CPSO committee members, including non-Council committee members.

Fiduciary Duty and Serving and Protecting the Public Interest

Fiduciary Duty

Council members and committee members are fiduciaries of the CPSO and owe a fiduciary duty to the CPSO. This means they are obligated to act honestly, in good faith and in the best interests of the CPSO, putting the interests of the CPSO ahead of all other interests, including their own interests and the interests of physicians.

As set out in the Declaration of Adherence, members must avoid situations where their personal interests will conflict with their duties to the CPSO. See the CPSO's Conflict of Interest Policy for further information.

Members who are appointed or elected by a particular group must act in the best interests of the CPSO even if this conflicts with the interests of their appointing or electing group. In particular:

- Professional members who are elected to Council do not represent their electoral districts or constituents.

- Academic professional members who are appointed to Council by their academic institutions do not represent the interests of their institutions.
- Public members of Council who are appointed by the Lieutenant Governor in Council do not represent the government's interests.

Serving and Protecting the Public Interest

The CPSO is the self-regulating body for the province's medical profession. In carrying out its role as a regulator governed by the RHPA, the CPSO has a duty to "serve and protect the public interest". This duty takes priority over advancing any other interest. For greater clarity, advancing other interests must only occur when those interests are not inconsistent with protecting and serving the public interest. As Council and committee members have a fiduciary duty to the CPSO, they must keep in mind that in performing their duties they are expected to work together to support the CPSO in fulfilling this mandate.

Advancing the Profession's Interests

It is possible that while serving and protecting the public, Council and committee members can also collectively advance the interests of the profession. However, there may be times when serving and protecting the public may not align with the interests of the profession. When this occurs, Council and committee members must protect and serve the public interest over the interests of the profession.

Conduct and Behaviour

Respectful Conduct

Members bring to the Council and its committees diverse backgrounds, skills and experiences. While members may not always agree on all issues, discussions shall take place in an atmosphere of mutual respect and courtesy and should be limited to formal meetings as much as possible.

For greater clarity, discussing Council or committee matters outside of formal meetings is strongly discouraged.

The authority of the President of Council must be respected by all members.

Council and Committee Solidarity

Members acknowledge that they must support and abide by authorized Council and committee decisions, even if they did not support those decisions. The Council and CPSO committees speak with one voice. Those Council or committee members who have abstained or voted against a motion must adhere to and support the decision of a majority of the members.

Media Contact, Social Media, and Public Discussion

Council and CPSO Spokespersons

The President is the official spokesperson for the Council. The President represents the voice of Council to all stakeholders. The Registrar/CEO is the official spokesperson for the CPSO.

Media Contact and Public Discussion

News media contact and responses and public discussion of the CPSO's affairs should only be made through the authorized spokespersons. Authorized spokespersons may include the President, the Registrar/CEO, or specified delegate(s).

No member of Council or a CPSO committee shall speak or make representations (including in social media or in private communications) on behalf of the Council or the CPSO unless authorized by the President (or, in the President's absence, the Vice-President) and the Registrar/CEO. When so authorized, the member's representations must be consistent with accepted positions and policies of the CPSO and Council and must comply with the confidentiality obligations under the RHPA.

Social Media Use

Members of Council or a CPSO Committee are held to a very high standard that moves beyond the Social Media policy that applies to physicians generally. In addition, Council and Committee members must recognize that effective advocacy is generally difficult to balance with their role at the CPSO.

Council and Committee members must always consider the potential impact of all their communications, social media use and online conduct on the reputation of, or public trust in, the CPSO, the profession, medical self-regulation or a CPSO stakeholder (including the

Ontario Medical Association, the government, medical schools and others). This applies to all manner of communications and social media use, whether private or public, and whether the member has or has not explicitly stated that their views do not reflect the views of the CPSO. For example, members mustshould:

- Speak on behalf of the CPSO only when authorized by the President or CEO/Registrar;
- Not engage on social media in any way that could be interpreted to represent or establish the position of the CPSO, reflect bias in the CPSO's decision-making, or compromise the reputation of the CPSO, its Council, or its Committees, even if the views expressed are noted to be a member's individual views and not representative of the CPSO;
- Not respond to any negative or confrontational content that is or could be seen to be related to the CPSO, and notify CPSO staff should they discover or receive any negative/confrontational content on social media; and,
- Be professional and respectful on social media, including but not limited to not engaging in harassing, discriminatory or otherwise abusive behaviour.

In particular, while using social media, members must not engage with matters (including posting, commenting, or reacting to them) when:

- The member's comments may be inconsistent with a stated CPSO position;
- The matters discussed relate to or touch upon specific cases or general themes with regards to cases that may ~~or~~ have come before a CPSO Committee. This may create a possible apprehension of bias on the part of the committee member for future cases. For example, strong statements about a specific physician or group of physicians, or an area of medical practice, that could give rise to the appearance of bias when deciding cases related to them.

Council and Committee members are permitted (and encouraged) to share, comment on, and positively comment on or interact with social media postings that have been approved by the CPSO, for example, sharing CPSO job postings, eDialogue, or other posts from CPSO official channels. Doing so is consistent with speaking with one voice when representing the CPSO.

All Council and Committee members are expected to respond to and cooperate with the CPSO if the CPSO raises concerns about the member's social media engagement. This may include but is not limited to complying with requests to remove or edit previous posts, comments, or reactions, or to cease further posts that cause similar or related concerns.

Council and Committee members are encouraged to obtain guidance from the CPSO prior to engaging with social media to assist with compliance with this Code of Conduct.

Representation on Behalf of the CPSO

Council and committee members may be asked to present to groups on behalf of the CPSO, or may be invited to represent the CPSO at events or within the community. Council and committee members are expected to first obtain authorization to do so, as noted above, and to coordinate with CPSO staff to develop appropriate messaging and materials for such presentations.

Every Council and committee member of the CPSO shall respect the confidentiality of information about the CPSO whether that information is received in a Council or committee meeting or is otherwise provided to or obtained by the member. The duty of confidentiality owed by Council and committee members is set out in greater detail in the CPSO's Confidentiality Policy.

Diversity, Equity, and Inclusion

Diversity, equity, and inclusion is important to the CPSO in order to fulfil our mandate to protect and serve the public interest. Council and committee members are expected to support the CPSO's work towards providing a more diverse, equitable, and inclusive environment at the CPSO, within the profession, and for our patients across the province. This includes Council and committee members approaching all work at the CPSO with a diversity, equity, and inclusion lens.

Email and CPSO Technology

More information on email and CPSO technology use can be found in the:

- Use of CPSO Technology Policy

- Information Breach Protocol
- E-mail Management Policy
- Protocol for Access to CPSO Information

CPSO Email Address

Council and committee members must use **only** their CPSO-provided email address (eg., cpso.on.ca) for all communications relating to their CPSO work. CPSO emails (including virtual meeting invitations) must not be forwarded or sent to a personal email address under any circumstances. This is very important to maintain the confidentiality of CPSO-related communications. The use of the CPSO email system by Council and committee members for personal matters should be incidental and kept to a minimum.

Members are expected to check their CPSO email account regularly. Council and committee members should not expect to receive notifications that CPSO email has been sent to them via a personal email, text or phone number, and should not ask CPSO staff to send these notifications. Council and committee members may contact IT for assistance with accessing or using their CPSO email, including having IT download the CPSO Outlook app on their personal mobile phones.

CPSO Technology

Council and committee members should have no expectation of privacy in their use of CPSO Technology or in CPSO Information. The CPSO may monitor and review the use of CPSO Technology by Council and committee members, and may open and review e-mail messages, instant messaging, internet activity and other CPSO Information (including those of a personal nature), at any time without notice for the purposes of verifying compliance with CPSO policies, to protect CPSO Information and other CPSO property and for other lawful purposes.

The CPSO Policy on Use of CPSO Technology applies to Council and committee members. As provided in that policy, all information and data (including e-mail and instant messaging) (referred to as CPSO Information) generated or stored on CPSO systems, devices and associated computer storage media (referred to as CPSO Technology) are the exclusive and confidential property of the CPSO.

Council and committee members must conduct CPSO work using CPSO-issued computers or laptops, not personal computers or laptops. Use of CPSO-issued computers or laptops

by CPSO Council and committee members for personal or non-CPSO matters should be kept to a minimum.

Additionally, the Information Technology department must approve any software downloads to CPSO Technology or systems.

CPSO information must be saved in CPSO systems, and Council and committee members should not download, save or store CPSO information on CPSO Technology (e.g. on C drive or desktop) or on personal devices.

Council and committee members should be aware that they leave a CPSO "footprint" on the internet when accessing it from the CPSO's wireless network or while using CPSO Technology or their CPSO email address. Members are reminded that when they use CPSO networks, they are representing the CPSO at all times during their Internet travels.

Other Council and Committee Member Commitments

In addition to any other obligation listed in this Code of Conduct or in the Declaration of Adherence, each Council member and committee member commits to:

- uphold strict standards of honesty, integrity and loyalty;
- adhere to all applicable CPSO by-laws and policies, in addition to those listed or referred to in this Code of Conduct;
- attend Council and committee meetings, as applicable to the member, be on time and engage constructively in discussions undertaken at these meetings;
- prepare prior to each Council and committee meeting, as applicable to the member, so that they are well-informed and able to participate effectively in the discussion of issues and policies;
- state their ideas, beliefs and contributions to fellow Council and committee members and CPSO staff in a clear and respectful manner;
- where the views of the Council or committee member differ from the views of the majority of Council or committee members, work together with Council or the committee, as applicable, toward an outcome in service of the highest good for the public, the profession and the CPSO;

- uphold the decisions and policies of the Council and committees;
- behave in an ethical, exemplary manner, including respecting others in the course of a member's duties and not engaging in verbal, physical or sexually harassing or abusive behaviour;
- participate fully in evaluation processes requested by CPSO that endeavor to address developmental needs in the performance of the Council, Committee and/or individual member;
- willingly participate in committee responsibilities;
- promote the objectives of the CPSO through authorized outreach activities consistent with CPSO's mandate and strategic plan and in accordance with this Code of Conduct;
- respect the boundaries of CPSO staff whose role is neither to report to nor work for individual Council or committee members; and,
- if a member becomes the subject of a hearing by the Ontario Physicians and Surgeons Discipline Tribunal[1] or the Fitness to Practice Committee of the CPSO, withdraw from the activities of Council or any committee on which the member serves until those proceedings are formally concluded.

Any member of Council or a CPSO committee who is unable to comply with this Code of Conduct or the Declaration of Adherence, including any policies referenced in them, shall withdraw from the Council and/or such committees.

Amendment

This Code of Conduct may be amended by Council.

Updated and approved by Council: ~~December, 9, 2021~~

[1] The Ontario Physicians and Surgeons Discipline Tribunal is the Discipline Committee established under the Health Professions Procedural Code. For convenience, it is referred to as the OPSDT in other instances in this package.

Council Motion

Motion Title	Amendments to the Declaration of Adherence and Council Code of Conduct (regarding Social Media)
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the amendments to the Council and Committee Code of Conduct, (a copy of which forms Appendix " " to the minutes of this meeting) and to the Declaration of Adherence, (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

September 2022

Topic:	*Medical Assistance in Dying* – Draft Policy for Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care Meaningful Engagement System Collaboration
Public Interest Rationale:	Setting clear expectations and guidance for physicians to support patient access to high quality medical assistance in dying in accordance with the federal legal framework.
Main Contact(s):	Michelle Cabrero Gauley, Senior Policy Analyst
Attachment(s):	Appendix A: *Medical Assistance in Dying* Policy Appendix B: *Medical Assistance in Dying: Legal Requirements* Appendix C: *Medical Assistance in Dying: Advice to the Profession*

Issue

- CPSO's *Medical Assistance in Dying (MAID)* policy is currently under review. A draft *MAID* policy has been developed along with two companion resources, a *Legal Requirements* document, and an *Advice to the Profession* (*Advice*) document.

- Council is asked whether the draft policy can be forwarded to Council for approval to release it for external consultation and engagement.

Background

- The *MAID* policy was first approved by the Executive Committee (on behalf of Council) in June 2016 and although it has been updated three times over the years,[1] the amendments were housekeeping in nature and this is the first comprehensive review of the policy.

[1] July 2017 (to reflect the amendments to provincial legislation set out in Bill 84); December 2018 (to reflect the federal regulations for the monitoring of MAID and the issues identified by the Office of the Chief Coroner and the Ministry of Health and Long-Term Care); and April 2021 (to reflect the new legal framework set out in Bill C-7).

- Council was briefed on the policy review at its December 2020 Council Meeting (see pages 102-111 for the Policy Review Kick-Off) and June 2021 Council Meeting (see pages 45-46 for the Consultation Report).

- Additional consultation and engagement activities that were undertaken as part of the policy review included: public opinion polling, a Stakeholder Roundtable Discussion (see page 14 of the 2021 Equity, Diversity, and Inclusion Report), and a Citizen Advisory Group discussion.

Current Status and Analysis

- The draft *MAID* policy (**Appendix A**) retains the majority of the core professional expectations set out by CPSO in the current *MAID* policy but it has been redesigned and streamlined.

- An overview of the key revisions is set out below, along with some examples of the specific policy provisions that have been revised and the new guidance that has been added to the *Advice*.

Structural revisions

- The draft *MAID* policy maintains the requirement that physicians must comply with the legal requirements for MAID (e.g., eligibility criteria, safeguards, and reporting) (Provision 1) but the actual legal requirements have been moved to a new companion resource (**Appendix B**).

    - The Working Group thought that the focus of the draft *MAID* policy should be on CPSO's professional expectations and moving the legal requirements to a separate resource would be more user-friendly for physicians. The legal framework has been, and continues to be, in a state of evolution and setting out the legal requirements in a companion resource (rather than in policy) would allow us to be nimble and make updates in real-time (rather than seeking policy amendments), consistent with right-touch regulation.

- The professional expectations regarding conflicts with physicians' conscience or religious beliefs have been removed from the draft *MAID* policy and physicians are directed to the draft *Human Rights in the Provision of Health Services* policy for these expectations.

    - The Working Group reaffirmed that CPSO's expectations are the same for all services, including MAID, and therefore it was not necessary to repeat these professional expectations in the draft *MAID* policy.

- The 'Process Map' section was removed and instead the *Advice* (**Appendix C**) provides links to process maps for MAID that have been developed by a health system partner.

    - The Working Group determined that much of the content in the 'Process Map' section was repetitive and thought it would be more helpful to provide examples of process maps that are in a flowchart format and visually more appealing.

Revisions to specific policy provisions

- The draft policy now clarifies that the patient must have capacity to consent at specific points in the MAID process (Provision 3a).

    - The Working Group thought that the current policy wording regarding the fluidity of capacity was unclear and instead the draft policy should articulate the specific points in the MAID process where patients must have capacity.

- The advice in the current *MAID* policy to notify the dispensing pharmacist as early as possible that medications for MAID will be required is now a requirement in the draft policy (Provision 6).

    - The Working Group considered feedback that indicated it may take some time for pharmacists to obtain medications for MAID as they aren't commonly stocked in every pharmacy and felt it would be important to make the advice a requirement to help prevent any delays.

- A new expectation has been added to the draft policy that requires physicians have a contingency plan in place before administering medications for MAID (Provision 7).

    - Research regarding the potential complications that can and do occur when administering MAID highlighted the importance of having a contingency plan in place. The addition of this expectation is consistent with a recommendation made by the Office of the Chief Coroner for Ontario.

New guidance added to Advice

- Some examples of the new guidance that has been added to the *Advice* include: how to navigate circumstances where it is not clear if the patient meets the eligibility criteria or the patient is ineligible (Lines 61-83); how mentorship affects independence between clinicians (Lines 121-132); and having an after-death plan in place (Lines 295-305).

    - The Working Group thought that it would be helpful to provide guidance on these issues given the research and feedback.

Next Steps

- Pending Council's approval, the draft policy will be released for external consultation and engagement. Feedback received as part of these activities will be shared with Council at a future meeting and used to further refine the draft.

Question for Council

1. Does Council approve the draft *MAID* policy for external consultation and engagement?

MEDICAL ASSISTANCE IN DYING

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

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

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

Definition

Medical Assistance in Dying (MAID): Under the federal legislation, MAID refers to circumstances where a physician[1] or nurse practitioner[2], at a patient's request: (a) administers medications that cause a patient's death; or (b) prescribes or provides medications for a patient to self-administer to cause their own death, in accordance with the legal requirements.

Policy

1. Physicians who assess patients for and/or provide MAID **must** comply with the relevant legal requirements for MAID, including those pertaining to the eligibility criteria, safeguards, and reporting (an overview of which is provided in the College's *MAID: Legal Requirements* companion resource).[3,4]

[1] A physician who is entitled to practise medicine in Ontario, including postgraduate medical trainees.
[2] A nurse who is entitled to practise in Ontario as a nurse practitioner by holding an extended class of certificate of registration.
[3] This includes: Sections 241.1-241.4 of the *Criminal Code*, R.S.C. 1985, c. C-46 (hereinafter, "*Criminal Code*"); *Regulation for the Monitoring of Medical Assistance in Dying*, SOR/2018-166, enacted under the *Criminal Code*; and Section 10.1 of the *Coroners Act*, R.S.O. 1990, c. C.37.
[4] Physicians may want to seek independent legal advice if they have questions about meeting the legal requirements.

2. Physicians **must** comply with the expectations set out in this policy and other relevant College policies[5], and the terms and conditions of their certificate of registration.
    a. Physicians who choose not to assess patients for or provide MAID for reasons of conscience or religion **must** comply with the expectations set out in the College's *Human Rights in the Provision of Health Services* policy.
    b. When assessing patients for and/or providing MAID, postgraduate medical trainees **must** comply with the terms and conditions of their certificate of registration.[6]
    c. Physicians **must** only assess patients for and/or provide MAID if they have the requisite knowledge, skill, and judgment to do so.

Capacity and Consent

3. Consistent with the College's *Consent to Treatment* policy, physicians **must** ensure the patient is capable[7] and provides valid consent[8] to receive MAID.
    a. Physicians **must** ensure the patient has the capacity to consent at these specific points in the MAID process:
        i. when the eligibility assessments are conducted; and
        ii. when MAID is provided; or
        iii. when entering into a written arrangement that waives the requirement for final express consent.[9]
    b. Where the patient's capacity or voluntariness is in question, physicians **must** conduct and/or refer the patient for a specialized capacity assessment[10].

4. As part of obtaining informed consent, physicians **must** discuss the following with patients who are indicating a preference for self-administered MAID:
    a. The location of the self-administration, including whether the patient is able to store the medications in a safe and secure manner so that it cannot be accessed by others;

[5] This includes the College's *Consent to Treatment*, *Decision-Making for End-of-Life Care*, *Human Rights in the Provision of Health Services,* *Medical Records Documentation*, and *Medical Records Management* policies.
[6] See Section 11(8) of Ontario Regulation 865/93, made under the *Medicine Act, 1991*, S.O. 1991, c. 30.
[7] Meaning the patient is able to understand and appreciate the history and prognosis of their medical condition, treatment options, the risks and benefits of their treatment options, and the certainty of death upon self-administering or having a physician administer the medications.
[8] In order for consent to be valid, it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.
[9] See Sections 241.2 (3.2)-(3.5) of the *Criminal Code* for more information. These written arrangements are also described in the College's *MAID: Legal Requirements* companion resource.
[10] See the Ministry of the Attorney General's website for a list of capacity assessors.

b. The potential complications associated with self-administration, including the possibility that death may not be achieved;
c. That should the patient's death be prolonged or not achieved, it will not be possible for the physician to intervene and administer medications to cause their death unless the patient is capable and can provide consent immediately prior to administering, or the patient has entered into a written arrangement providing advance consent for physician-administered MAID;[11] and
d. How patients and their family, friends and/or caregivers can prepare for the death if the physician is not present, including what to do when the patient is about to die or has just died (e.g., whom to contact at the time of death).[12]

Medications

5. Physicians **must** use their professional judgment in determining the appropriate medication protocol to achieve MAID,[13] and the goals of the protocol **must** include controlling the patient's pain and anxiety.

6. To allow a pharmacist sufficient time to obtain and/or prepare the medications required, physicians **must** notify the dispensing pharmacist as early as possible that medications for MAID will be required.

7. Before administering the medications for MAID, physicians **must** have a contingency plan in place to address potential complications.[14]

Medical Records Documentation and Management

8. Consistent with principles set out in the College's *Medical Records Documentation* policy, physicians **must** capture, where applicable, the following in the patient's medical record:

[11] See Section 241.2 (3.5) of the *Criminal Code* for advance consent for self-administration requirements. These written arrangements are also described in the College's *MAID: Legal Requirements* companion resource.
[12] For more information, see the College's *Advice to the Profession: End-of-Life Care*.
[13] Physicians may wish to consult the Canadian Association of MAID Assessors and Providers' resources on medication protocols or examples of medication protocols used in other jurisdictions.
[14] For more information, see the Canadian Association of MAID Assessors and Providers' Complication with MAID in the Community in Canada: Review and Recommendations resource.

a. all oral and written requests for MAID, the dates they were made, and a copy of the patient's written request;[15, 16]
b. each element of the patient's assessment in accordance with the eligibility criteria for MAID and a copy of the relevant Clinician Aid[17] with their written opinion;
c. the analysis undertaken to determine whether the patient's natural death was or was not reasonably foreseeable;
d. the steps taken to confirm that the relevant procedural safeguards were met and a copy of any Clinician Aid(s) and written opinion(s) or assessment(s) they received;
e. a copy of any written arrangement that waives the requirement for final express consent;[18]
f. the medication protocol used (i.e., drug[s] and dosage[s]); and
g. the time and date of the patient's death, if known.

9. Consistent with the College's *Medical Records Management* policy, physicians **must** provide patients and authorized parties[19] with access to, or copies of, all the medical records in their custody or control upon request, unless an exception applies.[20, 21]

Medical Certificates of Death

10. Physicians who provide MAID **must** complete the medical certificate of death.[22, 23]

11. When completing the medical certificate of death, physicians:

[15] This documentation requirement applies to all physicians who receive requests for MAID, including physicians who choose not to assess patients for or provide MAID for reasons of conscience or religion.
[16] The Ministry of Health has developed Clinician Aid A to assist patients who request MAID.
[17] The Ministry of Health has developed Clinician Aid B for physicians who provide MAID and Clinician Aid C for physicians who conduct an eligibility assessment.
[18] The Ministry of Health has developed Clinician Aids D-1 and D-2 for MAID providers and patients to use as templates for written arrangements.
[19] Authorized parties include substitute decision-makers and estate trustees/executors of the estate where applicable, and third parties where consent has been obtained.
[20] See Section 52 of the *Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sched A* for a comprehensive list of the exceptions.
[21] See the College's *Advice to the Profession: Protecting Personal Health Information* document for more information about requests for access to the patient's medical information.
[22] Section 21 of the *Vital Statistics Act*, R.S.O. 1990, c. V.4. For general information on certifying a patient's death, see the College's *Advice to the Profession: End-of-Life Care*.
[23] Sections 10 and 10.1 of the *Coroners Act* require physicians to report deaths to the Office of the Chief Coroner for Ontario (OCC) when the person's death is due to a non-natural cause (e.g., accident, homicide, etc.) or due to MAID. In circumstances where the OCC has discretion as to whether the death ought to be investigated, the OCC will make that determination and will complete the medical certificate of death (or a replacement medical certificate of death) for the deaths that they investigate.

a. **must** list the illness, disease, or disability leading to the request for MAID as the cause of death; and
b. **must not** make any reference to MAID or the medications administered on the certificate.[24]

[24] These requirements were jointly developed by the Ministry of Health, the Ministry of Government and Consumer Services, and the OCC.

MEDICAL ASSISTANCE IN DYING: LEGAL REQUIREMENTS

The *Criminal Code* sets out the legal framework for medical assistance in dying (MAID) (Sections 241.1 to 241.4)[1] and the *Regulations for the Monitoring of Medical Assistance in Dying* under the *Criminal Code* and the *Coroners Act* (Section 10.1) set out the reporting requirements.

The *Criminal Code* and its regulations and the *Coroners Act* will always prevail in the case of any discrepancy or inconsistency between the College's documents and the legislation and regulations.

Eligibility Criteria for MAID

To be eligible for MAID, a patient must:

a. Be eligible for health services funded by a government in Canada.

b. Be capable and at least 18 years of age.

c. Have a grievous and irremediable medical condition, meaning:

   - they have a serious and incurable illness, disease, or disability that is not a mental illness;[2]
   - they are in an advanced state of irreversible decline in capability; and
   - their illness, disease, disability, or state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions they consider acceptable.

d. Make a request for MAID voluntarily and not as a result of external pressure.

e. Provide informed consent to receive MAID after having been informed of the means available to relieve their suffering, including palliative care.

Safeguards for MAID

[1] Nothing in the *Criminal Code* compels an individual to provide, or assist in providing, MAID.
[2] Section 241.2 (2.1) of the *Criminal Code* specifically excludes a mental illness as an illness, disease, or disability that makes an individual eligible for MAID. For clarity, a patient suffering **solely** from a mental illness is not eligible for MAID but a patient with a mental illness may also have a serious and incurable illness, disease, or disability that makes them eligible for MAID provided all of the other eligibility criteria are met. For more information, see the *Advice to the Profession: Medical Assistance in Dying* document.

The federal legislation sets out safeguards that must be met before MAID is provided. The applicability of some safeguards depends on whether the patient's natural death is reasonably foreseeable.[3]

For the purposes of this document,

- "MAID provider" refers to the physician or nurse practitioner who: administers medications that cause a patient's death, or who prescribes or provides medications for a patient to self-administer, after first assessing the patient and determining that the patient meets all of the eligibility criteria and safeguards.
- "MAID assessor" refers to the physician or nurse practitioner who assesses the patient and provides a written opinion confirming that the patient meets all of the eligibility criteria.[4]

Natural Death Reasonably Foreseeable	**Natural Death *Not* Reasonably Foreseeable**
Before MAID is provided by administering a substance that causes a patient's death, or prescribing or providing a substance for a patient to self-administer to cause their own death, the MAID provider must:	
1. Be of the opinion that the patient has met all of the eligibility criteria.	
2. Ensure that the patient's request for MAID was made in writing and signed and dated by the patient after the patient was informed that they have a grievous and irremediable medical condition.[5] If the patient is unable to sign and date the request, another person (i.e., a proxy) — who is at least 18 years of age, who understands the nature of the request for MAID and who does not know or believe that they are a beneficiary under the will of the patient, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death — may do so in the patient's presence, on the patient's behalf and under the patient's express direction.	
3. Be satisfied that the request for MAID was signed and dated before an independent witness who then also signed and dated the request.	

