THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL – FEBRUARY 26, 2016
8:30 a.m. to 12:30 p.m.
Council Chamber, 3rd Floor, 80 College Street, Toronto

8:30 a.m.	**CALL TO ORDER**	
	President's Announcements	
2 Motions	**Council Meeting Minutes of December 4 & 5, 2015** **Council Meeting Minutes of January 26, 2016**	**4** **21**
	FOR DECISION	
Motion	**Physician Treatment of Self, Family Members or Others Close to Them - Revised Draft Policy for Final Approval** Revisions have been made to the draft *Physician Treatment of Self, Family Members, or Others Close to Them* policy to reflect feedback provided by Council at its December 2016 meeting. Council is asked whether it approves the policy.	**22**
Motion	**Prescribing Naloxone For Opioid Overdose Emergency Kits** Naloxone is a prescription drug that can reverse the life-threatening effects of an opioid overdose. Given the rise in opioid-related deaths in Ontario, Council is asked whether the Prescribing Drug policy should be revised to permit physicians to prescribe naloxone for distribution in opioid overdose emergency kits. Council is also asked whether the College should release a statement articulating support for wider availability of naloxone as part of the emergency treatment of opioid overdose.	**45**

Motion	**By-Law #107 (Membership Fee)** At its December meeting, Council proposed an increase to the membership fee for independent practice certificates. Consultation feedback on the proposed by-law (which sets the membership fee at $1,595) has been considered. Council is asked whether it approves the proposed by-law.	**67**
MEMBER TOPICS		
REGISTRAR'S REPORT **Strategic Update - Dashboard**		
PRESENTATION **Regulatory Models** **Council will be provided with an overview of regulatory governance, hearings and oversight models in other jurisdictions.**		
10:15 a.m.	**BREAK**	
PRESENTATION **Regulatory Models and an Overview of the Law Society of Upper Canada**		
10:30 a.m.	Mr. Robert G.W. Lapper, Q.C., Chief Executive Officer	**87**
COUNCIL AWARD PRESENTATION		
11:30 a.m.	Council Award – Dr. Stephen Feder, Ottawa, Ontario	**88**
11:45 a.m.	**PHYSICIAN ASSISTED DEATH (Update)**	

12:00 p.m.	**FOR INFORMATION**	
1.	Policy Report	**95**
2.	Governance Committee Report	**116**
3.	Support for Public Members	**117**
4.	Government Relations Report	**127**
5.	Discipline Committee – Report of Completed Cases, February	**129**
12:15 p.m.	**IN CAMERA SESSION**	
	ADJOURN	

COUNCIL MEETING MINUTES of December 3 and 4, 2015

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 26, 2016

It is moved by ....., and
seconded by .....,
that :

The Council accepts as correct the minutes of the meeting of the Council held on December 3 and 4, 2015.

- OR -

The Council accepts the minutes of the meeting of the Council held on December 3 and 4, 2015 with the following corrections:

1.

COUNCIL SPECIAL MEETING MINUTES OF JANUARY 26, 2016

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 26, 2016

It is moved by ....., and seconded by ....., that :

The Council accepts as correct the minutes of the special meeting of the Council held on January 26, 2016.

- OR -

The Council accepts the minutes of the special meeting of the Council held on January 26, 2016 with the following corrections:

1.

Physician Treatment of Self, Family Members, or Others Close to Them – Revised Draft Policy for Final Approval

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 26, 2016

It is moved by .....,

and seconded by ....., that:

The Council approves the revised policy "Physician Treatment of Self, Family Members, or Others Close to Them", formerly titled "Treating Self and Family Members", (a copy of which forms Appendix " " to the minutes of this meeting), as a policy of the College.

PRESCRIBING NALOXONE FOR OPIOID OVERDOSE EMERGENCY KITS

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 26, 2016

It is moved by .....,

and seconded by ....., that:

The Council approves the revised "Prescribing Drugs" policy, (a copy of which forms Appendix "" to the minutes of this meeting) as a policy of the College.

PRESCRIBING NALOXONE FOR OPIOID OVERDOSE EMERGENCY KITS

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 26, 2016

It is moved by .....,

and seconded by ....., that:

The Council approves the statement in support of naloxone for the emergency treatment of opioid overdose (a copy of which forms Appendix " " to the minutes of this meeting).

2016 ANNUAL FEE

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 25, 2016

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. 107:

By-law No. 107

Subsection 4(a) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted:

Annual Fees

4. Annual fees for the year beginning June 1, 2016, are as follows:

   (a) $1595 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;

COMMITTEE APPOINTMENTS

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

February 26, 2016

It is moved by ....., and seconded by ....., that:

The Council appoints Dr. Pauline Abrahams to the Patient Relations Committee and Dr. Mary Bell to the Inquiries, Complaints and Reports Committee, for the balance of the 2016 Council session.

**PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

December 3 and 4, 2015

Members:

Dr. Carol Leet (President)
Dr. El-Tantawy Attia (PhD)
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Ms. Diane Doherty
Mr. Harry Erlichman
Dr. Marc Gabel
Mr. Pierre Giroux
Dr. John Jeffrey
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Barbara Lent
Dr. Rick Mackenzie
Dr. Haidar Mahmoud
Dr. William McCready
Dr. Akbar Panju
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Ms. Joan Powell
Mr. Arthur Ronald
Mr. Ron Pratt
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Wayne Spotswood
Dr. Eric Stanton
Dr. Peter Tadros
Ms Peggy Taillon
Mr. Emile Therien
Dr. James Watters
Dr. Ronald Wexler

Non-voting Academic Representatives on Council: Dr. Michael Franklyn, Dr. John Jeffrey and Dr. Akbar Panju

Regrets: Ms. Peggy Taillon, Dr. Andrew Falconer
December 3 - Dr. John Jeffrey
December 4 - Dr. Akbar Panju, Dr. Wayne Spotswood, Dr. William McCready

CALL TO ORDER

President's Announcements

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

The President announced the results of the 2015 District Elections for Council include: Dr. John Rapin, District 6; Dr. Judith Plante and Dr. Dennis Pitt, District 7; Dr. Steven Bodley; District 8 and Dr. Andrew Turner, District 9.

The new NOSM rep for 2015-16 is Dr. Robert (Bob)Smith.

FOR DECISION

Council Meeting Minutes of September 10 and 11, 2015

01-C-12-03

It is moved by Sudershen Beri and seconded by Dr. Jerry Rosenblum that:

The Council accepts the minutes of the meeting of the Council held on September 10 and 11, 2015 with the following corrections:

1. Addition of Dr. Joel Kirsh, Mr. Peter Pielsticker and Dr. Peter Tadros to the attendee list;
2. Ms. Lynne Cram 'regrets' on September 11

CARRIED

FOR DECISION

Changing the Scope of Practice – Policy Revision

Council reviewed proposed updates to the Changing Scope and Re-entering Practice policies intended to ensure they reflect the current approach to managing physician requests and have been aligned with the current supervision definitions and requirements. Going forward, these policies will be reviewed and revised as part of the regular policy review cycle.

02-C-12-03

It is moved by Emile Therien and seconded by Dr. Eric Stanton that:

The Council approves the revised policy "Changing Scope of Practice", a copy of which forms Appendix A to the minutes of this meeting.

CARRIED

03-C-12-03

It is moved by Sudershen Beri and seconded by Dr. Jerry Rosenblum that:
The Council approves the revised policy "Re-Entering Practice" a copy of which forms Appendix B to the minutes of this meeting.

CARRIED

FOR DECISION

Blood Borne Viruses – Consultation Report and Revised Draft Policy

Dr. Bob Byrick presented the consultation feedback and revisions made by the working group relating to the expectations for physicians who perform or assist in performing exposure prone procedures with respect to reducing the risk of acquiring or transmitting Hepatitis B, Hepatitis C and HIV. The policy changes the testing requirements for HIV and HCV from every year to every three years. The policy only requires annual HBV testing for physicians who have not been confirmed immune to HBV.

04-C-12-03

It is moved by Lynne Cram and seconded by Dr. Peter Tadros that:

The Council approves the revised policy "Blood Borne Viruses", formerly titled "Blood Borne Pathogens", a copy of which forms Appendix C to the minutes of this meeting.

CARRIED

FOR DECISION

Physician Treatment of Self, Family Members, or Others Close to Them – Consultation Report and Revised Policy

Dr. Barbara Lent presented a report on the consultation feedback and changes made by the working group. Council determined that the draft needed further revisions and deferred its decision to approve.

05-C-12-03 Motion – Defeated.

The draft policy will return to Council once the changes have been made for consideration for approval.

Quality Management Partnership: "Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology"

Robin Reece provided an update regarding the latest QMP report and status of the initiative.

Fertility Services In Ontario: Ministry Request to Establish Quality Oversight Regime

Wade Hillier provided Council with an update on discussions and correspondence relating to the government's announced intention to fund IVF in Ontario beginning in 2016.

COUNCIL AWARD PRESENTATION

Council Award Winner – Dr. Sadhana Prasad, Waterloo Ontario

PUBLIC MEMBER ANNUAL REPORT

Ms. Lynne Cram presented the annual report for Council's information.

MOTION TO GO IN CAMERA

06-C-12-03 (1:07 p.m.):

It is moved by Dr. Eric Stanton and seconded by Dr. Marc Gabel that:

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

CARRIED

Returned to open session at 1:50 p.m.

FOR DECISION

Physician-Assisted Death – Draft Guidance for Consultation

Dr. Carol Leet provided an overview of the work done to develop the draft interim guidance for physicians.

The Supreme Court of Canada suspended its decision for 12 months to allow the federal and/or provincial governments to design, if they so choose, a framework to govern the provision of physician-assisted death. This decision takes effect on February 6, 2016, unless the federal government is granted an extension.

The interim guidance for the profession has been drafted in the event that the government does not have a framework in place when the decision goes into effect on February 6.

The draft interim guidelines include:

- The professional and legal obligations articulated in existing College policies and legislation that apply in the physician-assisted death context;
- The criteria for physician-assisted death as set out by the SCC; and
- Guidance for physicians on practice-related elements specific to the provision of physician-assisted death.

07-C-12-03

It is moved by Lynne Cram and seconded by Dr. Barbara Lent that:

The College engage in the consultation process in respect of the draft "Interim Guidance on Physician-Assisted Death", a copy of which forms Appendix D to the minutes of this meeting.

CARRIED

Factors of Risk and Support to Physician Performance: Pan-