[3] For more information on the meaning of "reasonably foreseeable natural death", see the *Advice to the Profession: Medical Assistance in Dying* document.
[4] For clarity, MAID assessors also have a role to play in ensuring that the following safeguards are met before MAID is provided: 5, 6, and where applicable, 5.1, 8, and 9.
[5] The federal legislation does not require that a patient be informed that they have a grievous and irremediable medical condition in the context of an eligibility assessment for MAID (i.e., it does not have to be contemporaneous).

Natural Death Reasonably Foreseeable	Natural Death *Not* Reasonably Foreseeable
An independent witness is someone who is at least 18 years of age, and who understands the nature of the request for MAID. An individual may not act as an independent witness if they: • Know or believe that they are a beneficiary under the patient's will, or are a recipient in any other way of a financial or other material benefit resulting from the patient's death. • Were the proxy who signed and dated the patient's request.[6] • Own or operate any health care facility at which the patient making the request is being treated or any facility in which the patient resides. • Are directly involved in providing the patient health care services or personal care, unless they provide health care services or personal care as their primary occupation and are paid to provide that care to the patient (e.g., a personal support worker who is a paid employee). However, the MAID provider, MAID assessor, and the practitioner who provided a consultation in light of their expertise in the condition causing the patient's suffering may *not* act as an independent witness.	
4. Ensure that the patient has been informed that they may, at any time and in any manner, withdraw their request.	
5. Ensure that a MAID assessor assessed the patient and provided a written opinion confirming that the patient meets all of the eligibility criteria.	
	5.1 If neither the MAID provider nor the MAID assessor has expertise in the condition that is causing the patient's suffering, the MAID provider must ensure that they or the MAID assessor consult with a physician or nurse practitioner who has that expertise[7] and must share the results of that consultation with each other.

[6] A proxy cannot be an independent witness because the proxy cannot be a witness to their own signature.

[7] The federal government has clarified that the practitioner with expertise would not be assessing the patient's eligibility for MAID, but instead would provide information on the patient's status and options, including the reasonable and available services and/or treatment options that might relieve the patient's suffering.

<table>
<tr><th>Natural Death Reasonably Foreseeable</th><th>Natural Death Not Reasonably Foreseeable</th></tr>
<tr><td colspan="2">6. Be satisfied that they and the MAID assessor are independent from each other and from the patient.
The MAID provider and MAID assessor are independent if they:
• Are not a mentor to the other, or responsible for supervising the other's work;
• Do not know or believe that they are a beneficiary under the will of the patient making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that patient's death, other than standard compensation for their services relating to the request; and
• Do not know or believe that they are connected to each other or to the patient making the request in any other way that would affect their objectivity.</td></tr>
<tr><td></td><td>7. Ensure that the patient has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care.</td></tr>
<tr><td></td><td>8. Ensure that they and the MAID assessor have discussed with the patient the reasonable and available means to relieve the patient's suffering and they both agree with the patient that the patient has given serious consideration to those means.</td></tr>
<tr><td></td><td>9. Ensure that there are at least 90 clear days[8] between the day of the first eligibility assessment for MAID and the date MAID is provided or — if the assessments have been completed and they and the MAID assessor are both of the opinion that the loss of the patient's capacity to provide consent</td></tr>
</table>

[8] The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day.

Natural Death Reasonably Foreseeable	Natural Death *Not* Reasonably Foreseeable
	to receive MAID is imminent — any shorter period that they consider appropriate in the circumstances.
10. If the patient has difficulty communicating, take all necessary measures to provide a reliable means by which the patient may understand the information that is provided to them and communicate their decision.	
11. Give the patient an opportunity to withdraw their request immediately before providing MAID and ensure that the patient gives express consent to receive MAID.[9]	

Final Consent – Waiver

Patients whose natural death is reasonably foreseeable have the option of entering into a written arrangement with the MAID provider, waiving the requirement that they give express consent immediately before receiving MAID, in the event they lose capacity to consent.

MAID can only be administered without meeting the requirement for final express consent set out in safeguard (11) if the patient's natural death is reasonably foreseeable and:

a. before the patient lost capacity to consent to MAID:
   (i) the patient met the eligibility criteria and all safeguards relevant for patients whose natural death is reasonably foreseeable;
   (ii) the patient and the MAID provider entered into a written arrangement that the provider would administer MAID on a specified day;
   (iii) the patient was informed by the MAID provider of the risk of losing the capacity to consent to receive MAID prior to the day specified in the written arrangement; and
   (iv) the written arrangement provides the patient's consent for the provider to administer MAID on or before the day specified in the arrangement if they lose their capacity to consent prior to that day;
b. the patient has lost the capacity to consent to receiving MAID;

[9] See *Final Consent – Waiver* and *Advance Consent – Self-Administration* sections below for exceptions.

c. the patient does not demonstrate, by words, sounds or gestures, refusal to have the substance administered or resistance to its administration; [10, 11] and

d. the MAID provider administers MAID for the patient in accordance with the terms of the written arrangement.

Advance Consent – Self Administration

Patients who choose to self-administer MAID have the option of entering into a written arrangement with a MAID provider, permitting the MAID provider to intervene to administer MAID if self-administration does not result in death within a specified period and the patient loses capacity to consent after attempting self-administration.

Advance arrangements relating to self-administration are available regardless of whether the patient's natural death is reasonably foreseeable.

MAID can only be provided to a patient who has unsuccessfully attempted self-administration, and who has lost capacity to consent, without meeting the requirement for final express consent set out in safeguard (11) if:

a. before the patient lost their capacity to consent to receive MAID, the patient and MAID provider entered into a written arrangement that:

   (i) states the MAID provider will be present when the patient is self-administering MAID;

   (ii) provides consent for the MAID provider to administer a second substance causing death if self-administration fails, i.e., if the patient does not die within a specified period and loses their capacity to consent; and

   (iii) specifies the time period after which the MAID provider may administer the second substance, if self-administration fails;

b. the patient loses capacity after self-administering MAID and does not die within the time period specified in the written arrangement; and

c. the MAID provider administers MAID for the patient in accordance with the terms of the written arrangement.

[10] Involuntary words, sounds or gestures made in response to contact do not constitute a demonstration of refusal or resistance.

[11] Once the patient demonstrates, by words, sounds or gestures refusal or resistance, MAID can no longer be provided on the basis of the patient's consent in the written arrangement.

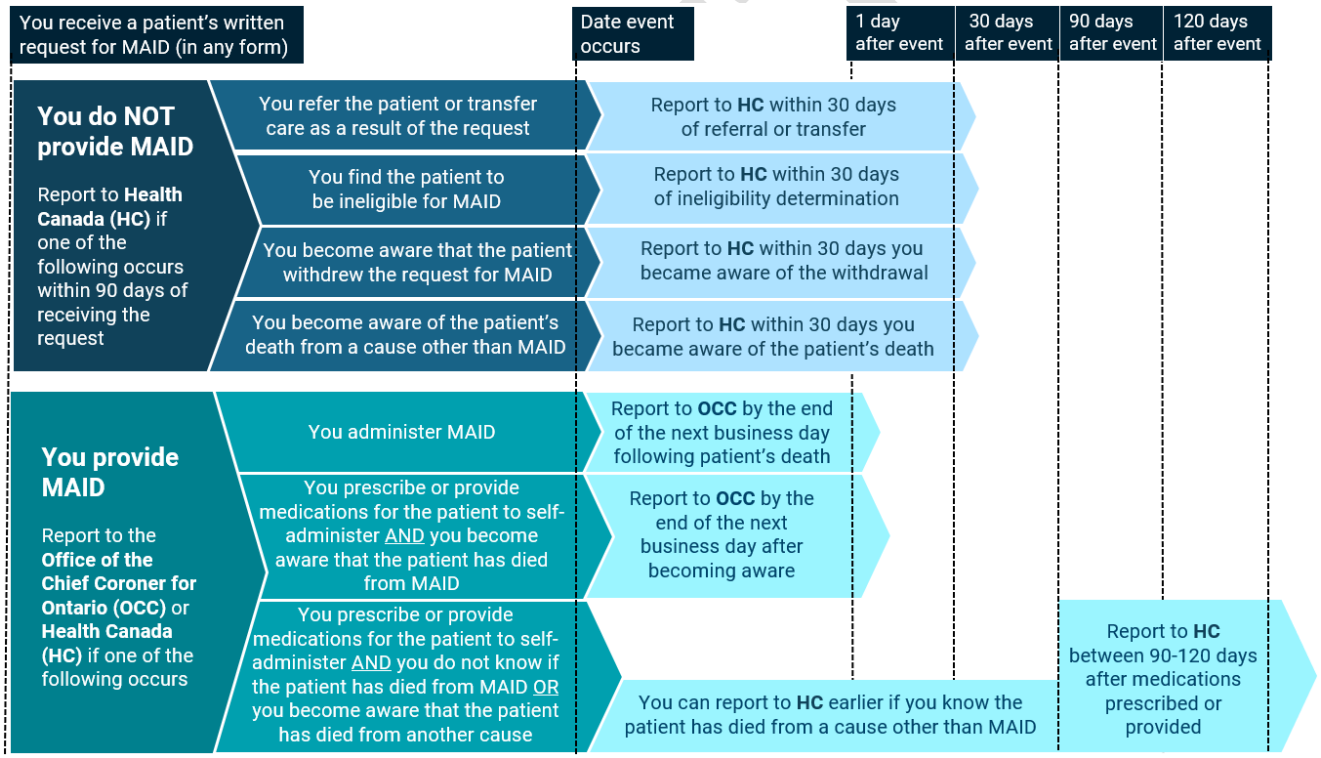
Providing MAID

MAID must be provided with reasonable knowledge, care, and skill and in accordance with any applicable provincial laws, rules, or standards.

Before any pharmacist dispenses a substance for MAID, the MAID provider must inform the pharmacist that the substance is intended for MAID.

Reporting MAID

Physicians are required to report in the following circumstances:



Reporting to Health Canada

The written request for MAID that triggers reporting requirements to Health Canada can be made in any in any form, including email or text message. It does not have to be the formal signed and witnessed request required under the *Criminal Code*.

Health Canada has stated that physicians are never required to actively seek out information regarding whether the patient has withdrawn their request for MAID or has died.

Physicians are required to use the Canadian MAID Data Collection Portal to make their report to Health Canada.

Reporting to the Office of the Chief Coroner for Ontario (OCC)

The OCC requires that physicians complete the relevant Clinician Aid (B for physicians who provide MAID or C for physicians who conduct an eligibility assessment) and where applicable, provide Clinician Aid C to the MAID provider so that they can fulfil their reporting obligations to the OCC following the provision of MAID.

After confirming or becoming aware that the patient has died, MAID providers are required to notify the OCC by completing and electronically submitting the prescribed form (add link) by the end of the next business day. In some circumstances, the OCC may request a copy of the patient's medical record and MAID providers are required to provide it.[12]

[12] MAID providers are required to provide the OCC with information about the facts and circumstances related to the MAID death that the OCC considers necessary to form an opinion as to whether the death ought to be investigated.

ADVICE TO THE PROFESSION: MEDICAL ASSISTANCE IN DYING

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

The *Medical Assistance in Dying (MAID)* policy sets out physicians' professional obligations regarding MAID and the *MAID: Legal Requirements* companion resource sets out the key legal obligations physicians have. This companion *Advice to the Profession* document provides additional information and guidance regarding the following: 1) interpreting/applying physicians' obligations; 2) tools/resources for physicians; and 3) information/resources for patients/caregivers.

1) Interpreting/Applying Physicians' Obligations

For the purposes of this section,

- "MAID provider" refers to the physician or nurse practitioner who: administers medications that cause a patient's death, or who prescribes or provides medications for a patient to self-administer, after first assessing the patient and determining that the patient meets all of the eligibility criteria and safeguards.
- "MAID assessor" refers to the physician or nurse practitioner who assesses the patient and provides a written opinion confirming that the patient meets all of the eligibility criteria.

When and how do I discuss MAID with patients?

Physicians will have to use their professional judgment to determine if, when, and how to discuss MAID with their patients. The Canadian Association of MAID Assessors and Providers (CAMAP) has a clinical guidance document on Bringing up MAID as a clinical care option, which includes the following:

- The appropriate timing of discussions regarding MAID is determined by the clinical context and the specific circumstances of the patient.
- When discussing MAID as a treatment option, be aware of the physician-patient power dynamic and ensure MAID is presented as *one* of the treatment options, and not as a coercive recommendation to pursue that option.
- It is important to approach discussions regarding MAID from a place of respect and trust and allow for sufficient time to have such sensitive conversations.

Also, the Centre for Effective Practice provides some guidance on how to navigate a patient's request for MAID, including the importance of carefully exploring and understanding the patient's suffering, as well as the psychosocial or non-medical conditions and circumstances that may be motivating the patient's request.

Are uninsured patients eligible for MAID? Can I charge patients for the activities involved in assessing patients for and/or providing MAID?

No. Only patients who are eligible for health services funded by a government in Canada can be eligible for MAID. As the activities involved in assessing patients for and/or providing MAID are publicly insured services for publicly insured patients, MAID providers/assessors are not able to charge patients for these activities.

What is a grievous and irremediable medical condition?

A patient must have a grievous and irremediable medical condition to be eligible for MAID. As set out in the *Criminal Code*, a patient has a grievous and irremediable medical condition if:

i. They have a serious and incurable illness, disease, or disability that is not a mental illness;

ii. They are in an advanced state of irreversible decline in capability; and

iii. That illness, disease, or disability, or that state of decline, causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable.

The federal government has clarified that "incurable" should be interpreted as including the limitation "by any means acceptable to the patient".

Also, the federal government has clarified that a patient can be in an advanced state of irreversible decline in capability in general terms, while still having moments of slight improvement. The loss of capability can be sudden or gradual, and ongoing or stabilized.

What if I'm not sure if a patient meets the eligibility criteria, or if I find a patient is ineligible for MAID?

In some cases, it may be difficult to determine whether the patient is eligible for MAID and MAID providers/assessors may wish to consider discussing the case with another physician or health care professional[1] to help them make that determination. However, you would need to form your own professional opinion regarding the patient's eligibility

[1] If the discussion includes sharing the patient's personal health information, the patient would need to provide express consent for the physician to disclose that information to a physician or health care professional who is outside of the circle of care. See the College's *Protecting Personal Health Information* policy for more information.

and take sole responsibility for that determination if you are the MAID provider/assessor.

If you are not able to form your own opinion regarding whether the patient meets the eligibility criteria or if you conclude that a patient does not meet the eligibility criteria for MAID, you will need to clearly and sensitively communicate this information to the patient as soon as is reasonable. You may wish to inform the patient that they are entitled to make a request for MAID to another MAID provider/assessor, who would reassess the patient using the eligibility criteria. If the patient indicates that they would like to be reassessed, you will need to consider whether the patient requires any assistance finding another MAID provider/assessor (e.g., by connecting them with the Care Coordination Service).

In addition to the documentation requirements set out in the policy, it may be prudent for physicians to note whether they discussed the case with another physician or nurse practitioner in making their determination, along with any discussions they had with the patient and/or any subsequent steps they took to help the patient get reassessed in circumstances where physicians were not able to form an opinion or concluded the patient does not meet the eligibility criteria.

What if a patient does not want to tell their family and/or friends about their decision to pursue MAID or a patient's family and/or friends disagree with their choice to pursue MAID?

It can be very challenging to navigate these situations and when they arise, it is important to keep in mind that it is ultimately a capable patient's right to decide which clinically appropriate treatment options they pursue and who they want to share this decision with.

Can requests for MAID be made through an advance directive or the patient's substitute decision-maker? Is final express consent required immediately before MAID is provided?

All requests for MAID must be made directly by the patient and cannot be made through an advance directive or by the patient's substitute decision-maker. The *Criminal Code* specifies that MAID is available only to patients who are capable of making decisions with respect to their health.

Immediately before providing MAID, the MAID provider must give the patient an opportunity to withdraw the request, and if the patient wishes to proceed, confirm that the patient has provided express consent. This must occur either immediately before the medications are administered by the MAID provider, or immediately before the prescription or medications are provided to the patient for self-administration.

However, the recent legislative changes now permit patients to enter into a written arrangement that waives the requirement that the MAID provider obtain their final

express consent immediately prior to administering MAID in two circumstances, as described in the in the *MAID: Legal Requirements* companion resource.[2, 3]

Is it necessary for the MAID provider to be present when the patient is self-administering MAID?

The *Criminal Code* does not require that the MAID provider be present during self-administration unless they have entered into a written arrangement that permits them to provide MAID if the patient (1) does not die within a specified period after self-administering the medications, and (2) has lost capacity to provide consent.

Given the risk of potential complications with self-administration, including the possibility that death might not be achieved, the MAID provider may want to encourage the patient to include them among those present during the self-administration even if there is no written arrangement. However, the MAID provider will have to explain that if there is no written arrangement, they cannot intervene and administer a second round of medications causing death if self-administration is prolonged or fails unless the patient is capable and can provide consent immediately prior to the provider administering MAID.

Can MAID providers/assessors be independent and objective when mentorship is involved?

No. Mentorship refers to the guidance provided by a physician who is perceived to have greater relevant knowledge, wisdom, or experience ("mentor") to another physician or nurse practitioner who is perceived to have less ("mentee"), and mentorship occurs regardless of the frequency of the guidance provided and the formality of the relationship. In practice, mentorship runs the risk of introducing either the appearance of, or actual, bias or lack of objectivity into the mentee's ability to conduct an independent MAID assessment.

Given the above, it is clear that postgraduate medical trainees and their mentor or supervisor cannot be the only MAID assessors who confirm the patient is eligible for MAID because this would not meet the legal requirement for independence.

The Criminal Code requires that MAID providers/assessors are independent from the patient requesting MAID; that is, the MAID provider/assessor cannot know or believe that they are connected to the patient making the request in a manner that would affect their

[2] See Sections 241.2 (3.2)-(3.5) of the *Criminal Code* for more information. The federal government has provided guidance on implementing waivers of final consent on its MAID: Implementing the framework webpage.

[3] The Ministry of Health has developed Clinician Aids D-1 and D-2 for MAID providers and patients to use as templates for written arrangements.

objectivity. How do I determine if the relationship I have with a patient or individual affects my objectivity?

MAID providers/assessors may want to consider the guidance on evaluating the nature of personal or close relationships set out in the College's *Advice to the Profession: Physician Treatment of Self, Family Members, or Other Close to Them* document. If the MAID provider/assessor believes that the nature of their relationship with the patient or individual would reasonably affect their emotional and/or clinical objectivity, they would not meet the independence requirement set out in the *Criminal Code*.

The applicability of some of the safeguards for MAID depend on whether the patient's natural death is reasonably foreseeable. How do I determine this?

The recent legislative changes have not altered the meaning of "reasonably foreseeable natural death". MAID providers/assessors can continue to rely on the guidance previously provided by the federal government and court to inform their assessment of whether a patient's natural death is reasonably foreseeable and therefore which procedural safeguards apply.

The guidance provided by the federal government includes the following:

- "Reasonably foreseeable natural death" requires a temporal, but flexible, connection between the patient's overall medical circumstances and their anticipated death.[4]
- A patient's condition does not have to be fatal or terminal for their natural death to be considered reasonably foreseeable.[5]
- "Reasonably foreseeable natural death" can result from a combination of multiple factors relevant to a patient's overall medical circumstances.[6]
- The nature of the illness causing the patient's intolerable and enduring suffering, and any other medical conditions or health-related factors such as age and/or frailty, are to be considered in assessing the patient's trajectory towards death. A patient's natural death is reasonably foreseeable if there is a real possibility of death, evidenced by the patient's irreversible decline, within a period of time that is foreseeable in the not-too-distant future.[7]

[4] Legislative Background: MAID (Bill C-14); and House of Commons Standing Committee on Justice and Human Rights – Bill C-7, An Act to amend the Criminal Code (MAID).
[5] Legislative Background: MAID (Bill C-14); and Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision.
[6] Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision.
[7] MAID: Glossary.

- It is important to acknowledge that anticipating how long a patient has to live is difficult, and clinical estimation of life expectancy becomes even more difficult the further away death is expected.[8]

The guidance previously provided by the Court[9] regarding the meaning of "reasonably foreseeable natural death" includes the following:

> "[...] *natural death need not be imminent and* […] *what is a reasonably foreseeable death is a person-specific medical question to be made without necessarily making, but not necessarily precluding, a prognosis of the remaining lifespan. Although it is impossible to imagine that this exercise of professional knowledge and judgment will ever be easy, in those cases where a prognosis can be made that death is imminent, then it may be easier to say that the natural death is reasonably foreseeable. Physicians, of course have considerable experience in making a prognosis, but the legislation makes it clear that in formulating an opinion, the physician need not opine about the specific length of time that the person requesting medical assistance in dying has remaining in his or her lifetime."*

Other guidance on the meaning of "reasonably foreseeable natural death" that MAID providers/assessors might find helpful includes:

- If the MAID provider/assessor can reasonably predict when *or* how the patient will die, then it is likely enough to establish that the patient will have a "reasonably foreseeable natural death".[10]

- If the patient expresses an intent to refuse treatments that would prolong their life and they will inevitably die without those treatments, then it is likely that the patient will meet the threshold for a "reasonably foreseeable natural death".[11]

Ultimately, MAID providers/assessors will have to use their professional judgement to determine whether the patient's natural death is reasonably foreseeable.

What does it mean to have "expertise" in the condition that is causing the patient's suffering? What role does this practitioner with "expertise" play?

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[8] Legislative Background: Bill C-7: Government of Canada's Legislative Response to the Superior Court of Québec Truchon Decision.

[9] *A.B. v. Canada (Attorney General)*, 2017 ONSC 3759.

[10] Canadian Association of MAID Assessors and Providers. Clinical Practice Guideline on Reasonably Foreseeable Natural Death; and Downie, J. and Chandler, J. (2018). Interpreting Canada's Medical Assistance in Dying Legislation.

[11] Canadian Association of MAID Assessors and Providers. Clinical Practice Guideline on Reasonably Foreseeable Natural Death. Expert evidence submitted in *Lamb v. Canada (Attorney General)* included that if Ms. Lamb indicated an intent to stop bilevel positive airway pressure (BiPaP) therapy, and refuse treatment when she next developed pneumonia, it is likely that she would be found to meet the threshold for having a reasonably foreseeable death…Most would consider it sufficient that she expresses certain intent to refuse treatment when this occurs, as she will inevitable develop a chest infection in the future.

The federal government has clarified that the expertise must be in the condition that is causing the patient the *greatest* suffering. In most cases, the condition that is causing the patient the greatest suffering will be the serious and incurable illness, disease, or disability; however, it can also be:

- Their state of advanced decline in capability.
- Their generalized pain associated with their multiple morbidities.
- A broader concept involving psychological, existential, or psychosocial suffering that flows from their state of decline *or* illness, disease, or disability.

Furthermore, a practitioner does not need to have a specialty designation or certification in order to be considered to have expertise in the patient's condition. Expertise regarding the condition could be obtained through education and training or experience (e.g., treating patients with a similar condition). It is possible that a family physician could be considered to have the necessary expertise if the condition causing the patient's unbearable suffering is within their scope of practice, and they have the knowledge, skill, and judgment to treat that condition, including being aware of reasonable and available treatments that may relieve that suffering.

If consultation with a practitioner with expertise is required (because neither the MAID provider nor the MAID assessor have expertise in the condition causing the patient's greatest suffering), the federal government has clarified that the practitioner with expertise would not be assessing the patient's eligibility for MAID. Instead, they would conduct a thorough assessment of the patient's status and treatment options, and provide advice regarding the reasonable and available services and/or treatment options that might relieve the patient's suffering. This may include advising on the nature or stage of the patient's condition or on the status of the patient's state of decline based on their knowledge of the trajectory associated with the condition. The information provided by the practitioner with expertise enables the MAID provider and MAID assessor to complete a fully informed assessment of the patient.

The federal government has also advised that the assessment information will need to be provided by the practitioner with expertise in writing, so both the MAID provider and MAID assessor will have access to it in its entirety.

What steps do I have to take to inform the patient of the means available to relieve their suffering? How do I know if the patient has "given serious consideration" to the reasonable and available means to relieve their suffering?

For patients whose natural death is not reasonably foreseeable, the *Criminal Code* requires that MAID providers inform patients of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care. Patients must be

offered consultations with relevant professionals who provide those services or that care. Both the MAID provider and MAID assessor must discuss these options with the patient and agree that the patient has given serious consideration to the reasonable and available means to relieve their suffering.

The federal government has clarified that the MAID provider is responsible for providing the patient with a description of the reasonable and available services and/or treatments and their potential impact, and giving the patient the opportunity to speak with relevant professionals who provide these services and/or treatments.

The federal government has noted that the legislation does not specify a timeline within which the referral to these services and/or treatment must take place. If the patient expresses interest in accessing services and/or treatments which may relieve their suffering, but it will take significant time and/or or resources to access them, the federal government advises MAID providers to take great care in assessing whether the patient's request for MAID is informed and voluntary if they proceed with MAID as a result of the barriers to obtaining those other services and/or treatments.

Ultimately, MAID providers and MAID assessors will need to use their professional judgement to determine whether they agree that the patient has "given serious consideration" to the reasonable and available means to relieve their suffering. In doing so, MAID providers/assessors may want to consider asking the patient about their thought process (e.g., which services and/or treatments they considered, what they learned about each service or treatment including the expected risks and benefits, whether they can appreciate the reasonably foreseeable consequences of accessing each service or treatment, etc.). The federal government has clarified that the patient is not required to have tried the services and/or treatment.

How is "90 clear days between the date of the first eligibility assessment for MAID and the date MAID is provided" calculated?

The federal government has clarified that the 90-day assessment period begins on the day the patient starts to undergo their first MAID eligibility assessment (e.g., the day on which the MAID provider/assessor first considers or reflects on information that forms part of a MAID assessment, such as reviewing the patient's file or meeting with the patient).

Can assessments of patient eligibility or witnessing of patient requests for MAID be done virtually, or do they need to be done in person? Can other elements of the MAID process be done virtually?

The *Criminal Code* is silent on whether elements of the MAID process can be done virtually. That said, the Ontario government has indicated that virtual care technology can be used to assess a patient's request for MAID.

The College acknowledges that virtual care may be used to conduct patient eligibility assessments, witness requests for MAID, and for other aspects of the MAID process (e.g., consultations with practitioners who have expertise in the condition causing the patient's suffering, written arrangements for waiver of final consent, etc.) in the same circumstances this technology is used for all health care: when physicians can satisfy all their legal and professional obligations.

As with virtual care in general, MAID providers/assessors must contemplate the appropriateness of using this modality on a case-by-case basis, ensuring they can meet their legal and professional obligations as set out in the College's *Virtual Care* policy. Using virtual care for MAID may introduce risks that need to be mitigated in order to ensure compliance with the *Criminal Code* (e.g., ensuring voluntariness) and physicians' professional obligations. In addition to using their professional judgment, MAID providers/assessors may want to review any resources that have been developed to support these practices.

If a patient is found to be eligible for MAID but withdraws their request and then subsequently changes their mind and wants to receive MAID, do they have to restart the process and make a new request for MAID, or is the initial request still valid?

The *Criminal Code* is silent on the validity of withdrawn requests and the federal government has not provided guidance on this issue. As such, the College cannot comment on whether a withdrawn request is still valid or whether the process must be restarted. However, the College can suggest some factors that MAID providers/assessors may want to consider if the patient withdraws their request for MAID and subsequently wants to pursue MAID again:

- the reasons why the patient changed their mind (e.g., whether their symptoms are no longer being managed);
- whether the patient has voluntarily changed their mind (e.g., they made the decision freely, without undue influence from external pressures); and
- whether there are any changes to the patient's capacity to consent to MAID.

Do after-death plans need to be in place when MAID is administered in community settings?

Yes. It is important for MAID providers to confirm that there is an after-death plan in place for their patients. Where MAID providers are developing or contributing to the after-death plan, it would be prudent for them to consider the patient's circumstances, including their racial/ethnic/cultural background, values, beliefs, worldview, etc., along with any specific needs they may have. The plan may include, but is not limited to, any of the following: removal of the patient's body; ethnic, cultural, or spiritual rituals, ceremonies, or practices at the end-of-life; supporting the patient's family and/or

friends; reporting the death to the Office of the Chief Coroner for Ontario; and/or completing the medical certificate of death, where necessary.

I am a primary care provider and my patient is exploring MAID with another physician or nurse practitioner. What are my obligations to this patient?

Patients may still require comprehensive care, including managing the symptoms that have led to their desire to explore MAID, and you have an obligation to ensure that continuity of care is provided unless the physician-patient relationship has formally ended. If the patient's natural death is not reasonably foreseeable, the MAID provider/assessor who is exploring MAID with the patient may also need your assistance to treat the patient's suffering by means other than MAID.

2) Tools/Resources for Physicians

Please note: the list of tools/resources below is not exhaustive.

Exploring the Patient's Goals, Values, and Wishes:

- Serious Illness Conversation Guide: To help clinicians talk to seriously ill patients about their goals, values, and wishes.

Assessing the Patient's Medical Condition:

- Clinical Frailty Scale: To summarize the overall level of fitness or frailty of an older adult.
- ePrognosis: A repository of published geriatric prognostic indices where clinicians can go to obtain evidence-based information on patients' prognosis.

Assessing the Patient's Capacity:

- Aid to Capacity Evaluation (ACE): Helps to systematically evaluate capacity when a patient is facing a medical decision
- NICE Capacity and Consent Tool: Consent to Treatment and Decisional Mental Capacity and Capacity Assessment

Assessing the Patient's Vulnerability:

- Assessing Vulnerability in a System for Physician-Assisted Death in Canada
- Vulnerable Persons Standard

Process Maps for MAID:

- Process Map: Natural death is reasonably foreseeable
- Process Map: Natural death is NOT reasonably foreseeable

Legislation/Regulations, Government, and Organizations:

- *Criminal Code*, R.S.C., 1985, c. C-46
- *Regulations for the Monitoring of Medical Assistance in Dying*, SOR/2018-166
- *Coroners Act*, R.S.O. 1990, c. C.37
- Government of Canada
- Government of Canada, MAID: Implementing the framework – for healthcare providers
- Government of Canada, Department of Justice
- Ministry of Health
- Clinician Registration for the Care Co-ordination Service (CCS) for MAID
- Canadian Association of MAID Assessors and Providers (CAMAP)
- Dying with Dignity

Educational/Professional Development Resources for MAID:

- Canadian Medical Association, Online Course (*Please note: requires CMA login*)
- Centre for Effective Practice
- University of Toronto, Postgraduate Medical Education

3) Information/Resources for Patients/Caregivers

Patients looking for information regarding MAID or assistance in accessing MAID can contact the Care Coordination Service (CCS). The CCS was established by the provincial government to help connect patients with willing providers of MAID-related services.

Patients may contact the CCS directly to receive information about end-of-life options in Ontario, including information about hospice care, other palliative care options in their communities, and MAID. Patients can also call the CCS to request to be connected to a MAID provider/assessor. The CCS can be reached toll free by calling 1-866-286-4023.

Resources for Patients/Caregivers (*Please note: this list is not exhaustive*):

- Health Canada: This website provides information for patients on obtaining MAID.
- Ministry of Health: This document provides information for patients on MAID.

- Dying with Dignity: This national human-rights charity is committed to improving the quality of dying, protecting end-of-life rights, and helping Canadians avoid unwanted suffering.
- Understanding MAID: For Individuals and Families: This booklet outlines key information on process and guidelines and answers common questions.
- Medical Assistance in Dying Q&A: This infographic answers five of the most common questions.
- 10 Myths about MAID: This infographic demystifies 10 common myths.
- Bridge C-14: This network helps individuals build meaningful connections of support through all stages of assisted death.
- Bridge 4 You: This organization provides compassionate "lived experience", support and connection, to family members and friends as they help their loved one who is considering or planning for MAID.
- Grief and MAID: This module on MyGrief.ca supports people grieving a death with MAID or an anticipated MAID death.
- Bereaved Families of Ontario: This organization's affiliates provide a safe, non-judgmental environment for families to discuss their experiences and learn about grief with others who have been there.

Council Motion

Motion Title	*Medical Assistance in Dying* – Draft Policy for Consultation
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft policy, "Medical Assistance in Dying", (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

September 2022

Topic:	Council Self-Assessment
Purpose:	For Decision
Relevance to Strategic Plan:	Continuous Improvement
Public Interest Rationale:	Reflective of good governance practices, Council conducts an annual self-assessment to identify strengths and areas of improving its effectiveness so that it can better fulfill its mandate to serve and protect the public interest.
Main Contacts:	Cameo Allan, Manager of Governance
Attachment:	Appendix A: Proposed Council Self-Assessment Appendix B: 1:1 Interview Questions

Issue

- Council is asked to approve the revised Council Self-Assessment model to replace the current Board Self-Assessment tool.

Background

- Council has been conducting annual performance assessments since 2004 and has used the results to identify areas of improvement and inform governance, education and orientation.

- Reflective of good governance practices, in 2020, the Executive Committee chose to use a Board Self-Assessment Tool for Not-For-Profit Organizations that was developed by the Ontario Hospital Association.

- Council members received a checklist of current governance practices and policies and were asked to refer to this information while completing the Council Annual Self-Assessment survey.

- At the March 2022 meeting of Council, the 2021 Self-Assessment survey results were presented. A discussion took place regarding the survey's suitability for Council given it was not developed for the specific context in which the College operates. Feedback was provided to Governance staff with regards to how to improve the suitability of the survey.

Current Status and Analysis

- Following the 2021 Council Self-Assessment process, the Governance Committee was engaged in a discussion to both evaluate the current approach and provide recommendations for modernizing the evaluation process.
    - In March 2022, the Governance Committee provided feedback that the current survey tool was no longer fit for purpose as it did not reflect the evolution and maturation of Council, nor did it provide the right opportunity for meaningful engagement in the evaluation process.
    - At that time, the Governance Committee provided suggestions that included exploring a mix of self-reflection, 1:1 discussions, and broader Council level discussions or engagement sessions.
    - Subsequently, in May 2022 the Governance Committee was invited to weigh in on a verbal update regarding the new proposed approach. More specifically, moving towards a multi-modal approach that includes a mix of activities building towards a robust engagement session at the Annual General Meeting of Council.
    - Finally, the proposed approach was presented for approval to the Governance Committee at the July 2022 meeting.
- Lastly, the proposed evaluation approach was presented for approval to the Executive Committee at the August 2022 meeting.
- As per feedback provided by the Governance Committee and Executive Committee, a Council Self-Assessment process has been developed and is outlined in Appendix A.
    - The 2022 Self-Assessment process will launch with optional semi-structured 1:1 interviews between Council Members and the President and Chair of Governance. Appendix B outlines the discussion questions for the 1:1 interviews.
    - Subsequently, at the Annual General Meeting of Council a multi-faceted engagement activity will be undertaken to identify areas of success and areas for improvement through a mix of facilitated, small group, and interactive polling exercises.

Next Steps

- Pending Council's approval, the process will commence in the fall with the 1:1 interview process followed by an engagement session at the Annual General Meeting of Council.

Question for Council

1. Does Council approve the refined Council Self-Assessment process?

Appendix A: Revised Council Self-Assessment

Optional Pre-Council Interviews

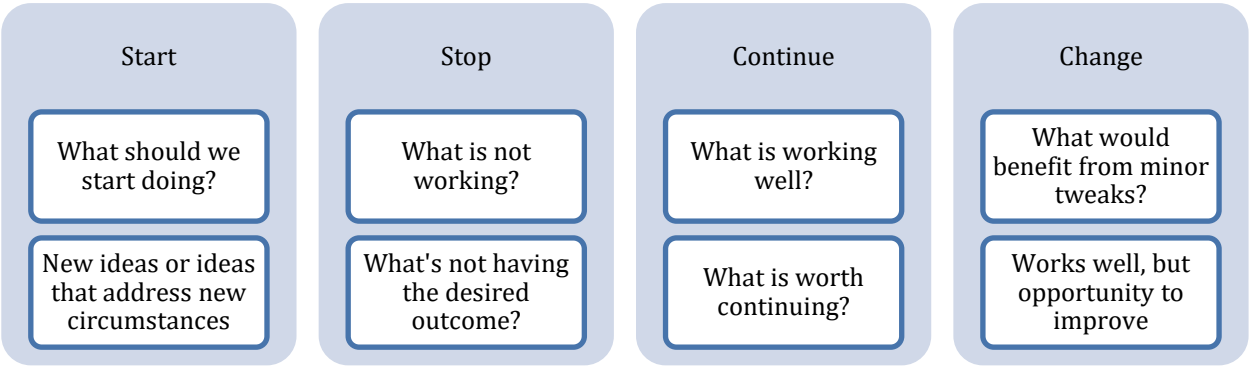
Prior to December Council evaluation, in the latter half of the calendar year, the Council President and Chair of Governance will undertake optional 1:1 meetings with all Council members to collect feedback. These discussions will be guided by a standard interview guide with two or three pre-determined questions to improve the reliability of the qualitative data collection. The focus of these interviews will be on getting feedback on how the Council is operating and where there might be areas of improvement. The results of the interviews will be aggregated and used to identify areas of improvement.

Council Self-Assessment Components

The proposed evaluation will take place in three parts during the in-camera portion of the December meeting of Council. The format and questions will be shared in advance of the meeting to ensure members of Council have adequate time to prepare and contribute to the discussion.

Part 1: Start, Stop, Continue, Change

- Independent feedback exercise, written feedback collected.
- Council members asked to answer each 'Start, Stop, Continue, Change' and submit their feedback around how Council has operated in the past year.
- Results will be used to inform subsequent year Council planning.



Part 2: Break Out Groups

- Break out into six groups of five or six and one group of four (based on the number of Council members present at the meeting)
- The groups will be pre-determined to ensure a mix of both physician and public members
- Each breakout group will be assigned one of the evaluation domains to discuss and rate using the domains and the 5-point scale (strongly agree – strongly disagree) from the 2021 Council Self-Assessment Survey:
    - Performing Board Roles
    - Board Role & Management Relationship
    - Board Quality
    - Board Structure
    - Meeting Processes
    - Overall Board Functioning
    - Individual Director's Functioning
- Each group will assign a speaker to present their rating and rationale to the rest of Council

Part 3: Clicker Exercise

- After the group has presented their rating of the assigned domain, all members of Council will be asked to indicate their agreement or disagreement with the group's evaluation.
    - E.g. Do you agree with the group's assessment of domain 1.1
- Results of the clicker exercise will be displayed using a polling tool and discussion amongst Council will be facilitated in cases where there is a misalignment with a group's rating
- The two lowest performing domains will be the areas of focus for the subsequent year of Council

Appendix B: 1:1 Interview Questions

Memorandum

Subject: **Council Interviews - 2022**

There are clearly identified governance modernization changes that have been identified and articulated by Council (i.e., reducing the size of Council etc.). However, the purpose of the questions below is to focus on enhancements that could be achieved within the current framework in which Council operates. Please keep this in mind when answering the below questions.

1) Is there anything about your experience on Council this past year that stands out (positively or negatively)?

2) Does Council strike the right balance in terms of oversight vs. operations? (living the 'why' not the 'how')

3) Do you get enough support for your work at the College and on Council?

Council Motion

Motion Title	Council Self-Assessment
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised Council Self-Assessment process, (a copy of which forms Appendix " " to the minutes of this meeting).

Council Briefing Note

September 2022

Topic:	Executive Committee Elections
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Accountability: Ensuring appropriate governance of the CPSO through elections of the Executive Committee.
Main Contacts:	Dr. Judith Plante, Chair, Governance Committee Cameo Allan, Manager of Governance Laura Rinke-Vanderwoude, Governance Analyst
Attachment:	Appendix A: Nomination Statements

Issue

- There are upcoming vacancies for the President, Vice President, and Executive Member Representative positions on the Executive Committee for 2023. A vote will take place at the September 22 and 23 meeting of Council to fill these vacancies.

Background

- The Executive Committee's current composition includes:
  - Dr. Janet van Vlymen, President
  - Dr. Robert Gratton, Vice President
  - Mr. Peter Pielsticker, Executive Member Representative
  - Ms. Joan Fisk, Executive Member Representative
  - Dr. Ian Preyra, Executive Member Representative
  - Dr. Judith Plante, Past President

Current Status and Analysis

- Nomination statements for the vacant positions have been received from:
    - Dr. Robert Gratton, for President
    - Dr. Ian Preyra, for Vice President or, alternatively, Executive Member Representative
    - Ms. Joan Fisk, for Executive Member Representative
    - Dr. Lydia Miljan (PhD), for Executive Member Representative
    - Mr. Peter Pielsticker, for Executive Member Representative
    - Dr. Sarah Reid, for Executive Member Representative.
- Nominations from the floor are permitted.
- All nominees will be given the opportunity to address Council prior to the election.
- Where there is only one candidate for a position, the candidates will be acclaimed. Where there is more than one candidate for a position, an election will be held using an electronic voting software that facilitates secret ballot voting (ElectionBuddy). All Council members must have access to their CPSO Email during the voting period to access the voting link.
- As per the General By-Law, the term for Executive Committee members is one year. Dr. Janet van Vlymen will serve as past president for the 2023 Executive Committee.

Question for Council

1. Who does Council elect as the 2022-2023 Executive Committee President, Vice President, and three Executive Member Representative positions?

Executive Committee Elections

Nomination Statement Package

Dr. Rob Gratton, District 2 Representative (London, ON)

Principal area of practice: Obstetrics and Gynecology

Nominated For:

President

Appointed Council Terms:

2016-2019
2019-2022
2022-2025

CPSO Involvement:

Executive Committee	2020-Present
Governance Committee	2021-Present
Finance & Audit Committee	2018-Present Vice-Chair, 2020-Present
Policy Working Group: Medical Records	2018-Present
Inquiries, Complaints & Reports Committee	2015-Present Specialty Panel Chair, Obstetrics, 2019-2021

Nomination Statement:

Thank you for considering my candidacy for President. I have served on the Executive Committee for 2 years and as Vice President for the last year. I have been on Council since 2016 and will begin my third term in December 2022. I have 7 years of experience on the complaints/investigation side of the college. I gained a much broader understanding of the College while serving on Council, the Finance and Audit committee, the Executive committee and the Governance committee.

In my clinical work, I am the Director of Maternal Fetal Medicine at London Health Sciences Centre and an Associate Professor at Western University. I have served as Chief of Obstetrics and held leadership roles in undergraduate and postgraduate medical education. My academic interest is in quality of care and patient safety.

This next year will be another challenging one but also one with exciting opportunities. Building on our substantial modernization, we will to continue to govern such that we contribute to the restoration of the public's confidence in the health care system. While keeping our regulatory mandate central, we will need to continue to show a strong message of support and guidance to the profession.

Executive Committee Elections

Nomination Statement Package

Dr. Ian Preyra, District 4 Representative (Burlington, ON)

Principal area of practice: Emergency Medicine

Nominated For:

Vice-President

Appointed Council Terms:

2019-2022
2022-2025

CPSO Involvement:

Governance Committee	2020-2021
Executive Committee	2021-Present
Finance & Audit Committee	2021-Present
Ontario Physicians and Surgeons Discipline Tribunal & Fitness to Practise Committee	2020-Present

Nomination Statement:

The last three years have been exciting ones for the College. The modernization of internal structures has allowed for streamlined operations that better serve both the public and our members. The environment in which we operate is a complex and dynamic one in which our interactions with external stakeholders have a profound impact on our ability to fulfil our mission of Trusted Doctors Providing Great Care. I've been fortunate to be a member of College committees that have played integral roles In moving this important work forward, including the Executive and Governance Committees. I have undertaken advanced training in Corporate Governance, and, if elected, I look forward to continuing to support and advance both operational and governance modernization. It has been a pleasure working with Dr. Whitmore and the Senior Team of the College, and I share their passion and commitment to effective, compassionate regulation which protects the public and advances the profession by supporting and promoting outstanding clinical practice and physician wellbeing. Our members are facing unprecedented levels of burnout and attrition, and the CPSO has an important role to play in building a healthy, sustainable community of Ontario physicians. Thank you in advance for your trust and support.

Executive Committee Elections

Nomination Statement Package

Dr. Sarah Reid, District 7 Representative (Ottawa, ON)

Principal area of practice: Pediatric Emergency Medicine

Nominated For:

Executive Member Representative

Appointed Council Terms:

2018-2021
2021-2024

CPSO Involvement:

Governance Committee	2021-2022
Quality Assurance Committee	2019-Present
Policy Working Group	2020-Present
Education Committee	2018-2019

Nomination Statement:

I am seeking to become Executive Member Representative because I am committed to upholding CPSO's vision of trusted doctors providing great care and now have the necessary experience through chairing two committees and serving on a third. In my role as a Pediatric Emergency Physician, I am also acutely aware of the profound strain that our system, patients, and providers are under.

I have been privileged to serve on Council since 2018 and was re-elected last year for a second term representing District 7. In addition to my work on Council, I am Chair of the Quality Assurance Committee and Policy Working Group, and member of the Governance Committee. My experience on QAC has afforded me a deeper understanding of the College's commitment to continuous improvement, right-touch regulation, and Quality Improvement. Policy development has provided me with an appreciation of our role in guiding the profession and integrating stakeholder feedback, legislation, best practices, and EDI principles. As a member of the Governance Committee, I have contributed to CPSO Council/committee composition, evaluation, and education.

My CPSO experience and clinical work make me an excellent candidate for the Executive Committee; to serve Ontarians as we support both system innovation and our members.

Executive Committee Elections

Nomination Statement Package

Dr. Lydia Miljan (PhD), Public Member of Council (Windsor)

Occupation: Professor, University of Windsor

Nominated For:

Executive Member Representative

Appointed Council Terms:

2020-2022
2022-2025

CPSO Involvement:

Governance Committee	2021-Present
Policy Working Group	2021-Present
Inquiries, Complaints & Reports Committee	2020-Present

Nomination Statement:

I have a varied and relevant work and volunteer experience that I believe would benefit the committee.

Professionally, I am a Professor of Political Science with over 20 years experience. My area of research is in Canadian public policy and political communication. I have been elected to my faculty association, having served on council, executive, and on the bargaining committee. I am on University Senate and been part of the Board of Governors committees on retirements, benefits, and investment.

Outside of academia I have also had executive relevant roles. For 9 years I was on the board of directors for the Council of Canadian Academies. In addition, I served on sub-committees including nominations and governance, and executive. Throughout these experiences I have used the many competencies required of the governance committee including communication, critical thinking, and decision-making. I am confident that my tenure on the ICRC committee, governance, and policy working group, has demonstrated my collegiality, teamwork, and meeting management.

Although I have no diversity attributes apart from gender, I have been interested in antiracism and anti-oppression and have taken steps to better educate myself on these issue by completing the Cultural Safety Training.

Executive Committee Elections

Nomination Statement Package

Mr. Peter Pielsticker, Public Member (Tehkummah, Ontario)

Occupation: Financial Consulting

Nominated For:

Executive Member Representative

Cumulative Council Term:

March 2015 – March 2024

CPSO Involvement:

Executive Committee	2019-Present
Policy Working Group	2020-Present
Finance & Audit Committee	Chair: 2017-2020 Member: 2015- 2017; 2021-Present
Staff Pension Committee	2017-2020
Quality Assurance Committee	2015-Present
Premises Inspection Committee	2015-Present
Ontario Physicians and Surgeons Discipline Tribunal & Fitness to Practise Committee	2015-Present

Nomination Statement:

I am seeking re election to the Executive Committee for 2023. This will be my last term as I will have reached term limits on my appointment to CPSO in the spring of 2024. Since joining CPSO in early 2015 I have been active on a variety of committees. For me this has been an exciting journey. I have experienced a breadth of opportunities, worked with some amazing people and hopefully have brought something meaningful to the table from time to time.

CPSO's role in our community is so critical and vital. Here, the only constant is change and through our leadership with our Registrar and CEO and with such a competent and committed Council we have led the way through some trying times. I would like to continue on the Executive Committee team and make whatever contribution I can to the furtherance of our Strategic Plan.

I am humbled by your past support and ask for your continued support one more time.

Executive Committee Elections

Nomination Statement Package

Ms. Joan Fisk, Public Member of Council

Chief Executive Officer

Nominated For:

Executive Member Representative

Appointed Council Terms:

Nov 2017 – Oct 2020
Nov 2020 – Nov 2023

CPSO Involvement:

Executive Committee	2020-Present
Inquiries, Reports & Complaints Committee	2017-Present General Panel Chair 2020-Present

Nomination Statement:

I would be honoured to receive the support of CPSO Council, to continue with my role on the Executive Committee.

My background is varied, with leadership in many roles, as part of my journey.

I believe I can continue to support the College with my Business and Governance experience.
I have enjoyed my 5 years as a member of Council, participating on ICRC Panel, and as a member of the Executive for the past 18 months.

The past 2 years have made many of us more reflective about our lives and futures and how we can be of service to the Health System that has been facing unprecedented pressure.

I would ask for your support to allow me to continue to be a member of the Executive Committee.

Joan Fisk

Council Motion

Motion Title	Executive Committee Elections
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario appoints
_____ (as President),

_____ (as Vice President),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

_____ (as Executive Member Representative),

And Dr. Janet van Vlymen (as Past President),

to the Executive Committee for the year that commences with the adjournment of the Annual General Meeting of Council in December 2022.

Item 12.2 Governance Committee Elections briefing materials pulled

Item 12.2 Governance Committee Elections briefing materials pulled

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Item 12.2 Governance Committee Elections briefing materials pulled

Council Briefing Note

September 2022

Topic:	2022-2023 Committee Appointments and Re-appointments
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation System Collaboration
Public Interest Rationale:	Ensuring that CPSO committees have qualified and diverse members will enable the College to carry out its strategic objectives and fulfill its mandate to serve in the public interest.
Main Contacts:	Dr. Judith Plante, Chair, Governance Committee Caitlin Ferguson, Governance Coordinator Cameo Allan, Manager of Governance

Issue

- The Governance and Executive Committee are making recommendations to Council for appointments and reappointments to fill Committee vacancies for the 2022-2023 year.

Background

- The Governance and Policy offices have worked together to modernize the recruitment process for committee appointments, including the introduction of a detailed, online application and a new screening process.

- The Governance office met with the leadership of six committees in early spring to identify recruitment needs for the coming year. Recruitment opened in mid-April for the specialties requested by committee leadership, as identified in the table below

-

Committee	Specialty Requested
Finance and Audit Committee	No recruitment needs identified
Inquiries, Complaints, and Reports Committee (ICRC)	One anesthesiologist
	One ophthalmologist
	One gynecologist
	Two psychiatrists
	Two to three family physicians

Patient Relations Committee	No recruitment needs identified
Premises Inspection Committee (PIC)	One ophthalmologist
	One plastic surgeon
Quality Assurance Committee (QAC)	One radiologist
	One internal medicine specialist
	One gynecologist
Registration Committee	No recruitment needs identified

Current Status and Analysis

- The current composition of all Committees can be found on the Committee Members page on the College website.
- The response to the Governance office's targeted recruitment efforts has been unprecedented. To date, more than 480 physicians have started an application, and 189 have completed their application.
    - The influx of applications combined with a more robust application process has led to increased resource expenditure in order to appropriately process and evaluate all candidates.
    - As a result, a prioritization process was undertaken to focus on appointments of greatest need and to deprioritize any appointments where uncertainty regarding need arose following the initial request.

Urgent Cross-Appointment – ICRC & PIC

- During succession planning discussions, the Premises Inspection Committee indicated an urgent need for an ophthalmologist that could begin hearing cases before the end of the year.
- As it has historically been difficult to recruit ophthalmologists for committee work, the Governance office focused their initial recruitment and screening efforts on applications received from this specialty.
- In further discussions with the Senior Management Team, it was noted that the workload for PIC members is significantly smaller than the workload for ICRC members.
- Cross-appointments to PIC for members of ICRC were recommended in order to provide a more balanced workload for committee members.
- Cross-appointment will provide additional benefits, including more committee experience and increased familiarity with committee processes due to regular exposure.

- After discussions with the legal team, it has been suggested that, although PIC originally requested one ophthalmologist, two ophthalmologists should be cross-appointed to ICRC and PIC. This way, if a conflict of interest arises and one of the members is unable to hear a particular case, the other can step in.

- The Governance and Executive Committees recommend the cross-appointment of Dr. George Beiko, the ophthalmologist currently serving on the ICRC, to the PIC. Dr. Beiko's term on PIC would begin at the September meeting of Council and end at the 2023 Annual General Meeting of Council, in order to align with the term he is currently serving on the ICRC.

New Cross-Appointment – ICRC & PIC

- Interviews have been completed for the cross-appointment of one additional ophthalmologist to ICRC and PIC. Interview feedback has been received from the Chair of the Governance Committee, current Committee Chairs and Vice-Chairs, and other support staff.

- The Governance and Executive Committees recommend the appointment of Dr. Michael Wan for a term beginning at the September meeting of Council and ending with the Annual General Meeting of Council in December 2024.

New Appointment – OPSDT & FTP

- Dr. Janet van Vlymen has expressed an interest in serving on the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) and the Fitness to Practice Committee (FTP). Mr. David Wright, the Chair of OPSDT and FTP, has confirmed his interest in having her join both OPSDT and FTP.

- As an Academic Representative on Council since 2016, Dr. van Vlymen must be re-appointed on a yearly basis, as per section 25 of the General By-Law. In addition, the Academic Advisory Committee must vote annually to select three Academic Representatives to be voting members of Council.

    - The Dean of Health Sciences at Queen's University has confirmed that she will re-appoint Dr. van Vlymen yearly until she reaches her Council term limit in December 2025.

    - As Past President for the 2022-2023 year, Dr. van Vlymen has been nominated by the Academic Advisory Committee to be a voting member of Council.

- The Governance and Executive Committees recommend the appointment of Dr. Janet van Vlymen to the OPSDT and FTP for a one-year term beginning immediately after the Annual General Meeting of Council in 2022, and ending at the Annual General Meeting of Council

in December 2023. Re-appointments will be considered based on the annual selection of Academic Representatives as voting members of Council.

Re-appointments of Existing Committee Members

- The committee members listed below have current appointments that will end at the Annual General Meeting of Council in December 2022.
- Committee Chairs have been canvassed to ensure that they would like the members to be re-appointed for a further term.
- The members have also been approached by their Chair or a member of the Governance Office to confirm that they would like to serve a subsequent term.
- Governance staff have verified that the members are eligible to serve the term(s) suggested without exceeding their term limit for the individual committee or their overall term limit for service on Council and committees.
- The Governance and Executive Committees recommend the following members for re-appointment:

Committee	Member Name	Term Length	End Date	Term Limit Date
Finance and Audit	Dr. Ian Preyra	3 years	December 2025	December 2030
	Mr. Peter Pielsticker	1 year	December 2023	March 30, 2024
Fitness to Practice	Dr. Heather-Ann Badalato	3 years	December 2025	December 2028
	Dr. Allan Kaplan			
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024	April 29, 2024[1]
Inquiries, Complaints, and Reports	Dr. Lydia Miljan (PhD)	3 years	December 2025	March 2029
	Dr. Trevor Bardell			December 2028
	Dr. Paula Cleiman			December 2028
	Dr. Karen Saperson			December 2028
Ontario Physicians and Surgeons Discipline Tribunal	Dr. Heather-Ann Badalato	3 years	December 2025	December 2028
	Dr. Allan Kaplan			

[1] Mr. Pielsticker's term limit on this committee occurs several days after his appointment as a public member ends. The proposed appointment length has been matched with the end date of his public member appointment, which occurs on March 30, 2024.

	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024	April 29, 2024[2]
Patient Relations	Ms. Sharon Rogers	3 years	December 2025	December 2028
	Dr. Diane Whitney			
Premises Inspection[3]	Dr. Robert Smyth	3 years	December 2025	December 2028

Next Steps

- Additional appointments will be presented to Council at its next meeting in December.

Questions for Council

1. Does Council recommend for appointment the individuals as laid out in this briefing note?
2. Does Council recommend for re-appointment the individuals as laid out in this briefing note?

[2] Ibid.
[3] Mr. Peter Pielsticker's re-appointment to the Premises Inspection Committee is being held back contingent on any decisions made with regard to this committee's composition requirements before his current term ends.

Council Motion

Motion Title	2022-2023 Committee Appointments and Re-appointments
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

1. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. George Beiko to the Premises Inspection Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2023; and,

2. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Michael Wan to the Inquiries, Complaints and Reports Committee and to the Premises Inspection Committee, effective immediately, with the term expiring at the close of the Annual General Meeting of Council in December 2024; and,

3. The Council of the College of Physicians and Surgeons of Ontario appoints Dr. Janet van Vlymen to the Ontario Physicians and Surgeons Discipline Tribunal and the Fitness to Practise Committee, for a term beginning at the close of the Annual General Meeting of Council in December 2022, and expiring at the close of the Annual General Meeting of Council in December 2023; and,

4. The Council of the College of Physicians and Surgeons of Ontario re-appoints the following individuals to the following Committees for the terms indicated below as of the close of the Annual General Meeting of Council in December 2022:

Committee	Member Name	Term Length	End Date
Finance and Audit	Dr. Ian Preyra	3 years	December 2025
	Mr. Peter Pielsticker	1 year	December 2023
Fitness to Practice	Dr. Heather-Ann Badalato	3 years	December 2025
	Dr. Allan Kaplan		
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024

Inquiries, Complaints, and Reports	Dr. Lydia Miljan (PhD)	3 years	December 2025
	Dr. Trevor Bardell		
	Dr. Paula Cleiman		
	Dr. Karen Saperson		
Ontario Physicians and Surgeons Discipline Tribunal	Dr. Heather-Ann Badalato	3 years	December 2025
	Dr. Allan Kaplan		
	Mr. Peter Pielsticker	1 year, 3 months, 21 days	March 30, 2024
Patient Relations	Ms. Sharon Rogers	3 years	December 2025
	Dr. Diane Whitney		
Premises Inspection	Dr. Robert Smyth	3 years	December 2025

Council Briefing Note

September 2022

Topic:	Premises Inspection Committee Public Member Update
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Meaningful Engagement
Public Interest Rationale:	Ensure appropriate governance of Committees and Advisory Groups
Main Contacts:	Laurie Reid, Director Investigations & Accreditation Cameo Allan, Manager of Governance Nathalie Novak, Chief Operating Officer Laura Rinke-Vanderwoude, Governance Analyst
Attachment:	Appendix A: Proposed PIC By-law amendments

Issue

- The Premises Inspection Committee (PIC) is undergoing governance modernization. As part of this modernization, staff recommend removing the requirement for public members to sit on the committee's panels for quorum to be met.

- Instead, public members may be asked to sit on panels as required by the content of materials to be considered.

Background

- PIC is a standing committee that administers and governs the College's Out-of-Hospital Premises (OHP) Inspection Program and was created in June 2009. It:

    - Ensures that adequate inspections and re-inspections are undertaken and completed in a timely manner;

    - Ensures that appropriate individuals are appointed to perform inspections and re-inspections; and,

  - Reviews premises inspection reports and determines whether premises pass, pass with conditions, or fail an inspection.

- In November 2009, Council approved a General By-law amendment to set the quorum requirement for the Committee, and requires at least one non-physician member be part of the quorum. That quorum requirement has remained unchanged in the by-law since it was implemented.

  - The briefing note presented to Council in November 2009 considered that the volume and requirements of PIC's work was still largely unknown at the time, and that these recommendations were largely for the Committee's initial composition to manage these unknowns effectively.

  - Materials indicate that it was preferable to have members on PIC that are familiar with the type of work happening at the facilities, and the three members should be picked according to that expertise. General surgeons, anesthesiologists, plastic surgeons, and modality specific practitioners were noted to be the groups who should be prioritized for PIC membership.

  - At the time, it was suggested in the briefing note that panels contain one physician and one public Council member. The historical rationale was that it was considered appropriate or valuable to have public representation on all committees. It was recommended these members come from the Out of Hospital Facilities (OHF) Council Working Group, which no longer exists.

  - Ultimately, Council approved a modified version of this proposal that required a public member (but not specifically any Council members) to sit on PIC. Originally, this requirement was filled by public members of Council, as contemplated in the proposal to Council. More recently, non-Council public members were appointed to help fulfill this by-law requirement to facilitate populating PIC panels and minimizing the additional regulatory burden on Public Members of Council.

- All College Committees are undergoing governance modernization. As part of this project, PIC's current governance structures were assessed, and recent changes were made to introduce 'specialty panels' similar in nature to those utilized by the Inquiries, Complaints, and Reports Committee (ICRC).

- Unlike statutory committees whose composition requirements are often set out explicitly in legislation (for example, ICRC), PIC is a creature of by-law. This means that the College may adjust its composition and quorum requirements through by-law amendments to meet the

Out of Hospital Premises Inspection Program's operational needs in service of the CPSO's public interest mandate.

Current Analysis

- Consideration has been given to whether it is necessary to include a member of the public on each PIC panel for the following reasons:
    - Public members of Council are a scarce resource that are legislatively required on several other committees. There is an interest in prioritizing their involvement on those committees over PIC and QAC, particularly to manage absences, vacancies, and sick leaves that further strain resources and leave some committees at risk of not meeting their legislative requirements.
    - Removing the by-law requirement for a public member to sit on every PIC panel enables scheduling flexibility for the committee and its members.
    - It is good governance to ensure that Council maintains the power to appoint members whom it feels are representative of the skills needed, rather than having additional non-legislative requirements for composition that may divert valuable resources.
- In addition, Council has consistently expressed a commitment to both ensuring separation of Council and member-specific committees by avoiding cross appointments between Council and Committees where it is not required; and,
- The program and committee are undergoing significant modernization for the first time since they were established in 2009. There has been learning about how the Committee can best function and oversee the work of the program. For example:
    - There is a greater understanding of PIC's day-to-day decision-making needs in regard to expertise and knowledge.
    - Experience operationally has shown that PIC is more similar in nature to the Quality Assurance Committee (QAC) than other statutory committees.
- Senior Program and Committee staff have worked with the governance team to evaluate the specific role and contributions of the public members of this committee. The findings indicate:

- The primary function of PIC and its panels is technical and clinical in nature, with less focus on broader issues of conduct, professionalism, or physician-patient relationship dynamics.

- Where significant areas of concern regarding physician conduct and practice outside the scope of OHP standards are identified, PIC is not charged with responsibility to adjudicate the conduct. Rather, they have the power to make referrals to ICRC as warranted for appropriate evaluation and determination and where public members play an essential role in the decision-making process.

- Notwithstanding the above, in line with the original reasoning for including public members in the quorum requirements, there may be a perceived value of balancing public members with physician members on the Committee in light of the College's mandate and the optics of having a committee be comprised solely of physicians.

- However, the similarities between QAC (which is not required to have public members by legislation) and PIC are greater than between committees like ICRC and the Registration Committee that are required to have a public member of Council on each panel, as explained below.

- In analyzing these findings, PIC's work contrasts with the work of ICRC and the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT). In these settings, public complaints and Registrar's investigations involve elements of care and conduct directly tied to the patient and public's experience. In this type of work, the perspective of a public member strongly and regularly benefits their work.

- The current public member requirements on PIC also are not consistent with the approach adopted for the Independent Health Facilities (IHF) inspection program, where IHF panels are comprised entirely of physicians and medical technologists recognizing the specialized knowledge required to opine on the inspection reports. In both cases, the recommendations and findings are more about correcting technical deficiencies and providing recommendations for the operation of a facility or the performance of a procedure.

- The standards PIC adheres to are set through policies at the Council level. This means that public members are also involved in developing the framework in which PIC operates. Between referrals to ICRC and the role of public members in setting policy at Council, the work of PIC can still be touched by a public perspective without a public decision-maker opinion on matters that require deep technical expertise.

- Given that public members are not commenting on physician care to protect the public interest and are involved in developing PIC's framework and setting policies at Council, it is proposed that changes to the by-law be made to allow PIC to function without public members being required for every panel.

Considerations

By-law Amendments

- A proposed amendment to the *General By-law* to remove the requirement for public members on panels is appended for Council's review.

- Of note, the amendment will largely align with the wording of PIC's quorum requirements with the wording of QAC's quorum requirements, which promotes consistency in the CPSO's by-laws in accordance with governance best practices.

Current Public Members

- The Chair and Vice-Chair of PIC have been engaged in a consultation regarding the proposed direction and generally support the proposal.

- Current public members on PIC have expressed the following regarding changes to the composition:

    - The by-law should not bar public members from serving on the committee and that the public perspective can offer a valuable contribution in some cases[1];

    - They feel adequately equipped to be part of the decision-making process; and,

    - Alternatively, additional non-Council public members could be recruited to the committee if a by-law change is not approved.

- There are currently three public members on PIC. Two are non-Council members, both first appointed in 2018 and expiring December 2023 (Mr. Ron Pratt and Dr. El-Tantawy Attia). There is only one Council public member on PIC (Mr. Peter Pielsticker), whose appointment ends in December 2022.

[1] The proposed by-law amendment would allow public members to be appointed to PIC, but would not require them to establish quorum for individual panels.

- PIC has been experiencing challenges with scheduling a Public Member on every panel. PIC would find current scheduling challenges substantially reduced by changing the by-law requirements to not require a Public Member's participation on every panel.

Next steps

- If the decision is made to proceed with changing the by-law requirements, the composition of the PIC will not change, but PIC will no longer be required to have a Public Member on every panel and have more flexibility in this regard.

Question for Council

1. Does Council approve the proposed by-law amendments?

Proposed By-law Amendments

Re Premises Inspection Committee

Premises Inspection Committee

47.2 A panel of t~~T~~hree members of the Premises Inspection Committee appointed by the chair of the Premises Inspection Committee~~, at least one of whom shall be a person who is not a member of the College~~, is a quorum, and may discharge the duties and exercise the authority, of the Premises Inspection Committee. ~~shall constitute a quorum.~~

Council Motion

Motion Title	By-law Amendments for Composition of Premises Inspection Committee
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 151:

By-law No. 151

Section 47.2 of the General By-law is revoked and substituted with the following:

47.2 A panel of three members of the Premises Inspection Committee appointed by the chair of the Premises Inspection Committee is a quorum, and may discharge the duties and exercise the authority of the Premises Inspection Committee.

Council Briefing Note

September 2022

Topic:	Education Advisory Group Dissolution
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Continuous Improvement
Public Interest Rationale:	Accountability: Ensuring that the CPSO's governance aligns with best practices for right-touch regulation.
Main Contacts:	Laura Rinke-Vanderwoude, Governance Analyst Marcia Cooper, Senior Legal Counsel and Privacy Officer Cameo Allan, Manager of Governance
Attachments:	Appendix A: Draft Academic Representative Roles and Responsibilities

Issue

- As part of governance modernization, work is underway to determine if redistributing the work of the Education Advisory Group (EAG) would help make CPSO processes more efficient and help achieve CPSO's strategic objectives. This includes:
    - Ensuring the work the EAG currently performs is completed elsewhere, and minimizing the duplication of work;
    - Maintaining the involvement of the Academic representatives in CPSO work; and,
    - Ensuring other groups that have representation as part of the EAG continue to be considered in regard to the CPSO's work.
- Council is asked to decide whether to dissolve the EAG effective at the close of December Council. [1]

[1] The Academic Roles and Responsibilities document can be approved by the Governance Committee and does not need to be approved by Council.

Background

- In September 2019, Council approved by-law amendments that dissolved the Education Committee. In November 2019, members of the former Education Committee were recruited to constitute the EAG, an advisory body that makes recommendations to the Quality Management Division by consensus. It is important to note that the EAG is not a formal decision-making body and largely serves to consider materials that are later approved or considered by other groups (including Council).

- The EAG is comprised of six CPSO members appointed by the dean of each university faculty of medicine in Ontario to the CPSO Academic Advisory Committee, and one representative each from the Ontario Medical Students Association (OMSA); Professional Association of Residents of Ontario (PARO); Council of the Ontario Faculties of Medicine (COFM); and Council of the Ontario Faculties of Medicine – CPD (COFM-CPD).

- The mandate listed in the Terms of Reference is to provide advice and support to the CPSO in its work related to:

    - Liaising with CPD offices to review and provide feedback on CPSO policies as they relate to undergraduate, post-graduate, and continuing professional development medical education (work performed four times since 2020);

    - Creating bilateral linkages between CPSO programs and activities in the medical education system[2] (24 times since 2020);

    - Developing CPSO strategies and programs involving physician education and remediation, including assessment, supervision, continuing professional development, and issues related to professionalism[3] (12 times since 2020); and,

    - Reviewing continuing professional development programs and tools for physicians in alignment with CPSO's strategic plan (twice since 2020).[4]

[2] Includes regularly providing suggestions for outreach (part of the Executive Committee's mandate) and outreach activities at medical schools through presentations by select members of the EAG.
[3] Included reviewing the Committee Mentoring Program and Governance Orientation eLearning Program, and receiving updates on Quality Improvement Programs and making recommendations. The EAG does not have decision-making authority on those matters.
[4] The EAG reviews the Medical Psychotherapy Association of Canada's (MDPAC) continued status as a third pathway CPD tracking organization with the CPSO.

Current Status and Analysis

- Staff analyzed the EAG's work under its current mandate. The Terms of Reference reflects the current work performed by the EAG. Some considerations that support dissolving the EAG include:

    - Much of the EAG's work is duplicative of work performed by other departments, committees, or initiatives, including its outreach work that falls under the mandate of the Executive Committee;

    - The non-Academic representatives present on the EAG have alternative pathways for involvement with the CPSO;

    - The work uniquely performed by the EAG may rest comfortably within the mandate of other committees, most notably, the Quality Assurance Committee (QAC); and,

    - There is an opportunity to better define the role of Academic representatives within the CPSO, which would keep them involved without the need for the EAG.

Duplicative Work and Role of non-Academic Representatives

- Much of this work performed by the current EAG duplicates work performed in other areas. For example:

    - CPSO representatives and staff that are not part of the EAG already work with stakeholders and groups involved in medical education, including the COFM-UG, COFM-PG, COFM-CPD, and CPD-Ontario. Strong relationships also exist outside the EAG with CPD offices. Therefore, pathways for feedback and input from those groups exist independent of the EAG.

    - Policies already have an external consultation process that includes invitations for feedback from relevant stakeholders, and the capacity exists to do targeted outreach to the Academic Representatives and faculties of medicine where specific input from a medical education lens is needed.

    - Representatives from OMSA and PARO are guests at Council, with the opportunity to attend, an opportunity to provide reflections, and are directly engaged as part of all

CPSO policy reviews. In addition, they have an opportunity to submit a medical learners report as a For Information item to Council. The PARO representative observes the Registration Committee. These opportunities ensure that these groups have the ability to provide feedback and input to CPSO without the EAG.

- Communications, with oversight from the Executive Committee, is responsible for the outreach strategy for UGME, PGME, and CPD, and the EAG has no decision-making power with regards to these elements.

- The review of education programs within the CPSO (for example, the Governance Orientation eLearning Program and Mentoring Program) already undergo extensive review by staff and by the Governance and Executive Committees prior to Council approval.

Work Unique to the EAG

- The aspects of the EAG's work that are not currently duplicative revolve primarily around CPD pathway approvals and its involvement in the medical education space.

- In s. 29 of Ontario Regulation 114/94 made under the Medicine Act, 1991, CPSO members are required to participate in a program of CPD that meets the requirements set out by the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), or another pathway approved by Council. These CPD requirements are contained within the Quality Assurance section of the Regulation.

- The only other pathway approved by Council is the Medical Psychotherapy Association of Canada (MPAC) pathway. It was approved as a CPD program by the Education Committee in November 2012 and Council in February 2013. The EAG currently reviews reports submitted by MPAC to maintain their status. Based on the current mandate, the EAG would also be responsible for advising on any future pathway applications prior to consideration by Council.

- The QAC could absorb this aspect of the EAG's mandate. As a statutory committee, the QAC also has the formal ability to make motions and approve pathways for consideration by Council. If further input was needed from academic representatives, an ad hoc working group could be assembled.

Role of Academic Representatives

- In line with effective governance strategies, the governance team has developed a sample role description for Academic representatives to more clearly define their role at the CPSO (see Appendix A).

- Clarifying the role of Academic representatives in this way helps to advance the strategic priorities of the CPSO and elevates the role of the Academic representatives to have a key strategic role in the communication of CPSO's priorities to their faculty. This is in contrast to the advisory role that the EAG currently holds.

- Both the Governance Committee and Executive Committee were supportive of the proposed approach.

- The academic representatives are aware of the changes and have provided feedback on the current draft of the proposed Roles and Responsibilities document. A final version will be circulated to the academic representatives before it is approved by the Governance Committee.

Considerations

- Consideration should be given as to whether there is any unique or distinct work that only the EAG can perform, and if not, what unique value the EAG brings when considering the CPSO's strategic direction and lean approach.

- Based on previous meetings, it is clear that pathways for Academic Representatives to be engaged in CPSO work are important to the Governance Committee and Executive Committee. The proposed role description is intended to provide the structure and guidance needed to support this commitment.

- The involvement of other members of the EAG with the CPSO can be considered, and whether their engagement is sufficient outside of the EAG.

Next Steps

- If the plan to dissolve the EAG is approved, staff will ensure its operational implementation. The suggested plan includes:
    - Reviewing the Role Description for Academic Representatives, and seeking approval from the Governance Committee to formalize their role at the CPSO even when they are not a voting member of Council;
    - Incorporating the unique aspect of the EAG's mandate into the QAC's mandate, a committee with decision-making authority over similar matters;
    - Engaging legal staff to ensure that all Academic Representatives have a fiduciary duty to the CPSO in respect of their work; and,
    - Dissolution of the EAG would be effective at the close of the December meeting of Council in 2022.

Questions for Council

1. Does Council approve the recommended approach to dissolving the EAG as of the close of the December meeting of Council 2022?

2. Does Council have any feedback regarding the Roles and Responsibilities document for academic members?

CPSO Governance Guideline:
Academic Representative Role and Responsibilities

Academic Representative's Role:

In addition to the individual's role on Council and on any committees they are appointed to, the role of an Academic Representative is to create a link between the CPSO and their academic institution, and to help inform the selection of voting Academic Representatives for Council.

Academic Representatives are considered to have a fiduciary duty to the CPSO as do other Council members, and are similarly accountable to all policies and requirements laid out in the Declaration of Adherence, the Council and Committee Code of Conduct, and its associated policies.

Academic Representative Selection:

Academic Representatives are selected by their Dean to join the Academic Advisory Committee. Criteria[1] Deans can use to select their Academic Representative according to the CPSO skills matrix include:

- Eligibility with respect to applicable term limits (a total of 9 years on Council)
- Demonstrated leadership experience
- Knowledge and support of the regulatory and/or statutory obligations of the CPSO
- Interest and availability
- Skills and competencies identified as needs by the CPSO

Academic Representative Responsibilities:

In addition to work related to Council and any Committees the individual may serve on, the responsibilities of Academic Representatives include:

- Advising the Governance Committee regarding interest in sitting as a voting member of Council for a given year;
- Academic Representatives, both voting and non-voting, are invited to attend Council meetings in their respective capacities.
- Exploring opportunities within their faculty and institution for the CPSO to perform outreach or make presentations;
- Promoting awareness of CPSO publication, for example, eDialogue, to medical students, residents, and other learners at their institution;
- Provide input when requested by Council, CPSO staff, and other committees; and,
- Soliciting involvement from colleagues, medical students, residents and other learners, and administrators at their institutions for policy, communications, or quality consultations and initiatives.

[1] Additional eligibility criteria are contained in s. 24(3) of the CPSO's *General By-Law.*

Academic Representatives should only assume the role of representing the CPSO at their institution when authorized by the CPSO, including but not limited to speaking or presenting on behalf of the CPSO.

Academic Representatives are expected to liaise with CPSO staff to obtain the resources and support needed to meet their responsibilities.[2]

[2] For example, booking rooms for conversations between Academic Representatives.

Council Motion

Motion Title	Education Advisory Group Dissolution
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the dissolution of the Education Advisory Group, effective as of the adjournment of the Annual General Meeting of Council in December 2022.

Council Briefing Note

September 2022

Topic:	Specialist Recognition Criteria in Ontario
Purpose:	For Decision
Relevance to Strategic Plan:	• Right-Touch Regulation • Continuous Improvement
Public Interest Rationale:	**Accessibility:** Ensuring individuals have access to services provided by the health profession of their choice and individuals have access to the regulatory system as a whole
Main Contact(s):	Samantha Tulipano, Director, Registration & Membership Services, ext. 709
Attachment(s):	Appendix A: *Specialist Recognition Criteria in Ontario – Existing Policy* Appendix B: *Specialist Recognition Criteria in Ontario – Revised Draft Policy*

Issue

- In April 2022, the Registration Committee recommended revising the existing Council Policy Specialist Recognition Criteria in Ontario ("Specialist Recognition") to provide increased clarity.

Background

- The Specialist Recognition policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College (*Appendix A*).
- The policy applies to individuals who have met the established criteria for registration and have been issued a certificate of registration to practice medicine in Ontario.
- Specialist Recognition by the College permits the physician to hold them self out as a specialist. Additionally, external agencies such as OHIP, hospitals, WSIB etc. rely on the College to confirm whether an individual is considered a specialist.

- The policy currently provides five routes to Specialist Recognition in Ontario, which include:
  i. Holds certification, or is eligible to take the certification exam, by the Royal College of Physicians and Surgeons of Canada (RCPSC)/ College of Family Physicians Canada (CFPC) or
  ii. Holds specialist certification by examination by the Collège des Médecins du Québec (CMQ) or
  iii. Holds US Board certification, completed accredited US training, and agrees to undergo a College practice assessment or
  iv. Is a certified specialist, holds a full-time academic appointment at an Ontario medical school at the rank of assistant, associate or full professor, and holds a restricted certificate authorizing academic practice or
  v. Is recognized as a certified specialist in the country where the specialty training was completed, practices under supervision and undergoes a successful College practice assessment.

Current Status and Analysis

- A redesigned policy has been drafted (*Appendix B)*, incorporating the changes outlined below.

A. Clarifying Requirements

- There were ongoing concerns that the language and spirit of the policy were open to misinterpretation, as physicians were applying for recognition in instances when they did not qualify.
- Additionally, since the policy was last updated, Registration Policies were introduced to recognize specialist certificate obtained by means other than examination.
- The language of the policy has been updated to include:
  - A preamble explaining the purpose of the policy
  - Expansion on the criteria necessary to qualify under each of the existing routes to Specialty Recognition, resulting in two additional routes for the sake of clarity
  - Clarification that specialists trained outside of North America must have training that is comparable in duration to a RCPSC/CFPC program
  - Increased clarity around the conditions leading to expiry of the CPSO specialist recognition

B. Combining "Family Medicine Specialist" and "Non-Family Medicine Specialist" Sections

- The Specialist Recognition policy currently distinguishes between "Specialists in Family Medicine" (i.e., certified by the CFPC) and "Specialists in Specialties Other than Family Medicine". However, the routes to certification are the same for both.
- The language of the policy is revised to no longer separate family medicine as a specialty.

C. Language Redesign

- In 2018, Council approved a proposal to redesign College policies in order to enhance clarity, without meaningfully altering the core content of the policy themselves.
- The language of the policy has been revised for conciseness and clarity.

Recommendation

- It is recommended that the simplified language changes be adopted alongside the previous recommendations.

Question for Council

1. Does Council approve the revised draft *Specialist Recognition Criteria in Ontario* policy as a policy of the College?

Specialist Recognition Criteria in Ontario

Policy Category: Registration
Approved by Council: April 2005
Reviewed and Updated: November 2011
College Contact: Registration Inquiries

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- Purpose
- Scope
- Policy

Purpose

In order to practice medicine in Ontario, an individual must hold a valid certificate of registration issued by the College. Specialty recognition is distinct from registration.

Ontario Regulation 114/94 provides that no member shall use a term, title or designation relating to a specialty or subspecialty of the profession in respect of his or her practice of the profession unless the member has been,

a. certified by the Royal College of Physicians and Surgeons of Canada in a specialty or subspecialty of the profession to which the term, title or designation relates;
b. certified by the College of Family Physicians of Canada in a specialty or subspecialty of the profession to which the term, title or designation relates; or
c. formally recognized in writing by the College as specialist in the specialty or subspecialty of the profession to which the term, title or designation relates.

This policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College of Physicians and Surgeons of Ontario.

Scope

This policy applies to individuals who have met the criteria for registration and have been issued a certificate of registration to practice medicine in Ontario.

Under this policy the College will recognize specialty titles only in areas for which specialties and sub-specialties is granted by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.

The determination as to which specialists should be paid as specialists under the Ontario Health Insurance Plan will be made by the Ministry of Health and Long-Term Care of Ontario.

Policy

Specialist in Family Medicine

A physician, who meets any of the requirements below, will be recognized by

the College as a **specialist in family medicine**:

1. holds certification in family medicine by the College of Family Physicians of Canada or is eligible to take the certification examination of the College of Family Physicians of Canada; or
2. holds a specialist certificate in family medicine, obtained by examination, by the Collège des médecins du Québec; or
3. a) holds certification in family medicine by the American Board of Family Medicine that was obtained by examination, following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), and
   b) Undertakes to participate in a practice assessment organized by the College, one year after having been granted specialist recognition; or
4. a) has successfully completed specialty training and obtained certification as a specialist in family medicine by the certifying body in the country where the individual completed his/her training, and
   b) holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor, and
   c) holds a restricted certificate of registration authorizing academic practice in Ontario; or
5. a) has successfully completed specialty training and obtained certification as a specialist in family medicine by the certifying body in the country where the individual completed his/her training, and
   b) has completed a minimum of one year of practice in Ontario, and
   c) has successfully completed a practice assessment that has been directed by the Registration Committee.[1]

Specialist in a Specialty other than Family Medicine

A physician who meets any of the requirements below will be recognized by the College as a **specialist, in a specialty other than family medicine**:

1. holds certification by the Royal College of Physicians and Surgeons of Canada or is eligible to take the certification examination of the Royal College of Physicians and Surgeons of Canada;
2. holds a specialist certificate, obtained by examination, by the Collège des médecins du Québec;
3. a) holds certification by a specialty member board of the American Board of Medical Specialties (ABMS) that was obtained by examination, following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), and
   b) Undertakes to participate in a practice assessment organized by the College, one year after having been granted specialist recognition; or
4. a) has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed his/her training, and
   b) holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor, and
   c) holds a restricted certificate of registration authorizing academic practice in Ontario; or
5. a) has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed his/her training, and
   b) has completed a minimum of one year of practice in Ontario, and

c) has successfully completed a practice assessment that has been directed by the Registration Committee [1]

1 Physician shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from request for specialist recognition.

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80 College Street, Toronto, Ontario, M5G 2E2

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Specialist Recognition Criteria in Ontario

Purpose

In order to practice medicine in Ontario, an individual must hold a valid certificate of registration issued by the College. Specialty recognition is distinct from registration.

The Ontario Regulation 114/94 provides that no member shall use a term, title or designation relating to a specialty or subspecialty of the profession in respect of their practice of the profession unless the member has been,

1. certified by the Royal College of Physicians and Surgeons of Canada in a specialty or subspecialty of the profession to which the term, title or designation relates;
2. certified by the College of Family Physicians of Canada in a specialty or subspecialty of the profession to which the term, title or designation relates; or
3. formally recognized in writing by the College as specialist in the specialty or subspecialty of the profession to which the term, title or designation relates.

This policy sets out the criteria that a physician must meet in order to be recognized as a specialist by the College of Physicians and Surgeons of Ontario.

Scope

This policy applies to individuals who have met the criteria for registration and have been issued a certificate of registration to practice medicine in Ontario.

Under this policy, the College will recognize specialty titles only in areas for which specialties and sub-specialties are granted by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada.

This policy does not apply to physicians who hold certification by Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada who are requesting sub-specialist recognition at a time when the sub-specialty examination is available.

Specialist recognition granted under paragraph 3 above is tied to the physician's practice in Ontario and will automatically expire upon expiry of the physician's certificate of registration.

The determination as to which specialists should be paid as specialists under the Ontario Health Insurance Plan will be made by the Ministry of Health and Long-Term Care of Ontario.

Policy

A physician who meets any of the requirements below will be recognized by the College as a **specialist**:

1. holds certification by the Royal College of Physicians and Surgeons of Canada; or
2. holds certification in family medicine by the College of Family Physicians of Canada; or
3. holds specialist certification, obtained by examination, by the Collège des médecins du Québec; or
4. holds certification by a specialty member board of the American Board of Medical Specialties (ABMS), and:
    a. ABMS certification was obtained by examination, and
    b. ABMS certification was obtained following successful completion of postgraduate specialty training in a program accredited by the Accreditation Council for Graduate Medical Education (ACGME), and
    c. undertakes to participate in a practice assessment organized by the College one year after having been granted specialist recognition; or
5. holds a restricted certificate of registration authorizing academic practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training, by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, and
    c. holds a full-time academic appointment at a medical school in Ontario at the rank of assistant professor, associate professor or full professor; or
6. has completed a minimum of one year of independent or supervised practice in Ontario, and:
    a. has successfully completed specialty training and obtained certification as a specialist by the certifying body in the country where the individual completed their training by an organization outside of North America that recognizes medical specialties, and
    b. the organization which recognized the applicant as a medical specialist did so using standards that are substantially similar to the standards of the Royal

College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, and

c. has successfully completed a practice assessment that has been directed by the Registration Committee; or

7. hold a restricted certificate of registration in Ontario that has been issued under the College's Restricted Certificates of Registration for Exam Eligible Candidates policy, and:
    a. have received written confirmation from the Royal College of Physicians and Surgeons of Canada of current eligibility, with no pre-conditions, to take the certification examination on the basis of satisfactory completion of a Royal College-accredited residency program in Canada or a Royal College recognized program outside of Canada; or
8. hold a restricted certificate of registration in Ontario that has been issued under the College's Restricted Certificates of Registration for Exam Eligible Candidates policy, and:
    a. have received written confirmation from the College of Family Physicians of Canada of current eligibility, with no pre-conditions, to take the certification on the basis of satisfactory completion of a College of Family Physicians of Canada-accredited residency program in Canada or a College of Family Physicians of Canada recognized program outside of Canada.

Endnotes

[1.] The physician shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from request for specialist recognition.

Council Motion

Motion Title	Specialist Recognition Criteria in Ontario
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves the revised policy, “Specialist Recognition Criteria in Ontario”, (a copy of which forms Appendix “ ” to the minutes of this meeting).

Council Briefing Note

September 2022

Topic:	Regulatory Proposal – Temporary Class of Licensure
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation
Public Interest Rationale:	A regulatory amendment is proposed to introduce a new temporary class of registration to support short term mobility within Canada.
Main Contact(s):	Craig Roxborough, Director, Policy Samantha Tulipano, Director, Registration & Membership Services
Attachment(s):	Appendix A: Proposed Regulatory Amendments Appendix B: Proposed By-Law Amendments

Issue

- Council is asked whether a regulatory proposal to create a new temporary class of registration designed to support mobility within Canada can be approved for submission to government and whether related by-law amendments can be circulated for consultation.

Background

- CPSO registration classes are set out in O. Reg. 865/93: REGISTRATION (hereinafter "Registration Regulation") under the *Medicine Act, 1991*. Along with a certificate for Independent Practice, the regulation creates other classes with various restrictions.

- Notably, the regulation includes a Supervised Practice of Short Duration (hereinafter "Short Duration certificate") which enables the issuance of a 30-day license where:
    - The applicant holds an MD;
    - There is a system sponsor, typically a hospital, given the narrow range of options;
    - There is an urgent need that cannot otherwise be remedied; and
    - The applicant will be supervised by another member of the CPSO.

- CPSO is also required under the Canadian Free Trade Act (CFTA) to issue equivalent licenses to applicants who hold a license in another Canadian jurisdiction.

Current Status and Analysis

- A regulatory proposal to introduce a new temporary class of registration has been developed along with necessary by-law amendments to operationalize this proposal. An overview of the key considerations is outlined below.

Broader Context

- Throughout the pandemic and continuing, the Short Duration certificate has been used to help hospitals address immediate and temporary physician shortages. Notably, this class has been used 18 times since May to provide urgent coverage in hospitals, including temporarily licensing Manitoba physicians providing coverage in Northern Ontario.

- The ongoing health care system crisis, health human resource shortages, and Emergency Department closures have garnered significant attention and government is under pressure to take steps to rectify both the underlying systemic issues and provide immediate relief.

Minister's Letter and CPSO Response

- In early August, the Minister of Health issued a letter directing CPSO to "make every effort to register out of province and internationally educated physicians to the College as expeditiously as possible."

- CPSO's response to the Minister outlined that we are but one part of the broader solution and put forward a range of options to address the current crisis and underlying issues.

- Notably, the response included a proposal to introduce regulatory amendments enabling the creation of a temporary class of registration to support temporary mobility between provinces and territories. The new class would fill a gap between existing classes and support a more timely and robust mechanism for movement within Canada, offering benefits over the Short Duration certificate in important ways:

    - Not requiring supervision, enabling physicians to practice independently;
    - Extending the duration of a license (3 months), enabling greater flexibility;
    - Allowing a broader range of system sponsors, including community-based settings;
    - Reducing administrative burden on the sponsor, the physician, and CPSO.

Proposed Regulatory Amendment

- In response to our proposal, government has specifically requested that we work to implement the regulatory amendment and to do so as quickly as possible.

- A draft regulatory amendment to the Registration Regulation has been developed to implement the proposal above (**Appendix A**). The proposal focuses on accepting applications from physicians holding an independent practice license (including those with licenses permitting independent practice within a defined scope).

- The intent of the proposed regulation is to provide a more flexible option that supports potential applicants who wish to assist with system needs on a temporary basis, enabling them to practice at full scope, and reducing the administrative burden for all involved.

- Due to the urgent system need, notification of other medical regulatory authorities of this proposal has occurred in advance of the Council meeting to allow for feedback prior to submission to government. Additionally, a waiver for the standard 60-day consultation period required by the Health Professions Procedural Code has been made to the Minister and Council's confirmation of this approach is sought.

Fees By-Law Amendment

- Fees associated with registration are set out in the *Fees and Remuneration* by-law. Should the government enact the proposed regulatory amendments, CPSO by-laws will need to be updated to operationalize this new class of registration.

- Reflecting the term of the proposed class of registration, it is proposed that application fees be set at 25% of the annual fee (**Appendix B**).

- The proposed by-law amendments must be circulated to the profession (60 days) and then considered for final approval by Council.

    - It is proposed that the by-law be circulated for consultation in advance of government enactment to shorten the implementation period.

    - Council's final approval will be sought once the consultation period is completed and provided government approves the proposed regulation.

Questions for Council

1. Does Council approve the proposed regulatory amendment for submission to government and exempting the consultation requirements?

2. Does Council approve the proposed by-law amendments for external consultation?

PRACTICE FOR THE PROVISION OF TEMPORARY SERVICES

(1) The standards and qualifications for a certificate of registration authorizing practice for the provision of temporary services are as follows:

1. The applicant must hold a full, unrestricted license or certificate of practice for independent practice in a Canadian jurisdiction, which may include an indication of the specific area of medical practice in which the physician is licensed to practise independently, based on education, qualifications and experience; and

2. The applicant must hold an offer from, agreement with, or appointment by a sponsor satisfactory to the College to provide medical services on a temporary basis in Ontario.

(2) A sponsor under section (1)2 may include a hospital or organization that facilitates the provision of medical services or an individual who engages in the provision of medical services.

(3) The terms, conditions, and limitations of a certificate of registration authorizing practice for the provision of temporary medical services are that,

(a) the holder practise medicine only to the extent required by the holder's offer, agreement or appointment with the holder's sponsor to provide medical services on a temporary basis in Ontario;

(b) the holder practise medicine in accordance with any defined scope of independent practice to which the holder's licence or certificate of practice is subject in another Canadian jurisdiction; and

(c) the certificate expires on the earliest of the following days:

(i) the ninetieth day after the certificate is issued; or

(ii) the day after the holder ceases to be subject to an offer, agreement, or appointment by or with the holder's sponsor.

Fees and Remuneration By-law (By-law No.2)

APPLICATION FEES

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a);

(b.1) For a certificate of registration authorizing practice for the provision of temporary services, 25% of the annual fee specified in section 4(a);

(c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

(e) *[repealed]: May 31, 2019]*

(f) For a certificate of authorization, $400.00;

(g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a);

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d).

2. Application fees are due at the time the application is submitted. Application fees are not refundable, either in whole or in part.

ANNUAL FEES

3. Every holder of a certificate of authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing practice for the provision of temporary services, shall pay an annual fee.

4. Annual fees as of June 1, 2018, are as follows:

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, ~~and other than~~ a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing practice for the provision of temporary services;

(b) For a holder of a certificate of registration authorizing postgraduate education applying to renew his/her certificate of registration, 20% of the annual fee set out in subsection 4(a); and

(c) Notwithstanding subsections 4(a) and (b), where the holder of a certificate of registration will be taking parental leave for a period of four months or longer during the membership year for which the annual fee applies because the holder is pregnant, has recently given birth or will be caring for their newborn or newly adopted child, the annual fee for such membership year is as follows:

i. 50% of the annual fee set out in subsection 4(a) for holders of a certificate of registration (except as set out in subsection 4(c)(ii)); or

ii. 50% of the annual fee set out in subsection 4(b) for holders of a certificate of registration authorizing postgraduate education,

so long as the holder applies to the College for this parental leave reduced annual fee prior to the close of the annual renewal period for such membership year. Where applications for the parental leave reduced annual fee are received after the close of such annual renewal period, the parental leave reduced annual fee will be applied to the following membership year. The parental leave reduced annual fee is not available for holders of a certificate of registration authorizing supervised practice of a short duration.

Council Motion

Motion Title	Regulatory Proposal for Temporary Class of Licensure
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves:

1. making an amendment to Ontario Regulation 856/93: Registration, regarding a certificate of registration authorizing practice for the provision of temporary services (a copy of which amendment forms Appendix " " to the minutes of this meeting) and submitting it to the Minister of Health for review and the approval of the Lieutenant Governor in Council; and

2. exempting the regulatory amendment from the requirement under subsection 95(1.4) of the *Health Professions Procedural Code* to circulate it to the profession, if such exemption is approved by the Minister.

Council Motion

Motion Title	By-law Amendments for Fees for Temporary Services Certificate of Registration
Date of Meeting	September 22, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 153, after circulation to stakeholders:

By-law No. 153

1. Section 1 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Application Fees

1. A person who submits an application for a certificate of registration or authorization shall pay an application fee. The application fees are as follows:

(a) For a certificate of registration authorizing postgraduate education, 25% of the annual fee specified in section 4(a);

(b) For a certificate of registration authorizing supervised practice of a short duration, 20% of the annual fee specified in Section 4(a);

(b.1) For a certificate of registration authorizing practice for the provision of temporary services, 25% of the annual fee specified in section 4(a);

(c) For an application for reinstatement of a certificate of registration, 60% of the annual fee specified in s. 4(a);

(d) For any other certificate of registration, 60% of the annual fee specified in Section 4(a);

(e) *[repealed]: May 31, 2019]*

(f) For a certificate of authorization, $400.00;

(g) For an application to the Registration Committee for an order directing the Registrar to modify or remove terms, conditions or limitations imposed on the member's certificate of registration by the Registration Committee, 25% of the annual fee specified in section 4(a);

(h) If the person:

(i) meets the registration requirements applicable to the class of certificate of registration applied for, as prescribed in the Registration Regulation, Ontario Regulation 865/93 under the *Medicine Act, 1991*; and

(ii) requests the College to conduct the initial assessment of the application within three weeks after receipt by the College of the application,

an additional fee equal to 50% of the application fee applicable to such person under subsection 1(a), (b), (b.1) or (d).

2. Section 3 of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

Application Fees

3. Every holder of a certificate of authorization, other than a holder of a certificate of registration authorizing supervised practice of a short duration or authorizing postgraduate education for an elective appointment or authorizing practice for the provision of temporary services, shall pay an annual fee.

3. Subsection 4(a) of the Fees and Remuneration By-law (By-law No. 2) is revoked and substituted with the following:

(a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education, a certificate of registration authorizing supervised practice of a short duration, or a certificate of registration authorizing practice for the provision of temporary services;

Explanatory Note: This proposed by-law must be circulated to the profession.

Council Motion

Motion Title	Motion to Go In-Camera
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

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

Exclusion of public

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

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

(d) personnel matters or property acquisitions will be discussed; and

(e) instructions will be given to or opinions received from the solicitors for the College.

Council Briefing Note

CPSO

September 2022

Topic:	Filling Vacancies on Council – By-law Amendment
Purpose:	For Decision
Relevance to Strategic Plan:	Meaningful Engagement Continuous Improvement
Public Interest Rationale:	Appropriate constitution of Council, so College can perform its duties in the public interest
Main Contact(s):	Lisa Brownstone, Chief Legal Officer Marcia Cooper, Senior Corporate Counsel and Privacy Officer
Attachment(s):	Appendix A: - General By-law: Proposed Amendment to Provisions for Filling Council Vacancies

Issue

- Current by-laws require a by-election to be held if an elected Council member seat becomes open more than twelve months before the expiry of the member's term of office. The question was raised about changing the by-law to provide more flexibility in filling a vacancy by making by-elections discretionary regardless of when in a term a Council vacancy occurs.
- If by-law amendments are made in this regard, should the vacant Council seat (left by Dr. Pirzada) be filled and if so, how and when?

Background

- The Executive Committee discussed whether the College had to hold a by-election in the event Dr. Pirzada's position on Council became vacant.
- The current by-law requires a by-election to be held if there are more than twelve months remaining in the Council member's term before the expiry of the member's term of office.
- There are more than twelve months remaining in Dr. Pirzada's term (his term would have expired in December 2023).

- If there are fewer than twelve months before the term of the vacant seat expires, the By-law currently provides Council three options:
  - Leave the seat vacant;
  - Hold a by-election; or
  - Allow Council to appoint the candidate who had the most votes of the unsuccessful candidates in the last election for the district in question.
- The Executive Committee considered proposed by-law amendments so that a by-election would not be required where there are more than 12 months remaining in the term; rather, there would be discretion as to when and whether to hold a by-election. The Executive Committee recommended bringing the proposed amendments forward to Council for consideration.
- The Executive Committee also recommended that if Council approves the by-law amendments, the current elected member vacant seat on Council not be filled before the expiry of its term in December 2023.

Current Status and Analysis

Benefits of changing the by-law

- The benefit of changing the by-laws is that it provides discretion to Council as to whether to leave a seat vacant, hold a by-law election or appoint the "runner-up" candidate in any given circumstance.
- If a by-election is held in the fall or the prior "runner up" candidate is appointed (after the by-laws are amended) to fill the current vacancy left by Dr. Pirzada's resignation, the new Council member's term would be only about one year (ending in December 2023). Campaigning for the spring election for the following three year term would start only a few months into the new Council member's term. This could prove distracting and time-consuming for the new member. In addition, it is possible that the winner of the by-election would not run for election the following year or would not prevail. This would mean Council would onboard two members for the same seat in short succession.

Risk of changing the bylaw

- If the by-law is changed, Council will have the option of not filling a vacant seat (unless there are more two or more vacancies).
- If a vacant seat is not filled (whether by way of holding a by-election or appointing the "runner-up" candidate) and another Council member resigns, or becomes incapacitated or otherwise ineligible to serve on Council, Council will not have the minimum number (15) of elected physician members required by legislation.
- A decision would then have to be made as to what to do in terms of filling the vacancies (which vacancy to seek to fill, in what order, and how quickly they could be filled).

Proposed by-law amendments

- The proposed by-law amendments (in Appendix A) provide Council all three of the options outlined above whenever there is a vacancy, regardless of when in a term a Council vacancy occurs.
- However, if the vacancy leaves Council with less than the minimum number (15) of elected physician members that is required under the *Medicine Act*, Council would have to fill at least one of those vacancies so that it is properly constituted.

Next Steps

- This by-law does not require circulation to the profession before it comes into effect.
- If the By-law is passed by Council, Council should determine whether to fill the current vacancy and how.
- If the By-law is not passed by Council, a by-election will need to be held to fill the current vacancy.

Questions for Council

1. Does Council approve the proposed by-law amendment?
2. If Council approves the by-law amendment, what course of action does Council wish to take for the current vacant Council seat (i.e. leave it vacant or fill it, and how)?

Appendix A

General By-law

Proposed Amendment to Provisions for Filling Council Vacancies

Filling of Vacancies

23. (1) If the seat of an elected councillor becomes vacant, ~~not more than twelve months before the expiry of the member's term of office~~ the council may,

a. leave the seat vacant, subject to subsection (2);

b. appoint as an elected member the candidate if any who had the most votes of all the unsuccessful candidates in the last election of councillors for that electoral district; or

c. direct the registrar to hold a by-election for that electoral district in accordance with this by-law.

(2) If the number of remaining elected councillors is less than the minimum number required by law, the council shall act under clause (1)(b) or clause (1)(c) to fill the number of vacant seats needed so that the number of elected councillors is not less than the minimum number required by law.

~~If the seat of an elected councillor becomes vacant more than twelve months before the expiry of the member's term of office, the registrar shall hold a by-election for that electoral district in accordance with this by-law.~~

(3) The term of office of a member appointed under clause (1)(b) or elected in a by-election expires when the former councillor's term would have expired.

Council Motion

Motion Title	By-law Amendments re: Filling Council Vacancies
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 152:

By-law No. 152

Section 23 of the General By-law is revoked and substituted with the following:

Filling of Vacancies

23. (1) If the seat of an elected councillor becomes vacant, the council may,

(a) leave the seat vacant, subject to subsection (2);

(b) appoint as an elected member the candidate if any who had the most votes of all the unsuccessful candidates in the last election of councillors for that electoral district; or

(c) direct the registrar to hold a by-election for that electoral district in accordance with this by-law.

(2) If the number of remaining elected councillors is less than the minimum number required by law, the council shall take action under clause (1)(b) or clause (1)(c) to fill the number of vacant seats needed so that the number of elected councillors is not less than the minimum number required by law.

(3) The term of office of a member appointed under clause (1)(b) or elected in a by-election expires when the former councillor's term would have expired.

Council Motion

Motion Title	Current Council Vacancy
Date of Meeting	September 23, 2022

Whereas there is currently a vacant Council seat for an elected physician Council member in District 5 (the “Vacant Seat”),

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario approves leaving the Vacant Seat vacant until the 2023 Annual General Meeting of Council in accordance with the General By-law.

Council Briefing Note

September 2022

Topic:	Out-of-Hospital Premises Inspection Program (OHPIP) - Draft Standards for External Consultation
Purpose:	For Decision
Relevance to Strategic Plan:	Right-Touch Regulation Quality Care
Public Interest Rationale:	The OHP Program Standards are being redesigned and revised to enhance their utility, to align the OHPIP with the CPSO's Strategic Plan and to ensure the public interest is being effectively served.
Main Contact(s):	Courtney Brown, Policy Analyst Tanya Terzis, Senior Policy Analyst Craig Roxborough, Director of Policy Laurie Reid, Director of Investigations and Accreditation Roxanne Halko, Manager of Accreditation
Attachment(s):	Appendix A: Draft OHP Standards and Advice documents

Issue

- The Out of Hospital Premises Inspection Program (OHPIP) is currently undergoing modernization, including redesigning and revising the Program Standards to be clearer and more concise, and to enhance their utility.

- Council is provided with an overview of the work undertaken to date, including a set of ten new draft standards and is asked whether the draft standards can be released for external consultation.

Background

- To ensure out-of-hospital premises (OHPs) are operating safely and effectively, the OHPIP inspects all facilities performing procedures requiring the use of anesthesia or sedation and through the inspection regime enforces a set of standards (called "Program Standards"), outlining the core requirements that must be met when performing these procedures in OHPs.

    - The Program Standards include details regarding the inspection regime, outline the different levels of premises within the program, and set out specific standards in relation to, for example, infection-prevention and control, quality assurance, and physical infrastructure.

  - Additional procedure specific standards are also set out for premises providing interventional pain, endoscopy, and induced abortion care that generally clarify how the standards apply in these contexts.

- Internal and external feedback indicates that the Standards can be difficult to navigate and understand. This is due in part to their length and format.

- As a result, a commitment has been made to modernize and redesign the Program Standards. Council was provided with an update on this modernization work, at their December 2021 meeting, and the Premises Inspection Committee (PIC) has been updated and provided feedback throughout this process.

Project Scoping – Identifying the Challenges and Potential Areas for Improvement

- As outlined in the December 2021 Council Materials, significant activities have been undertaken to gain an understanding of the challenges within the program and potential opportunities for improvement. These activities informed the key objectives of this modernization project, including:

  - Aligning the broader regulatory approach with the Strategic Plan (i.e., a focus on Right-Touch Regulation), including a focus on areas of greatest risk;

  - Updating the Standards to increase clarity, to reference and align with existing external standards, and to promote and allow for professional judgment;

  - Coordinating and leveraging existing regulatory tools, such as: existing standards, policies, and clinical practice guidelines (e.g., holding individual physicians practising in OHPs accountable for compliance); the role of Medical Directors (e.g., expanding oversight and responsibility); the quality monitoring and oversight regime offered by OHPIP and PIC; and finally, the investigative process.

Current Status and Analysis

- Updating the current Program Standards has involved a two-part process: 1) redesigning the current structure and format of the Standards and 2) revising and redrafting the existing expectations in an effort to focus on areas of greatest risk and creating principle-based expectations where possible.

- A small ad hoc Working Group comprised of both Council and PIC members with relevant experience was convened to confirm the proposed approach, provide direction on key issues, and to ensure that the proposed revisions support a right-touch approach.[1]

[1] The members of this Working Group include: Janet van Vlymen, Catherine Smyth, Roy Kirkpatrick and Ted Xenodemetropoulos (Vice Chair of PIC). Additional support was provided by Anil Chopra and Saroo Sharda (Medical Advisors) and Elisabeth Widner (Legal Counsel).

- The process of updating the Standards has resulted in significant structural changes to the layout of the Standards and how the expectations are articulated.
    - There has been a move away from one single long, dense and detailed document, to a set of ten separate, succinct, standalone documents that more clearly convey the expectations of OHPs and the members who work within them.
    - Substantive changes have been made to make the new Standards more principle-based and refer to existing external standards and guidelines, where appropriate.
    - Companion *Advice* documents have also been developed for each Standard to answer key questions, along with one general *Program Overview* document that captures details about the Program, the inspection process, and CPSO's role.

A. Overview of Standards and Key Revisions

- The following schematic outlines each of the new draft Standards along with a brief overview of their function.

Co-operation with the Program	Medical Director	Physicians Practising in OHPs	Physical Space	Drugs and Equipment
• Sets out requirements related to providing accurate/timely information, reporting to CPSO, the inspection process, and consequences for failure to comply with Standards.	• Elevates and leverages the role of Medical Director and their responsibility for all care provided in the OHP while setting out requirements relating to their eligibility and specific responsibilities.	• Captures the range of responsibilities for physicians working in OHPs including compliance with Standards, CPSO policies, external guidelines and the standard of care.	• Sets out requirements for the size and layout of the OHP in order to provide safe care, with some additional requirements relating to necessary anesthetic equipment.	• Sets out requirements to maintain appropriate drugs and equipment for certain urgent and emergency scenarios/conditions.

Patient Selection	Procedures	IPAC	Adverse Events	Quality Assurance
• Emphasizes the importance of appropriate selection, along with key factors to be considered and additional requirements for ASA III patients.	• Sets out requirements for pre, during and post procedure, and requires compliance with external guidelines such as the CAS Guidelines and Surgical Safety Checklist.	• Sets out requirement to comply with Public Health Ontario's "IPAC for Clinical Office Practice", and to take appropriate action where substandard IPAC practices are occurring.	• Sets out requirements for preparing for, managing, reporting, and analyzing and learning from adverse events.	• Sets out requirements related to creating a culture of safety and quality in the OHP, along with requirements for the Quality Assurance Committee and monitoring quality of care.

- While the draft Standards retain many of the core expectations of the current Program Standards, some significant revisions have been made. An overview of key revisions made provided below.

Medical Director

- Given the important role of the Medical Director, and the fact that the quality of care in an OHP correlates with the quality of oversight and level of involvement of the Medical Director, this draft Standard significantly elevates and leverages the role. It does so by more clearly and explicitly articulating existing requirements and setting out new requirements relating to both eligibility and responsibility. In particular, the draft Standard sets out:
    - additional criteria to hold the position of a Medical Director;
    - new responsibilities related to credentialing and ensuring staff competence; and
    - new expectations related to supervision and the frequency that Medical Directors must be on site to fulfil their duties.
- This draft Standard emphasizes Medical Directors' accountability for all of the care provided within the OHP.

Drugs and Equipment

- The current approach of articulating a specific and detailed list of drugs and/or equipment that must be on premises has been updated. Instead, the draft Standard focuses on articulating the events, conditions, or scenarios that need to be appropriately managed.
    - The updated approach is intended to allow for some flexibility with respect to required drugs and equipment, with additional details included in *Advice*.

Patient Selection

- In response to internal and external feedback about the critical importance of patient selection with respect to procedures performed in an OHP, a new draft standard has been created to address this issue and highlight its importance.
- The draft Standard sets out general selection considerations, reiterates key requirements from the Canadian Anesthesiologists' Society (CAS) Guidelines (i.e., ASA I and II patients can be appropriately treated in an OHP, along with some ASA III patients), and then sets out additional guidance to evaluate the appropriateness of treating patients at higher risk (i.e., ASA III patients).

Procedures

- This draft Standard has been significantly revised from the current Program Standards which are very clinical and extremely prescriptive in regard to managing patient care.

- The draft Standard streamlines and simplifies expectations by setting out principled expectations and pointing to existing clinical practice guidelines where they exist, including the CAS Guidelines, PeriAnesthesia Nursing Standards and the Surgical Safety Checklist.

    - The intention is to support instead of supplant professional judgment, where appropriate, and to rely on existing guidelines and the standard of care.

Adverse Events

- The draft Standard captures existing expectations for adverse events reporting and monitoring, along with new expectations around planning for and managing adverse events to create a more robust framework, inspired by the Canadian Incident Analysis Framework.

- In particular, the draft Standard requires that:

    - there are written protocols in place to support the recognition and reporting of adverse events and to appropriately manage any adverse events that occur;
    - OHPs have a formalized transfer agreement with a local hospital in the event of an emergency; and
    - physicians take appropriate and timely action, including initiating a timely transfer to hospital, where necessary.

- In addition, the reporting timeline has been changed to a more reasonable 5 business days rather than 24 hours, given that the Program takes no immediate action following a report.

- With the change to a single requirement regarding when an adverse event must be reported, the current distinction between Tier 1 and Tier 2 events has been removed. CPSO will continue to review all adverse events that occur and respond accordingly.

Additional substantive changes

- The remaining draft Standards have been revised to: more clearly identify and articulate existing expectations, remove explanatory or duplicative content, reference existing external guidelines, emphasize specific areas of importance, and clarify responsibilities.

B. Key Program Changes

- In addition to the revisions made to the Standards themselves, some changes are also being made to some key elements of the program more generally.

Levels

- OHPs are currently classified by levels which are determined by the type of procedures done in the premises and the type of anesthesia used.[2] As a result of the new approach to the Standards, it is no longer necessary for OHPs to be classified by levels as the requirements articulated in the Standards are now specifically linked to the type of anesthesia or sedation used.

Scope of Program: Clarifying and refining the procedures captured by the OHPIP

- Procedures that are captured by the program are generally determined by the General Regulation under the *Medicine Act* ("the Regulation") and are those that require anaesthesia or sedation, along with nerve blocks and others.

- However, the Regulation requires some interpretation and is not always clear with respect to determining what procedures fall within it (e.g., with respect to some cosmetic procedures) and there are some procedures that would fall into a grey zone (e.g., are technically captured but wouldn't necessarily meet the spirit of the Regulation).

- Efforts have been made in the *Program Overview* document to clarify the scope of the Program and the procedures captured, with a focus on capturing procedures that represent the greatest risk and excluding those that can be safely done in an office setting.

Next Steps

- Subject to Council's approval, the draft Standards will be released for external consultation.

Questions for Council

1. Does Council agree that the draft OHP Standards be released for external consultation?

[2] Each level represents the level of risk or invasiveness of the procedures occurring in that facility, with Level 1 carrying the least risk (minimally invasive, local anaesthesia) and Level 3 carrying the most risk (significantly invasive, general anesthesia).

Out-of-Hospital Premises Inspection Program Overview

The Out-of-Hospital Premises Inspection Program (OHPIP) supports continuous quality improvement through developing and maintaining standards for the provision of procedures in Ontario out-of-hospital premises (OHPs) and by inspecting premises for safety and quality of care. The OHP Standards are intended to articulate the core requirements for the performance of procedures in certain settings/premises outside a hospital as defined in Ontario Regulation 114/94 under the *Medicine Act, 1991* (hereinafter "the Regulation").

The Standards are used for the inspection of premises and are applicable to all physicians who work in such premises. The standards include information applicable to the range of all procedures performed in OHPs.

The OHPIP is overseen by CPSO's Premises Inspection Committee. Decisions made by the Premises Inspection Committee will be based on the information within these Standards as well as any additional relevant guidelines, protocols, standards and legislation (e.g. the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*, the *Food and Drugs Act*, etc.), including requirements set out by other regulatory bodies and provincial guidelines.

What is the purpose of the Regulation?

The Regulation creates the framework for the regulation of OHPs in Ontario and sets out which procedures are captured by the OHPIP, along with CPSO's powers and responsibilities in relation to inspection of OHPs.

The Regulation sets out specific criteria regarding the procedures that are captured by the OHPIP. How do I determine which procedures are captured by the OHPIP, and therefore can only be performed in an OHP that meets the requirements set out in the Standards?

Any procedure performed under general or regional anesthesia or parenteral sedation is captured by the program and is therefore subject to the requirements set out in the Standards, including approval of and inspection by CPSO.

Some procedures that are performed using local anesthesia are also captured by the Program. This includes any procedure performed with local anesthetic that is:

- A procedure using tumescent anesthesia[1]
- A nerve block for chronic pain
- A cosmetic procedure involving the alteration or removal of tissue or
- A cosmetic procedure where a substance or material (including tissues from the patient's own body i.e. autologous tissue) is injected or inserted into a patient.

There are some procedures performed with local anesthetic that **are not** captured by the Program, including:

- A minor dermatological procedure such as the removal of skin tags, benign moles and cysts

[1] The practice of injecting a very dilute solution of local anesthetic combined with epinephrine and sodium bicarbonate into tissue until it becomes firm and tense.

- A procedure involving the alteration or removal of tissue where done for clinical and *not* cosmetic reasons
- Procedures using only an external topical anesthetic (e.g. Lasik eye surgery).

Minor cosmetic procedures that do not require local anesthesia (e.g. Botox, sclerotherapy) are not captured by the Program.

How are the different types of anesthesia defined?

The following definitions have been adapted from "Continuum of Depth of Sedation" and "Statement on Safe Use of Propofol" by the American Society of Anesthesiologists (ASA):

Local Anesthesia refers to the application, either topically, intradermally or subcutaneously, of agents that directly interfere with nerve conduction at the site of the procedure.

Sedation is an altered or depressed state of awareness or perception of pain brought about by pharmacologic agents and which is accompanied by varying degrees of depression of respiration and protective reflexes.

Minimal Sedation ("Anxiolysis") is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.[2]

Moderate Sedation ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully[3] to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Note: Due to the potential for rapid and profound changes in sedative/anesthetic depth and the lack of antagonist medications, patients that receive potent intravenous induction agents (including, but not limited to Propofol, Ketamine, Etomidate, and Methohexital) must receive care that is consistent with deep sedation even if moderate sedation is intended. These medications must be administered by a physician qualified to provide deep sedation.

Regional anesthesia: Major nerve blocks include, but are not limited to, spinal, epidural, caudal, retrobulbar, stellate, paravertebral, brachial plexus, transcapular, intravenous regional analgesia, celiac, pudendal, hypogastric, sciatic, femoral, obturator, posterior tibial nerve and cranial nerve block.

[2] For the purpose of the Standards, sole or minimal use of oral anxiolysis for the purpose of pre-medication is not considered sedation.
[3] Reflex withdrawal from painful stimulus is NOT considered a purposeful response.

General anesthesia is regarded as a continuum of depressed central nervous system function from pharmacologic agents resulting in loss of consciousness, recall, and suppression of somatic and autonomic reflexes.

What are CPSO's responsibilities in relation to regulating OHPs?

CPSO is responsible for considering all issues related to the provision of procedures requiring the use of anesthesia and/or sedation that are performed within OHPs.

CPSO's responsibilities include but are not limited to:

1. Developing and maintaining "OHP Program Standards"
2. Approving any new premises
3. Approving OHP Medical Directors
4. Conducting inspection of the premises and in some cases observing procedures to ensure that services for patients are provided according to the standard of the profession
5. Determining the outcome of inspections
6. Maintaining a current public record of inspection outcomes on the CPSO website
7. Issuing notices for payment of OHP fees.

What does the inspection process involve?

New premises or relocating premises will be inspected within 180 days of notification. All OHPs are inspected every 5 years, or more often if CPSO deems it necessary or advisable.

The inspection may involve but is not limited to:

1. completion of the on-line notification form
2. completion of a pre-visit visit questionnaire
3. a site visit by a nurse inspector appointed by CPSO that includes:
    - a review of records and other documentation
    - review of the OHP's compliance with accepted standards
    - review of any other material deemed relevant to the inspection
4. enquiries or observation of procedures where relevant.

Nurse inspectors provide OHP inspection reports to CPSO, and CPSO provides a copy of the report to the Medical Director.

As outlined in the Regulation, the Premises Inspection Committee determines the inspection outcome and an OHP will be given either a "Pass", "Pass with Conditions", or "Fail" outcome.

What does a "Pass" outcome mean?

A "Pass" outcome means the OHP Standards are met for the specific procedures identified by the OHP at the time of the inspection and that no deficiencies were identified.

What does a "Pass with Conditions" outcome mean?

A "Pass with Conditions" outcome means that deficiencies have been identified in the OHP. If

an OHP receives this outcome they may:

1. be restricted to specific procedures
2. be required to make submissions in writing to CPSO within 14 days of receiving the report
3. be subject to a follow-up inspection at CPSO's discretion within 60 days of receiving the OHP's written submission
4. receive a "Pass" outcome when deficiencies have been corrected to CPSO's satisfaction.

What does a "Fail" outcome mean?

A "Fail" outcome means that significant deficiencies have been identified in the OHP. Where a "Fail" outcome is given:

1. All OHP procedures must cease in the OHP;
2. The OHP may make submissions in writing to CPSO within 14 days of receiving the report; and
3. A follow-up inspection may be conducted at CPSO's discretion within 60 days of receiving the OHP's written submission.

The Medical Director is responsible for ensuring compliance with the OHP Standards and providing any information necessary in relation to the premises. Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee, in accordance with the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard and may result in the removal of the Medical Director and direction to appoint a new Medical Director.

Co-operation with the Out-of-Hospital Premises Program Standard

Co-operation with the Out-of-Hospital Premises Inspection Program Standard

Those working in OHPs, including Medical Directors, have an obligation to communicate promptly and accurately with CPSO, to foster a respectful relationship and demonstrate co-operation with the Out-of-Hospital Premises Program (OHPIP). Failure to communicate with or provide information to CPSO in the required manner may result in an outcome of Fail by the Premises Inspection Committee, which requires the OHP to cease operation, or may trigger a reinspection or a referral to CPSO's Inquires, Complaints, and Reports Committee.

Standards

1. All physicians practising in OHPs **must**:

    a. provide accurate information to CPSO, in the form and timeframe specified by CPSO;
    b. co-operate with inspections undertaken by CPSO in order to ensure compliance with the OHP Standards.

2. Medical Directors **must** annually confirm, in the form and manner required by CPSO, their understanding of their responsibilities as set out in the Standards and that they are compliant with these responsibilities. This will include agreement to:

    a. perform their duties with due diligence and in good faith;
    b. ensure that the OHP complies with the Standards and meets its responsibilities,
    c. ensure the OHP provides safe and effective care.

3. Medical Directors **must** respond to CPSO requests for documentation and information in the form and timeframe required, as follows:

    a. within 5 business days for information regarding adverse events;
    b. within 14 days for regular CPSO requests, or
    c. any otherwise specified timeframe as identified by CPSO for other CPSO requests.

4. Medical Directors **must** ensure the OHP does not:

    a. operate in contravention of the Standards;
    b. operate in contravention of any conditions or restrictions imposed by the OHPIP and/or the Premises Inspection Committee.

5. Medical Directors **must** cease operation of an OHP if they receive a fail outcome from an inspection.

6. All physicians planning to practise in an OHP **must** complete the online Staff Affiliation form prior to performing procedures in an OHP.

Notification to CPSO

7. Medical Directors who plan to operate a new OHP **must** notify CPSO of their plans to do so.

8. Medical Directors **must** ensure that no procedures are performed in the OHP until they receive approval from the OHPIP to do so and that only approved OHP procedures are performed.

9. Medical Directors **mus**t notify CPSO of any adverse event in the OHP in writing within 5 business days of learning of the event.[1]

10. Medical Directors **must** notify CPSO in writing at least two weeks prior to any of the following changes to the OHP:

    a. ownership of the OHP
    b. name of the OHP
    c. numbers of procedures performed: any significant increase/decrease (>50% of the last reported inspection)
    d. a new arrangement to rent space to other physicians for the performance of any surgical or anesthetic technique covered by the OHP policy and procedures
    e. decision to cease operation of the OHP[2].

11. Medical Directors **must** notify CPSO in writing at least two weeks prior to any of the following intended changes to the OHP and receive approval (and where necessary undergo a re/inspection):

    a. OHP Medical Director (in accordance with the *Medical Director* Standard);
    b. OHP location/address;
    c. structural changes to patient care areas (including equipment);
    d. new types of procedures or practices;
    e. permitting overnight stays.

Inspection Process

12. Medical Directors and physicians practising in the OHP **must** participate fully in the inspection process and comply with CPSO requests in relation to this process, including:

    a. submitting to an inspection of the OHP;
    b. promptly answering any questions or complying with any requirement of the inspector that is relevant to the inspection;
    c. co-operating fully with CPSO and the inspector who is conducting the inspection;
    d. providing the inspector with any requested records;
    e. allowing direct observation of a physician, including direct observation by an inspector of the physician performing a procedure on a patient;

[1] Please see the *Adverse Events* Standard for more information.
[2] For more information on the appropriate steps to follow when ceasing operation, please see CPSO's *Closing a Medical Practice* policy.

i. Where observation will be occurring, Medical Directors **must** inform the patient prior to the scheduled procedure that an observation of the procedure may take place as a component of the inspection process.

13. Medical Directors **must** ensure that complete records are onsite on the date of planned inspections, including all books, accounts, reports, records or similar documents that are relevant to the performance of a procedure done in the OHP.

14. Medical Directors **must** participate in any requested post inspection processes (e.g., an exit interview with the inspector, completion of a post inspection questionnaire, and providing any required follow-up documentation).

Advice to the Profession: Co-Operation with the Out-of-Hospital Premises Inspection Program Standard

As the Medical Director, how do I need to annually confirm my understanding of my responsibilities?

Medical Directors will need to confirm their understanding of their responsibilities through an Annual Attestation. This attestation is made as part of the annual premises renewal process and is done through the Member Portal.

If I am planning to operate a new OHP, what do I need to do?

Before you can perform any procedures at a new OHP you will need to complete and submit a New Premise Application, pay the required fee and pass a premise inspection, which will be conducted within 180 days of receiving your notice. To complete the application:

1. log into the CPSO Member Portal,
2. click on the OHP tile,
3. click on the New Premises Application button.

Where I am required to notify CPSO of specific changes to the OHP, how do I do this?

You will need to complete a New Request or Notification form and include as many details as possible regarding the change to the OHP. CPSO will then decide if your OHP needs to be re-inspected. To complete a New Request or Notification form:

1. log into the CPSO Member Portal,
2. click on the OHP tile,
3. click on the OHP number of the OHP for which you wish to make changes,
4. click on OHP Requests/Notifications on the left-hand navigation,
5. select the appropriate request or notification button.

What information needs to be available for inspections?

The Standard requires that the Medical Director ensures that complete records are onsite on the date of the inspection. In carrying out an inspection of an OHP, the inspector may require any examination and copies of books, accounts, reports, records or similar documents that are, in the opinion of CPSO, relevant to the performance of the OHP.

More information related to inspections can be found in the *Out of Hospital Premises Inspection Program Overview* document.

Medical Director Standard

Medical Director Standard

Definitions

Medical Director: The Medical Director is the CPSO approved physician responsible for the management and oversight of the OHP.

Acting Medical Director: An "Acting Medical Director" refers to a CPSO approved physician who is overseeing the OHP in the absence of the Medical Director.

Standards

1. All OHPs **must** have a Medical Director or an Acting Medical Director who has been approved by CPSO, and who is responsible for oversight of the OHP, including ensuring compliance with all applicable legislation, regulations, by-laws, CPSO policies, and the requirements in the Standards.

2. Medical Directors **must** annually confirm their understanding of their responsibilities in relation to the OHP, in the manner and form required by CPSO (e.g., sign an annual declaration of responsibilities[1]).

Qualifications

3. Physicians acting as a Medical Director in an OHP **must** have the skills and experience necessary to effectively oversee the OHP[2] and **must** at minimum meet the following criteria:

    a. reside in Ontario;
    b. hold a valid and active CPSO certificate of registration;
    c. not be the subject of any disciplinary or incapacity proceeding in any jurisdiction;
    d. not have lost their hospital privileges or been terminated from employment for reasons of professional misconduct, incompetence, or incapacity; and
    e. not have any terms, conditions or limitations on their certificate of registration that would impact their ability to fulfill the role of a Medical Director.[3]

4. Medical Directors **must** inform the CPSO if, during the course of serving as a Medical Director, they become the subject of a disciplinary or incapacity proceeding and may be required to appoint an Acting Medical Director at the discretion of CPSO.

    a. The Medical Director **must** only resume the role upon CPSO approval.

[1] Please see the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard for more information
[2] For more information about the types of skills and experience necessary to effectively oversee an OHP, please see the *Advice to the Profession* document.
[3] For additional considerations please see the *Advice to the Profession* document.

Appointment of Acting Medical Director

5. Medical Directors **must** ensure that whenever they are unable or unavailable to perform all of their duties, they have designated another physician practising in the OHP to do so.

6. Medical Directors who plan to take an extended leave of absence or who will be unable to fulfill the duties of their role for an extended period of time (i.e., greater than one month) **must** inform CPSO, who will then determine whether an Acting Medical Director needs to be appointed.

7. Where an Acting Medical Director needs to be appointed, Medical Directors **must** ensure the Acting Medical Director who is appointed:

    a. meets the criteria set out in provision 3 above; and
    b. is approved by CPSO.

8. Where an Acting Medical Director is appointed, the Acting Medical Director **must** sign an agreement with the Medical Director that articulates all of their responsibilities.

9. The Medical Director or Acting Medical Director **must** ensure that all staff working in the OHP are notified when an Acting Medical Director is appointed.

Credentialing and Ensuring Competence

Ensuring competence is a key component of the role of the Medical Director and Medical Directors are ultimately accountable and responsible for all the care provided in the OHP (i.e., for the care provided by the staff practising in the OHP).

10. Medical Directors **must** ensure that all staff practising within the OHP have the requisite knowledge, skill, and judgment to do so competently and safely and that they are practising within their scope of practice and any limitations of their certificate of registration.

11. Medical Directors **must** ensure all staff practising in the OHP have the appropriate qualifications[4] and competence prior to working in the OHP, by at minimum, ensuring the following:

    a. the training and credentials of all staff who wish to practise in the OHP have been reviewed and verified;
    b. all staff are in good standing with their regulatory body, where applicable (i.e., a Certificate of Professional Conduct has been reviewed) including that they:

        i. have a valid and active certificate of registration with their regulatory body;
        ii. are not the subject of any disciplinary or incapacity proceeding in any jurisdiction;
        iii. have not lost their hospital privileges or been terminated from employment for reasons of professional misconduct, incompetence, or incapacity;

[4] For additional information on appropriate qualifications please see Appendix A.

iv. do not have any terms, conditions or limitations on their certificate of registration that would impact their ability to practise in an OHP.

12. Medical Directors **must** ensure that all staff:

    a. read the Policies and Procedures (P&P) manual upon being hired and annually, or where there is a change, and confirm this action (e.g., with a signature and date);
    b. read their individual job descriptions of duties and responsibilities, indicating they have been read and understood (e.g., with a signature and date); and
    c. have professional liability protection as required by their regulatory body, where applicable.

Appropriate Supervision

13. Medical Directors **must** provide a level of supervision and support that ensures safe and effective care within the OHP.

14. Medical Directors **must:**

    a. be on site as needed, to oversee the premises and ensure the OHP is operating safely and effectively, at least one day per month; and
    b. be readily available to provide appropriate oversight and assistance, when necessary.

15. Medical Directors **must** be satisfied that all staff practising within the OHP:

    a. understand the extent of their responsibilities; and
    b. know when and who to ask for assistance, if necessary.

16. Medical Directors **must:**

    a. take reasonable steps to ensure that all staff are practising in accordance with the standard of care; and
    b. take appropriate action where there are concerns about the conduct or care of any staff practising in the OHP (e.g., concerns about the number of adverse events), including:

        i. Addressing and documenting the issue with the individual;
        ii. Ensuring appropriate remediation;
        iii. Suspending or terminating the individual, where appropriate;
        iv. Reporting to the professional's regulatory body, where necessary.

Appendix A: Staff Qualifications

Appropriate qualifications generally include the following:

If pediatric care is provided to children 12 and under, staff will:

a. be trained to handle pediatric emergencies; and
b. maintain a current PALS certification.

If administering or recovering pediatric patients from general or regional anesthesia or sedation, staff will need to have recent clinical experience doing so (i.e., within 2 years).

Qualifications for Physicians Performing Procedures

Physicians who perform procedures using local anesthesia in OHPs will hold one of the following:

a. Royal College of Physicians and Surgeons of Canada (RCPSC) or College of Family Physicians of Canada certification that confirms training and specialty designation pertinent to the procedures performed;
b. CPSO recognition as a specialist that would include, by training and experience, the procedures performed (as confirmed by the CPSO's *Specialist Recognition Criteria in Ontario* policy);
c. Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Qualifications for Physicians Administering Anesthesia

Physicians Administering General or Regional Anesthesia or Deep Sedation

Physicians administering general or regional anesthesia or deep sedation will hold:

a. RCPSC designation[5] as a specialist in anesthesia or one of the following:
    i. Completion of a program accredited by the College of Family Physicians of Canada under the category of "Family Practice Anesthesia";
    ii. CPSO recognition as a specialist in anesthesia, or other specialty pertinent to the regional anesthesia performed, as confirmed by CPSO's *Specialist Recognition Criteria in Ontario* policy.

[5] Physicians who are trained in general or regional anesthesia or deep sedation but who have not been practising in this area for two years or more would be subject to CPSO's *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policy, if they wished to return to this area of practice.

Physicians Administering Minimal to Moderate Sedation

Where a physician is not qualified to administer general anesthesia or deep sedation, but is administering minimal-to-moderate sedation, the physician will hold:

- Education and experience to manage the potential medical complications of sedation/anesthesia, including ability to:
    i. identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia,
    ii. assist in the management of complications, and
    iii. understand the pharmacology of the drugs used, and
- Current ACLS certification.

Nurse Qualifications

Nurses working in OHPs will have training, certification, and appropriate experience as required for the procedures performed, including holding qualifications in accordance with those set out in the National Association PeriAnesthesia Nurses of Canada's *Standards for Practice*, where applicable, as well as current ACLS if administering sedation to, monitoring or recovering patients (RNs only).

Appendix B: OHP Policies and Procedures

The OHP policies and procedures, which must be regularly reviewed, updated, and implemented include the following:

Administrative issues and responsibilities, including:
a. responsibility for developing and maintaining the policy and procedure manual,
b. scope and limitations of OHP services provided,
c. overnight stays, if applicable,
d. staff qualifications, hospital privileges, and records.

Response to emergencies, including those related to:
a. need to summon additional staff assistance urgently within the OHP,
b. fire,
c. power failure,
d. other emergency evacuation,
e. need to summon help by 911, and coordination of OHP staff with those responders.

Urgent transfer of patients, including:
a. appropriate transportation (e.g., ambulance) and accompaniment (e.g., Most Responsible Physician, OHP staff, etc.), and
b. timely transfer of relevant documentation/medical records.

Job Descriptions, including:
a. OHP staff job descriptions that define scope and limitations of functions and responsibilities for patient care; and
b. Responsibility for supervising staff.

Procedures related to:
a. Adverse events (i.e., monitoring, reporting, reviewing and response)
b. Combustible and Volatile Materials
c. Delegating controlled acts and medical directives
d. Routine maintenance and calibration of equipment
e. Infection control, including staff responsibilities in relation to the *Occupational Health and Safety Act*
f. Medications handling and inventory
g. Patient booking system
h. Detailed and clear patient selection/admission/exclusion criteria for services provided
i. Patient consent in accordance with CPSO's *Consent to Treatment* policy
j. Patient preparation for OHP procedures
k. Response to allergic reactions (e.g., latex)
l. Safety precautions regarding electrical, mechanical, fire, and internal disaster
m. Waste and garbage disposal

Forms used

Inventories/Lists of equipment to be maintained

Advice to the Profession: Medical Director Standard

The role of the Medical Director is central to ensuring safe and quality care within an OHP. The quality of the leadership and oversight of the OHP correlates with the quality of the care provided within the OHP.

Accordingly, many of the expectations set out within the Standards are the responsibility of the Medical Director. This companion *Advice* document is intended to help Medical Directors interpret their obligations as set out in the *Medical Director* Standard and provide guidance around how the expectations may be effectively discharged.

The Medical Director Standard sets out minimum criteria that must be met in order to be a Medical Director. If I meet the minimum criteria, will I automatically be approved to be a Medical Director?

No. Satisfaction of minimum criteria does not guarantee approval to be a Medical Director. CPSO will exercise reasonable discretion in approving Medical Directors. Additional considerations may include, but will not be limited to, whether:

- a physician has active investigation(s) and the nature of the investigation(s) (e.g. whether the complaint has a specific impact on the ability to perform in the role);
- a physician is subject to any other regulatory activity or condition that may be relevant to the role;
- a physician is the subject of a discipline finding;
- a physician has had their certificate of registration revoked or suspended.

The Medical Director Standard requires that Medical Directors have the skills and experience necessary to effectively oversee the OHP. What are the skills and experience necessary to oversee an OHP?

The role of a Medical Director is key to ensuring safe and quality care within an OHP. Relevant skills needed to be effective in the role include strong leadership skills, relevant clinical expertise, and knowledge of relevant clinical practice guidelines, quality improvement, and infection prevention and control standards. There are a variety of ways in which the necessary skills and experience can be acquired. While some Medical Directors may have such knowledge, skills and experience before taking on this role, others may acquire the skills over time. For those seeking additional training to help develop the necessary skills, professional development is available. For example, leadership training is offered through programs such as the Canadian Medical Association's The Physician Leadership Institute.

I'm considering hiring a regulated health professional whose certificate of professional conduct (CPC) indicates they have an active investigation. Am I permitted to hire them?

It depends. The *Medical Director* Standard sets out minimum criteria that must be met for staff practising in an OHP. Given that Medical Directors are responsible for their staff

and all of the care provided in the OHP, even if these criteria are met, Medical Directors will need to use their professional judgement and carefully consider the nature and seriousness of the complaint or investigation and how quickly it will be resolved.

Medical Directors are responsible for ensuring their staff are appropriately qualified and have the competence necessary to practise safely in an OHP. Depending on the nature and seriousness of the complaint or investigation (e.g., whether there are concerns about clinical competence) Medical Directors may wish to hold off on hiring the individual until the outcome of the investigation is known, or to take additional steps to satisfy your obligation to ensure the individual's competence. Medical Directors are ultimately responsible for the care provided in the OHP and for exercising due diligence when hiring.

What happens if CPSO determines that a Medical Director cannot fulfill their duties?

The Medical Director is professionally accountable for fulfilling all of their obligations and duties to the OHP and CPSO. In the event that CPSO determines that the Medical Director is not performing their duties in accordance with the legislation, regulations, and policies, CPSO can require the OHP Medical Director to appoint an Acting Medical Director acceptable to CPSO and/or take such other steps as deemed necessary.

If I go on vacation do I need to appoint an Acting Medical Director to fulfill my duties?

Whenever a Medical Director is unable to fulfill their duties as set out in the Standards, they are required to ensure that another physician practising in the OHP can fulfil these duties. If the Medical Director will be unavailable or unable to fulfill their duties for an extended period of time (i.e., more than a month) they are required to notify the CPSO and where deemed necessary, appoint an Acting Medical Director who meets the criteria set out in the Standard and who is approved by CPSO. Temporary or short term absences (less than a month) do not require undergoing the process of appointing an Acting Medical Director that is approved by CPSO, but do require the Medical Director to appoint a physician within the OHP to perform their role while they are unavailable.

Medical Directors are required to be on site as needed, but at least one day per month, to oversee the premises and ensure the OHP is operating safely and effectively. What kind of things would a Medical Director be doing when they are on site?

There are a number of responsibilities that Medical Directors have with respect to the OHP, including those related to supervision, quality assurance, and infection prevention and control. In order to effectively fulfill these duties, it is important that Medical Directors are on site as needed to oversee the premises, ensure that policies and procedures are being adhered to and to ensure that safe, quality care is being provided. The more present and involved a Medical Director is within the OHP, the better the patient care tends to be.

Physicians Practising in Out-of-Hospital Premises Standard

Physicians Practising in Out-of-Hospital Premises Standard

Standards

1. All physicians practising in an Out-of-Hospital Premises (OHP) **must**:
    a. have completed the online Staff Affiliation form for each OHP they wish to practise in, prior to practising in that OHP;
    b. meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided;
    c. practise within their scope of practice and within the limits of their knowledge, skill and judgement;
    d. comply with all applicable requirements in the Standards, including:
        i. cooperating with and providing information to CPSO in accordance with the *Co-operation with the Out-of-Hospital Premises Inspection Program* Standard;
        ii. being appropriately qualified to perform all procedures they perform in that OHP, in accordance with Appendix A of the *Medical Director* Standard;
        iii. complying with pre-procedure, intra-procedure and post-procedure care requirements when performing procedures in accordance with the *Procedures Standard*;
        iv. complying with all infection prevention and control standards and requirements in accordance with the *Infection Prevention and Control* Standard;
        v. managing and reporting all adverse events in accordance with the requirements in the *Adverse Events* Standard;
        vi. participating in quality assurance processes within the OHP, in accordance with the *Quality Assurance* Standard;
        vii. complying with all applicable policies and procedures of the OHP, as set out in Appendix B of the *Medical Director* Standard;
    e. comply with all applicable CPSO policies[1];
    f. comply with the requirements for the OHP set out by the Medical Director and in the OHP's policies and procedures; and
    g. comply with existing standards or guidelines from applicable specialty societies.

[1] This includes but is not limited to the following: *Availability and Coverage*, *Consent to Treatment*, *Delegation of Controlled Acts*, *Disclosure of Harm*, *Physician Behaviour in the Professional Environment*, *Prescribing Drugs*, *Managing Tests*.

Physical Space Standard

Physical Space Standard

Standards

General

1. Medical Directors **must** ensure that the requirements in Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice* document regarding physical spaces, including the surgical space and reprocessing space, are met.

2. Medical Directors **must** ensure:

    a. The OHP complies with all applicable building codes including fire and safety requirements;
    b. All electrical devices are certified by the Canadian Standards Association (CSA) or are licensed for use in Canada;
    c. There is an emergency power supply that allows for safely completing a procedure that is underway and for recovering the patient;
    d. Access for persons with disabilities complies with provincial legislation[1] and municipal bylaws;
    e. Necessary spaces can be accessed by and accommodate stretchers and wheelchairs;
    f. The size of the OHP is adequate for all the procedures that will be performed within it;
    g. The OHP layout facilitates safe patient care and patient flow; and
    h. The following areas of the OHP are functionally separate:
        i. administration and patient-waiting area
        ii. procedure room and/or operating room
        iii. recovery area
        iv. clean utility area
        v. dirty utility room
        vi. reprocessing room
        vii. endoscope cabinet (where applicable)
        viii. staff change room and staff room.

3. Medical Directors **must** ensure the physical space allows for appropriate movement of patients in an emergency, including:

    a. safely evacuating patients and staff if necessary (i.e. stretchers, wheelchairs, or other adequate methods of transport are available), and
    b. appropriate access to the patient for an ambulance to transfer the patient to a hospital.

[1] *Accessibility for Ontarians with Disabilities Act, 2005*, S.O. 2005, c. 11.

Procedure Room/Operating Room Physical Standards

Physical Requirements

4. Medical Directors **must** ensure the OHP has:

    a. lighting as required for the specific procedure being performed;
    b. floors, walls, and ceilings that can be cleaned to meet infection control requirements;
    c. immediate access to hand-washing facilities and proper towel disposal;
    d. openings to the outside effectively protected against the entrance of insects or animals; and
    e. space sufficient to accommodate equipment and staff required for the procedure, and to move around while sterile, without contamination.

Ventilation

5. Medical Directors **must** ensure:

    a. there is ventilation sufficient to ensure patient and staff comfort, and fulfill occupational health and safety requirements;
    b. there is ventilation and air circulation augmented to meet manufacturer's standards and address procedure-related air-quality issues (e.g., cauterysmoke, endoscopy, disinfecting agents, anesthesia gases), where applicable; and
    c. air exchanges meet infection control standards[2] for the type of procedure being performed;
    d. if using gas sterilization for reprocessing, a positive pressure outbound system is used, vented directly to the outside.

Equipment

6. Medical Directors **must** ensure:

    a. Medical equipment is maintained and inspected yearly by a qualified biomedical technician and has an active service contract;
    b. Equipment necessary for emergency situations (i.e., defibrillators, oxygen supply, suction) is inspected on a weekly basis and documented;
    c. Related documentation for all equipment is available, including:
        i. record of certification of medical equipment by a qualified biomedical technician,
        ii. equipment operating manuals,
        iii. equipment maintenance contracts with an independent and certified biomedicaltechnician,
        iv. log for maintenance of all medical devices, and
    d. The following equipment is available:
        i. cleaning equipment as required for the specific procedure,
        ii. accessible anesthetic drugs and equipment,
        iii. blood pressure and oxygen saturation monitoring equipment,

[2] For more information see Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice.*

iv. sterile supplies and instruments,
v. table/chair that permits patient restraints and Trendelenberg positioning, where applicable,
vi. table/chair/stretcher that accommodates procedures performed and provides for adequate range of movement for anesthetic procedures,
vii. suction equipment and backup suction, for anesthesia provider's exclusive use.

Anesthetic and Ancillary Equipment

7. Where an OHP administers general anesthesia, regional anesthesia or sedation, Medical Directors **must** ensure:

    a. Both anesthetic and ancillary equipment and medical compressed gases and pipelines comply with the Canadian Standards Association (CSA) or are licensed for use in Canada;
    b. A second supply of (full cylinder) oxygen capable of delivering a regulated flow is present;
    c. An anesthetic machine and anesthetic cart with appropriate drugs[3] and equipment is provided, where general anesthesia is being administered.
        i. In accordance with the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*, appropriate equipment includes at minimum:
            - Pulse oximeter;
            - Apparatus to measure blood pressure, either directly or noninvasively;
            - Electrocardiography;
            - Apparatus to measure temperature;
            - Neuromuscular blockade monitor when neuromuscular blocking drugs are used;
            - Capnography for general anesthesia and to assess the adequacy of ventilation for moderate or deep procedural sedation; and
            - Agent-specific anesthetic gas monitor, when inhalational anesthetic agents are used.

Recovery Area Physical Standards

8. Medical Directors **must** ensure a sink is available for hand washing.

9. Where an OHP provides general anesthesia, regional anesthesia or sedation, Medical Directors **must** ensure:

    a. The size of the recovery area can accommodate the number of patients for two hours of operating room time (i.e., 1 hour procedure = 2 patients, 0.5 hour procedure = 4 patients);
    b. The recovery area allows for transfer of patients to/from a stretcher and performance

[3] For more information on what drugs are needed, see the *Drugs and Equipment* Standard.

of emergency procedures; and

c. Monitoring, suction, oxygen, bag-valve mask devices, and other emergency airway equipment, intravenous and other medical supplies are immediately available.

Drugs and Equipment Standard

Drugs and Equipment Standard

Standards

General

1. Medical Directors **must** ensure the following practices are undertaken in the OHP:

    a. a general drug inventory record is maintained;
    b. periodic inspection of all drugs is undertaken to ensure drugs are not expired;
    c. single dose vials of drugs are used wherever possible;
    d. if multidose vials of drugs must be used, they are dated on opening, disposed of according to manufacturer's guidelines, and are used in accordance with Public Health Ontario's *Updated Guidance on the Use of Multidose Vials*[1];
    e. drugs are labelled in accordance with the *Food and Drug Act*[2] and the *Controlled Drugs and Substances Act*[3] and any regulations made under those statutes;
    f. drugs are stored securely and in accordance with the manufacturer's recommendations (e.g., refrigeration if required); and
    g. emergency drugs are stored in a common location[4].

Controlled Substances

2. Medical Directors **must** ensure that controlled substances are:

    a. handled, stored, and administered in accordance with *Food and Drug Act* and the *Controlled Drugs and Substances Act* and any regulations made under those statutes;
    b. accessed by a qualified designated staff member[5];
    c. stored securely and appropriately to prevent theft and loss; and
    d. accounted for in a "Log of Controlled Substances".[6]

3. Medical Directors **must** ensure that at the beginning and end of each day that controlled substances are used, a balance of the inventory is calculated by physical count and verified.

4. In the event of a discrepancy, Medical Directors **must** ensure that an investigation is conducted and documented with the action taken.

Drugs and Equipment for Urgent or Emergency Situations

5. Medical Directors **must** ensure that staff are prepared to address urgent or

[1] For more information on appropriate use of multidose vials see Public Health Ontario's *Updated Guidance on the Use of Multidose Vials*.
[2] *Food and Drug Act* R.S.C., 1985, c. F-27, s. 1
[3] *Controlled Drugs and Substances Act* (CDSA)S.C. 1996, c.19
[4] A crash cart may be appropriate in OHPs where procedures are done in multiple procedure rooms.
[5] For example, an RN, RPN with medication skills, or a physician.
[6] For additional information on appropriate practices please see the Canadian Society of Hospital Pharmacist's *Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management and Diversion Prevention.*

emergency situations or resuscitate a patient using appropriate equipment[7] and current drugs, when necessary.

6. Medical Directors **must** ensure that, at minimum, the OHP has the following drugs immediately available:

    a. Oxygen
    b. H1 antihistamines (e.g., Diphenhydramine)
    c. Epinephrine for injection
    d. Bronchodilators (e.g., Salbutamol)
    e. Atropine
    f. Intralipid if using Lidocaine/Bupivacaine/Ropivacaine.

7. Medical Directors **must** ensure that other appropriate equipment and drugs are immediately available to respond to the following situations, proportionate to the level of anesthesia or sedation being administered[8]:

    a. Hypertension
    b. Hypotension
    c. Anaphylaxis
    d. Cardiac events, including those covered in the ACLS Algorithms
    e. Respiratory Events
    f. Malignant Hyperthermia, if using triggering agents [9]
    g. Benzodiazepine reversal
    h. Opioid reversal
    i. Neuromuscular blockade reversal, if using nondepolarizing muscle relaxants
    j. Acidosis
    k. Relevant potential electrolyte disturbances
    l. Hyper and Hypoglycemia
    m. Emesis.

8. If services are provided to infants and children, the Medical Director **must** ensure that required drugs are available and appropriate for that population.

[7] Please see the *Advice* document for more information on the equipment that would be typically required within an OHP.
[8] The drugs required will depend on the type of anesthesia used at the OHP (i.e., local, IV sedation or general). Please see the *Advice* document for more information on the drugs typically used to respond to the listed conditions.
[9] For more information see Malignant Hyperthermia Association of the United States' *What should be on an MH cart?*

Advice to the Profession: Drugs and Equipment Standard

Where can I find more information on how to appropriately store and handle controlled substances?

Additional information on appropriate practices relating to controlled substances can be found in the Canadian Society of Hospital Pharmacists' document *Controlled Drugs and Substances in Hospitals and Healthcare Facilities: Guidelines on Secure Management and Diversion Prevention.*

The Drugs and Equipment Standard requires drugs to be immediately available to respond to a number of situations – which specific drugs are recommended?

Medical Directors are responsible for ensuring that the OHP has the appropriate drugs needed to address the situations outlined in the Standard. This may be achieved in a number of ways but generally speaking the following drugs will support physicians in managing urgent and emergency situations:

Hypertension

- Antihypertensive IV such as Labetalol, Hydralazine or Nitroglycerine (at least 1 for circumstances where sedation or regional anesthesia is being administered, and at least 2 where general anesthesia is being administered)
- BETA Blocker IV such as Metoprolol, Propranolol, Esmolol
- Lasix IV

Hypotension

- At least 2 of:
    - Epinephrine
    - Ephedrine
    - Vasopressin
    - Phenylephrine

Anaphylaxis

- Diphenhydramine IV
- Hydrocortisone IV

Cardiac Events

- Epinephrine
- Amiodarone IV
- ASA
- IV agent for supraventricular tachycardia such as Adenosine, Esmolol, Verapamil, or Metoprolol (at least 2 for circumstances where sedation or regional anesthesia is being administered, and at least 3 where general anesthesia is being administered)
- Nitroglycerine spray
- Atropine IV
- Benzodiazepine IV such as Midazolam, Diazepam, or Lorazepam
- Calcium IV

- Lidocaine 2% pre-filled syringe

Respiratory Events

- Bronchodilators

Malignant hyperthermia

- An adequate supply of Dantrolene, and other appropriate drugs as per MHAUS guidelines

Benzodiazepine Reversal

- Flumazenil IV

Opioid Reversal

- Naloxone IV - if narcotics are stocked

Electrolyte Disturbances

- Magnesium Sulfate IV

Hypoglycemia

- Dextrose 50% IV

Other

- Neuromuscular blocking reversal agents
- Sodium bicarbonate IV

What kind of equipment is appropriate to have immediately available for urgent or emergency situations?

Medical Directors are responsible for ensuring that the OHP has the appropriate equipment needed to address the situations outlined in the Standard. This may be achieved in a number of ways but generally speaking the following equipment will support physicians in managing urgent and emergency situations:

- AED
- IV setup
- Adequate equipment to manage local anesthetic toxicity
- Appropriately sized equipment for infants and children, if required
- Assortment of disposable syringes, needles, and alcohol wipes
- Laryngeal mask airways
- Means of giving manual positive pressure ventilation (e.g., manual - self-inflating resuscitation device)
- Cardiopulmonary resuscitation equipment with current ACLS/PALS - compatible defibrillator
- Qualitative and quantitative means to verify end-tidal CO2
- ECG monitor

- Intubation tray with a variety of appropriately sized blades, endotracheal tubes, and oral airways
- Oxygen source
- Pulse oximeter
- Suction with rigid suction catheter
- Devices to provide active warming
- Torso backboard
- Cognitive Aids (for example, for difficult airways, ACLS algorithms, Malignant Hyperthermia, etc)

The *Physical Space* Standard contains requirements around maintaining and inspecting equipment. Please see that Standard for more information.

Patient Selection Standard

Patient Selection Standard

Patient selection is a crucial component of ensuring procedures performed in an OHP are safe. The appropriateness of performing a procedure in the OHP setting depends on ensuring that the proposed procedure can be performed safely for that particular patient and their particular circumstances.

Standards

1. Physicians **must** use their professional judgement to determine whether a procedure can be provided to a particular patient safely and effectively in an OHP, on a case by case basis.

2. Physicians **must** only perform a procedure on a patient where they are satisfied that the procedure can be safely and effectively performed in the OHP, and it is in the patient's best interest to do so, taking into account:

    a. the patient's existing health status (e.g., any co-morbidities, frailty, stability of any existing conditions), their specific health-care needs and the specific circumstances;
    b. the potential complications that could arise from that specific procedure, including potential complications in surgical management if more than one procedure is to be performed at a time;
    c. anesthetic or sedation factors that may place the patient at a higher risk;
    d. the resources that may be required to perform a procedure on that particular patient;
    e. the duration of the procedure and the potential for a prolonged recovery period; and
    f. the location of the OHP and its proximity to emergency services or hospitals[1], should complications arise from the procedure.

3. Where a prospective patient would be required to undergo general or regional anesthesia or sedation, the physician administering the anesthesia or sedation **must** assign an ASA classification[2] for that prospective patient.

    a. Generally, only patients with ASA classifications of I and II are appropriate for procedures in an OHP setting. Physicians **must** only perform procedures involving the administration of general or regional anesthesia or sedation on patients classified as ASA III if:
        i. the comorbid condition is unlikely to add significant risk to the anesthetic, sedation or procedure; and
        ii. the comorbid condition could not reasonably be expected to be adversely affected by the anesthetic, sedation, or procedure;
    b. The physician administering the anesthesia or sedation and the physician performing the procedure **must** discuss all potential ASA III cases well in advance of the scheduled procedure, with regard to the:

[1] The *Adverse Events* Standard requires OHPs to have an established protocol to facilitate the urgent transfer of patients to the most appropriate hospital for the management of an urgent adverse patient event.
[2] For more information on ASA classifications see the *Advice to the Profession* document.

i. appropriateness of OHP setting for the safe performance of the procedure (including the factors listed in Provision 2 above),
ii. pre-procedure assessment and care required, and
iii. intra-procedure and post-procedure requirements.

Advice to the Profession: Patient Selection Standard

Why is patient selection so important in an OHP?

Appropriate patient selection is critical to help ensure that patients can receive safe care in OHPs. The Out-of-Hospital Premises Inspection Program has historically seen a number of adverse events that result from inappropriate patient selection. The *Patient Selection* Standard requires physicians to classify patients, prior to a procedure where general or regional anesthesia or sedation will be used, using the American Society of Anesthesiologists' Physical Status Classification System and only perform procedures on patients who are classified as ASA I, ASA II or, in some circumstances, ASA III.

The process of determining suitability of a patient to undergo a procedure in an OHP involves the complex interplay of several factors, and there can be a significant difference in the way physicians classify patients and determine which ASA III patients they consider appropriate to treat in an OHP. This Standard is intended to help physicians appropriately exercise professional judgment in relation to these patients.

How do I determine which ASA classification a patient should have?

In determining the appropriate ASA classification for a patient there are a number of factors that need to be considered. The table below[1] outlines some examples of conditions or diseases that would influence the determination of a patient's ASA classification.

ASA Classification	**Definition**	**Adult Examples**
I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): • current smoker, • well-controlled diabetes mellitus or hypertension, • mild lung disease
III	A patient with severe systemic disease	Substantive functional limitations; 1 or more moderate to severe diseases. Examples include (but not limited to): • poorly controlled diabetes mellitus or hypertension, • chronic obstructive pulmonary disease, • transient ischemic attack, • coronary artery disease/stents

[1] Modified from Rajan, N, Rosero E, and Joshi, G 2021, 'Patient Selection for Adult Ambulatory Surgery: A Narrative Review', *International Anesthesia Research Society*, vol. 133, no. 6, pp 1415-1430. Please see this article for more information.

What kind of comorbidities may make a patient inappropriate to perform a procedure on in an OHP?

Several comorbid conditions have been demonstrated to have an effect on patient outcomes after procedures in an OHP type setting and therefore need to play a major role in patient selection. Independent factors identified by a majority of studies include:

- advanced age
- obesity
- obstructive sleep apnea
- cardiac disease,
- chronic obstructive pulmonary disease
- diabetes mellitus
- end-stage renal disease
- transient ischemic attack/stroke,
- chronic opioid use or opioid use disorder, and
- malignant hyperthermia.[2]

Generally, patients would be unsuitable for a procedure in an OHP where they:

- have unstable or poorly managed chronic illnesses such as diabetes, hypertension, hepatitis, etc.;
- have unmanaged alcohol or substance use disorders; or
- are undergoing active immunosuppressant cancer treatment.

Physicians are required to exercise their professional judgement when determining the appropriateness of performing procedures on patients in an OHP, and where they are unsure or where the patient is classified as ASA III, are required to consult with the physician administering the anesthesia or sedation well in advance of the procedure.

Why do physicians need to discuss ASA III cases well in advance?

The *Patient Selection* Standard does allow room for professional judgement when it comes to determining which ASA III patients may be appropriate to have a procedure in an OHP. However, it is important that professional judgment in these circumstances be exercised in a considered way. Requiring that discussions take place between the physician who will be performing the procedure and the physician administering the anesthesia or sedation will help to ensure that both physicians have thought through the potential complicating factors of performing a procedure on the patient in the OHP setting, and both agree that it is appropriate to do so in the circumstances. It is important for discussions to take place in advance in order to manage patient expectations and avoid any pressure to perform a procedure that has been scheduled where it might not be appropriate.

[2] Rajan, N, Rosero E, and Joshi, G 2021, 'Patient Selection for Adult Ambulatory Surgery: A Narrative Review', *International Anesthesia Research Society*, vol. 133, no. 6, pp 1415-1430.

Procedures Standard

Procedures Standard

Standards[1]

1. Physicians **must** meet the standard of practice of the profession, which applies regardless of the setting in which care is being provided.

2. Physicians administering anesthesia or sedation **must** do so in accordance with the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia,* including requirements for patient assessment, pre-procedural testing, fasting guidelines, patient monitoring, documentation of care in the patient record, and anesthesia support personnel.

    a. Where a physician is administering anesthesia or sedation to a pediatric patient they **must** do so in accordance with the Canadian Pediatric Society's *Recommendations for procedural sedation in infants, children, and adolescents*.

3. Physicians **must** use the Surgical Safety Checklist for all surgical procedures.

4. The Medical Director **must** ensure that nursing staff comply with National Association of PeriAnesthesia Nurses of Canada *Standards for Practice*, including requirements for appropriate staffing, discharge of patients from recovery phases, documentation of care in the patient record and appropriate discharge instructions.

5. Prior to procedure acceptance, physicians **must** have assessed the suitability of the patient to undergo the procedure in the OHP setting in accordance with the *Patient Selection* Standard.

    a. For patients with significant co-morbidities, physicians **must** undertake appropriate consultation (for example, with an anesthesiologist or other specialists) as required, prior to making a decision to proceed with the procedure in the OHP setting.

6. Physicians **must** ensure all elements of patient care are appropriately documented in accordance with CPSO's *Medical Records Documentation* policy. For more information on appropriate documentation, please see the *Advice to the Profession* document.

Pre-Procedure Requirements

7. Physicians **must** provide appropriate pre-procedure instructions to patients including any fasting instructions, and whether they will require adult accompaniment upon discharge from the OHP.

8. The physician performing the procedure **must** undertake an appropriate pre-procedure assessment and ensure a baseline history and physical has been taken.

9. Where anesthesia or sedation will be administered, the physician administering the anesthesia or sedation **must**, on the day of the procedure, undertake a pre-anesthetic

[1] Where this standard uses the term "physician" the expectation can be fulfilled by either the physician performing the procedure, or the physician administering the anesthesia or sedation. Expectations that must be fulfilled by a specific physician state this explicitly.

assessment.

10. Physicians **must** ensure informed consent has been obtained for the procedure, including the use of anesthesia or sedation where applicable, in accordance with CPSO's *Consent to Treatment* policy.

Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

11. If the physician administering the regional anesthesia or sedation is also performing the procedure, the physician **must** ensure the patient is attended by a second individual[2] who is not assisting in the procedure, and is appropriately qualified, in accordance with Appendix A of the *Medical Director* Standard, to monitor patients undergoing regional anesthesia or sedation.

Post-Procedure Patient Care

12. A physician **must** remain on site until the patient has met discharge criteria for the most acute phase of recovery, in accordance with the National Association of PeriAnesthesia Nurses of Canada *Standards for Practice*.

13. Medical Directors **must** ensure that where there is an overnight stay at an OHP, all of the following conditions are met:

    a. A physician, appropriately qualified in accordance with Appendix A of the *Medical Director* Standard, is immediately available by telephone and can be available onsite at the premises within thirty minutes for urgent medical matters; and
    b. A minimum of two nurses appropriately qualified to monitor and recover patients from anesthesia or sedation are on premises.

Patient Discharge After General or Regional Anesthesia or Sedation

14. When a patient is being discharged, a physician **must:**

    a. write the discharge order for a patient, and
    b. direct that the discharge summary be distributed to the patient's primary care provider, if there is one and, the patient has provided consent.

15. Recovery area staff **must** ensure that patients are:

    a. Provided with appropriate written discharge instructions[3];
    b. accompanied by an adult when leaving the OHP, and are advised to have an adult stay with the patient during the postoperative period (most commonly 24 hours);
    c. informed that they need to notify the OHP of any unexpected admission to a hospital within 10 days of the procedure.

[2] Such as a physician, respiratory therapist, RN or anesthesia assistant.
[3] For example, no driving for 24 hours, who to contact for routine and emergency follow-up, and instructions for pain management, wound care, and activity.

Advice to the Profession: Procedures Standard

What kind of pre-procedure assessments are appropriate to undertake before performing a procedure on a patient in an OHP?

The *Procedures* Standard requires that an appropriate pre-procedure assessment is undertaken including a baseline history and physical examination.

Where anesthesia or sedation will be administered, the Standard also requires the physician administering the anesthesia or sedation to complete a pre-anesthetic assessment. Such an assessment would typically include the following:

- American Society of Anesthesiologists' (ASA) physical status classification of the patient
- a review of the patient's clinical record (including pre-procedure assessment)
- an interview with the patient
- a physical examination relative to anesthetic aspects of care
- a review and ordering of tests as indicated
- a review or request for medical consultations as necessary for patient assessment and planning of care
- a review of pre-procedure preparation such as fasting, medication, or other instructions that were given to the patient.

When determining which tests are indicated or appropriate for a particular patient, physicians may wish to consult Choosing Wisely Canada's recommendations in relation to anesthesia.

What elements of patient care need to be documented when administering anesthesia or sedation in an OHP?

As the *Procedures* Standard states, physicians must comply with *Medical Records Documentation* policy.

When anesthesia or sedation is administered, an Anesthesia/Sedation Record is required to be completed. A typical Anesthesia/Sedation record includes the following information:

a. pre-procedure anesthetic/sedation assessment
b. all drugs administered including dose, time, and route of administration
c. type and volume of fluids administered, and time of administration
d. fluids lost (e.g., blood, urine) where it can be measured or estimated
e. measurements made by the required monitors:
    - Oxygen saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated, a supraglottic airway is used, or moderate to deep sedation is being administered, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals
    - Pulse and blood pressure documented at least every 5 minutes until patient is recovered from sedation
    - Temperature and neuromuscular blockade monitors
f. complications and incidents (if applicable)
g. name of the physician responsible (and the name of the person monitoring the patient, if applicable)

h. start and stop time for anesthesia/sedation care.[1]

What elements of care need to be documented during the recovery period?

In relation to care provided during the recovery period appropriate documentation would typically include:

a. patient identification
b. date and time of transfer to recovery area
c. initial and routine monitoring of: blood pressure, pulse, respirations, oxygen saturation, temperature, level of consciousness, pain score, procedure site and general status
d. continuous monitoring of vital signs until the patient has met requirements of discharge criteria using an objective scoring system from time of transfer to recovery area until discharge
e. medication administered: time, dose, route, reason, and effect
f. treatments given and effects of such treatment
g. status of drains, dressings, and catheters including amount and description of drainage
h. summary of fluid balance
i. discharge score using a verified discharge scoring system.

What other documents or notes would typically be included in the patient record?

The *Medical Records Documentation* policy states that the goal of the medical record is to "tell the story" of the patient's health care journey. In order to ensure that a full picture of the patient's health care journey is reflected in their record, the following documents or notes would typically be included:

- Documentation of the consent process in accordance with CPSO's *Consent to Treatment* policy, including a record of any forms that were used
- Pre-procedure assessment
- A copy of the completed Surgical Safety Checklist
- The Anesthetic/Sedation Record
- Discharge summary, where applicable
- Any adverse event reports, as required by CPSO.

[1] For more information see the Canadian Anesthesiologists' Society *Guidelines to the Practice of Anesthesia*.

Infection Prevention and Control Standard

Infection Prevention and Control (IPAC) Standard

All OHP staff are responsible for complying with appropriate IPAC practices and for taking action where inappropriate practices are occurring (i.e., those that are out of line with infection prevention and control standards). Everyone has a responsibility to monitor their own practice as well as the practice of the other health care providers working in the OHP to ensure patient safety.

Standards

1. Medical Directors **must** ensure appropriate infection prevention and control practices are occurring within the OHP, including compliance with all applicable legislation and regulations[1], as well as with Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice*[2].[3]

2. In particular, Medical Directors **must** ensure that the following is occurring within the OHP:

    a. Adherence to Routine Practices[4] and Additional Precautions[5];
    b. Compliance with safe medication practices;[6]
    c. Maintenance of a clean and safe health care environment with environmental cleaning and disinfection appropriate to the clinical setting performed on a routine and consistent basis;
        i. Areas where surgery and invasive procedures are performed are cleaned and disinfected according to standards set by the Operating Room Nurses Association of Canada (ORNAC);[7]
    d. Reprocessing of medical equipment is done in accordance with the manufacturer's instructions and/or accepted standards and reflects the intended use of the

[1] This includes, for example, the *Occupational Health and Safety Act* (hereinafter OHSA), as well as the *Needle Safety Regulation (O. Reg 474/07)* under the *OHSA,* and the Workplace Hazardous Materials Information System (WHMIS).
[2] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. *Infection Prevention and Control for Clinical Office Practice*. 1st Revision. Toronto, ON: Queen's Printer for Ontario; April 2015.
[3] A summary of mandatory practices and best practice recommendations for clinical office practice is set out on page 72 of *Infection Prevention and Control for Clinical Office Practice*.
[4] Routine Practices are based on the premise that all patients are potentially infectious, even when asymptomatic, and that the same standards of practice must be used routinely with all patients to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms.
[5] "Additional Precautions" refer to IPAC interventions (e.g., barrier equipment, accommodation, additional environmental controls) to be used in addition to Routine Practices to protect staff and patients and interrupt transmission of certain infectious agents that are suspected or identified in a patient.
[6] For additional information see *Appendix H: Checklist for Safe Medication Practices* set out in *Infection Prevention and Control for Clinical Office Practice*.
[7] For more information about environmental cleaning in surgical areas refer to the Operating Room Nurses Association of Canada (ORNAC) standards, which are now under the auspices of the Canadian Standards Association.

equipment or device and the potential risk of infection involved in the use of the equipment or device[8];

e. Accepted standards of handling regulated waste are adhered to[9].

3. Medical Directors **must** ensure the following is in place to support appropriate IPAC practices:

    a. well documented policies and procedures which are periodically reviewed by staff;
    b. all staff are properly trained and are provided with regular education and support to assist with consistent implementation of appropriate IPAC practices;
    c. responsibility for specific obligations are clearly defined in writing and understood by all staff; and
    d. mechanisms are in place for ensuring a healthy workplace, appropriate staff immunizations and written protocols for exposure to infectious diseases, including a blood-borne pathogen exposure protocol.[10]

4. Where substandard IPAC practices are occurring, all staff **must** take appropriate action, including advising the Medical Director, addressing the issue with the individual responsible for the infraction, and/or reporting to Public Health, where required.

[8] For additional information see *Appendix I: Recommended Minimum Cleaning and Disinfection Level and Frequency for Medical Equipment* set out in *Infection Prevention and Control for Clinical Office Practice*.
[9] "Regulated Waste" means: a) liquid or semi-liquid or other potential infectious material; b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed; c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling; d) contaminated sharps; e) pathological and microbiological wastes containing blood or other potentially infectious materials.
[10] For additional information see *Appendix J: Checklist for Office Infection Prevention and Control* set out in *Infection Prevention and Control for Clinical Office Practice*.

Advice to the Profession: Infection Prevention and Control (IPAC) Standard

Why is it important to ensure OHPs are complying with IPAC standards?

IPAC is an important element of care in any health care institution. Given the nature of the procedures done in OHPs, for example the level of invasiveness, it is important to ensure that appropriate IPAC practices are in place and that standards are met. Failure to do so can have serious consequences for both patients and staff.

What are common IPAC infractions observed during inspections?

Many OHPs that fail their inspections do so from a failure to comply with IPAC standards. Common IPAC deficiencies seen during inspections include the following:

- Sinks with no backsplash
- Items stored underneath sinks
- Aerosol or spray trigger cleaning chemicals
- Cloth furniture that is porous
- Biomedical waste that is stored with other supplies
- Refrigerator used for medications with no temperature log
- Multi-use gel or cleaning solutions not dated upon opening
- Multi-use medications not dated upon opening
- Housekeeping supplies not stored in a designated space
- Reprocessing issues (e.g. technician not appropriately trained, reprocessing done incorrectly, missing items essential to reprocessing, reprocessing brushes that are not designed for re-use being used multiple times).

Medical Directors are responsible for compliance with the requirements set out in Public Health Ontario's *Infection Prevention and Control for Clinical Office Practice*[1] and for ensuring the practices within the OHP are current and reflect any changes in requirements relating to IPAC.

What are some actions that minimize risk of infection in the operating room?

Actions that minimize risk of infection in the operating room include adherence to proper use of disinfectants, proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors), proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms), and prompt management of water intrusion into OHP structural elements.

[1] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. *Infection Prevention and Control for Clinical Office Practice*. 1st Revision. Toronto, ON: Queen's Printer for Ontario; April 2015.

Adverse Events Standard

Adverse Events Standard

Definitions

Adverse Event: An incident that has resulted in harm to the patient as a result of the care provided in the OHP (also known as a "harmful incident"). For specific examples, please see the *Advice to the Profession* document.

Standards

Preparing for Adverse Events

1. Medical Directors **must:**

    a. ensure there are written protocols in place to support the recognition and reporting of adverse events and to appropriately manage any adverse events that occur;
    b. ensure there is an established protocol to facilitate the urgent transfer of patients to the most appropriate hospital for the management of an urgent adverse patient event;
    c. ensure there is a formalized transfer agreement with a local hospital;
    d. be available to provide assistance in managing any adverse events, if necessary;
    e. be satisfied that staff practising within the OHP are capable of managing any adverse events themselves, if necessary; and
    f. have a communication plan in place to keep informed of any adverse events that take place and any actions taken to manage them.

Managing Adverse Events

2. When an adverse event occurs, physicians involved in the adverse event **must** take appropriate and timely action, including:

    a. managing any urgent adverse events appropriately by:
        i. providing any necessary care to address the patient's immediate needs;
        ii. ensuring timely initiation of emergency care or services, where necessary (i.e., where the patient is experiencing severe suffering or is at risk of sustaining serious bodily harm if treatment is not administered promptly);
        iii. initiating a timely transfer to hospital, where necessary;
        iv. accompanying the patient to hospital, where necessary;
        v. communicating with the receiving physician or premises to notify them of the transfer, where the patient is unaccompanied;
        vi. ensuring essential medical information and the referring physician's contact information is sent with the patient to support continuity of care;
    b. caring for, supporting, and following-up with patients, family, and caregivers as necessary.

Documenting and Reporting Adverse Events

3. When an adverse event occurs, physicians involved in the adverse event **must**:

    a. document the details of the adverse event in the patient's medical record;

b. provide a written report to the Medical Director within 24 hours of learning of the event which includes the following information:
    - name, age, and gender of the person(s) involved in the incident, including staff and patients
    - name of witness(es) to the event (if applicable)
    - time, date, and location of event
    - description of the incident and treatment rendered
    - date and type of procedure (if applicable)
    - analysis of reasons for the incident
    - outcome;
c. report the incident, including the details captured in provision 3b, to CPSO in writing within 5 business days of learning of the event;
d. provide CPSO with any relevant medical records and additional information as requested;
e. ensure appropriate disclosure to the patient, in accordance with CPSO's *Disclosure of Harm* policy; and
f. where a death occurs, make a report to the Coroner.

4. Where an adverse event occurs, Medical Directors **must** ensure the reporting obligations set out above are complied with (e.g., that the adverse event has been reported to the CPSO within 5 business days).[1]

Incident Analysis

5. Once the adverse event has been appropriately managed, Medical Directors **must** initiate a process to analyze and learn from the event, including:

    a. undertaking an investigation to understand how and/or why the incident occurred;
    b. developing recommendations to help prevent similar incidents from occurring;
    c. sharing the learnings and recommendations with other staff in the OHP.

6. Medical Directors **must** ensure that recommendations are implemented within the OHP and are monitored over time to assess their effectiveness.

Analyzing and Learning from Adverse Events

7. Medical Directors **must**:

    a. critically review all adverse events that have occurred over a 12 month period and evaluate the effectiveness of the OHP's practices and procedures to improve patient safety;
    b. document the review and any relevant corrective actions and quality improvement initiatives taken; and
    c. provide feedback to all staff regarding identified patterns of adverse events.

[1] Failure to report an adverse event may result in an outcome of Fail by the Premises Inspection Committee.

Advice to the Profession: Adverse Events Standard

An adverse event is defined as an incident that has resulted in harm to the patient as a result of care provided in the OHP. What are some specific examples of adverse events that must be reported to CPSO?

A key component of the definition is that the adverse event must be related to the procedure performed in the OHP. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure itself. This includes both serious complications, such as:

- Death within the premises;
- Death within 10 days of a procedure performed at the premises;
- Any procedure performed on the wrong patient, site, or side; or
- Transfer of a patient from the premises directly to a hospital for care.

It also includes other quality assurance incidents which are deemed less critical for immediate action, such as:

- Unscheduled treatment of a patient in a hospital within 10 days of a procedure performed at a premises in relation to the procedure;
- Complications such as infection, bleeding, or injury to other body structures;
- Cardiac or respiratory problems during the patient's stay at the OHP;
- Allergic reactions; or
- Medication-related adverse events.

Patient harm that occurs as a result of an unrelated activity is not considered an adverse event as defined by the Standard and does not need to be reported to CPSO. For example, if a patient has an injury that results in a hospital stay within 10 days of the procedure performed in the OHP but is unrelated to the OHP procedure, this would not be considered an adverse event.

Why is it important for Medical Directors to track adverse events?

Adverse events can serve as a good indicator of where quality improvement can occur in an OHP, both with respect to policies and procedures in the OHP, and with respect to an individual physician's practices. Keeping track of this information is intended to assist OHPs with learning from and improving patient safety within the premises. Reviews of adverse events (and near misses) are considered an effective approach to improving patient safety.

What is the purpose of reporting adverse events to CPSO? What will you do with this information?

CPSO is responsible for the effective oversight of OHPs. Reviewing the severity and frequency of adverse events within each OHP helps CPSO to fulfill this duty by helping to identify any concerning trends. In order to fulfill CPSO's obligation to monitor for higher risk events, and to fulfill their own obligations, Medical Directors are accountable to CPSO for reporting this information and for taking any appropriate corrective action.

CPSO recognizes that adverse events can result from a variety of factors, including risks inherent in the procedure, system failures, or even performance issues with individual

physicians, however they offer opportunity for learning and improvement and can offer insight into areas which might benefit from practice improvement or additional safety measures. Depending on the nature and frequency of adverse events, they are not necessarily an indication of poor practice. However, lack of reporting of adverse events may serve as indication that OHPs are failing to comply with their obligations as set out in the *Adverse Events* Standard.

CPSO is committed to assisting OHPs with improving their practices and collecting information regarding adverse events helps us to do so.

How can I report adverse events and what information needs to be submitted to CPSO?

Adverse events can be reported through the Member Portal on CPSO's website. Physicians involved in the adverse event are required to submit a report with the following information:

- name, age, and gender of the person(s) involved, including staff and patients;
- name of witness(es) to the event (if applicable);
- time, date, and location of event;
- description of the incident and treatment rendered;
- date and type of procedure (if applicable);
- analysis of reasons for the incident;
- outcome;
- any additional information as requested by CPSO.

Physicians will also be asked to submit relevant medical records, including any referral letters, pre- and post-operative notes and tests, surgical notes, the anesthesia record, and an updated memo of the patient's outcome.

Why has CPSO moved away from distinguishing between Tier 1 and Tier 2 adverse events?

With the implementation of CPSO's new Member Portal, you are now required to report all adverse events as they occur, so the distinction between Tier 1 and Tier 2 adverse events no longer serves a purpose. CPSO will continue to review all adverse events that occur within OHPs and respond accordingly.

Where can I learn more about adverse events?

The CMPA's Good Practices Guide and *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions* have additional guidance related to adverse events, including the best approach for reviewing these events.

Quality Assurance Standard

Quality Assurance Standard

Standards

Creating a Culture of Safety and Quality

1. Medical Directors **must** foster a culture of safety and quality within the OHP.

2. Medical Directors **must** ensure that the OHP maintains a Quality Assurance program and that it undertakes initiatives to improve the quality of care within the premises.

3. Medical Directors **must** ensure the OHP has a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance to ensure appropriate volume and scope of services provided.

4. Medical Directors **must:**

    a. hold, at a minimum, two QA committee meetings at each OHP site per year, that address quality issues (e.g., infection control, adverse events, etc.);
    b. ensure meetings are attended by all staff providing patient care where possible, and that all staff who are unable to attend are updated on the meeting discussions and outcomes;
    c. ensure all meetings, including the staff who were in attendance, are documented and that the documentation is available to CPSO upon request.

5. Medical Directors **must** hold periodic staff meetings to review policies and procedures, challenging cases, near misses[1], adverse events, and protocols as appropriate to minimize adverse events.

6. Medical Directors **must** ensure that members of staff undertake continuing education relevant to their practice in the OHP, in accordance with applicable regulatory requirements, to maintain clinical competency and knowledge of best practices.

Monitoring Quality of Care

7. Medical Directors **must** ensure there is a documented process in place to regularly monitor the quality of care provided to patients through activities, including the following:

    a. review of all staff performance (i.e., both medical and non-medical staff);
    b. review of individual physician care to assess:
        - patient and procedure selection are appropriate
        - patient outcomes are appropriate
        - adverse events;
    c. review a selection of individual patient records to assess completeness and accuracy of entries by all staff;

[1] Near miss incident is defined in CPSO's *Disclosure of Harm* policy as an incident with the potential for harm that did not reach the patient due to timely intervention or good fortune (also known as a "close call"). For specific examples, please see the *Advice to the Profession: Disclosure of Harm*.

d. review of activity related to cleaning, sterilization, maintenance, and storage of equipment;
e. documentation of the numbers of procedures performed (i.e., any significant increase/decrease (>50% of the last reported assessment)).

Advice to the Profession: Quality Assurance Standard

What is "Quality Assurance" and what does it mean to foster a culture of safety and quality within the OHP?

The term "Quality Assurance" generally refers to the identification, assessment, correction, and monitoring of important aspects of patient care. The *Quality Assurance* Standard sets out a number of quality assurance activities that must be undertaken in an OHP which, when undertaken effectively, can help to foster a culture of safety and quality within the OHP.

The CMPA's *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*[1] also has guidance around fostering a just culture of safety within an institution.

The Quality Assurance Standard requires that Medical Directors hold periodic staff meetings to review policies and procedures, challenging cases, near misses, adverse events, and protocols as appropriate to minimize adverse events. How often should staff meetings be held?

Medical Directors can determine the frequency of staff meetings based on the needs of the OHP and its staff, any updates or changes in polices and procedures, or any adverse events, near misses, or challenging cases that may need to be reviewed.

Medical Directors are required to regularly monitor the quality of care provided to patients through activities such as reviewing a selection of patient records. What are best practices with respect to this quality assurance activity?

An annual review of a random selection of medical records (e.g., 5-10 records) can help to monitor the quality of care within an OHP, including review of the following:

- record completion[2] and documentation of informed consent
- percentage and type of procedures
- appropriate patient selection[3]
- appropriate patient procedure
- where required, reporting results in a timely fashion
- evaluation of complications
- assessment of transfer to hospital, where required
- follow up of abnormal pathology and laboratory results.

[1] *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions*. Ottawa, ON: Canadian Medical Protective Association; 2009.
[2] For more information see the *Advice to the Profession: Procedures Standard* document.
[3] For more information see the *Patient Selection* Standard.

Council Motion

Motion Title	Out-of-Hospital Premises Inspection Program (OHPIP) - Draft Standards for External Consultation
Date of Meeting	September 23, 2022

It is moved by_____, and seconded by_____, that:

The Council of the College of Physicians and Surgeons of Ontario engage in the consultation process in respect of the draft "Out-of-Hospital Premises Standards", (a copy of which forms Appendix " " to the minutes of this meeting).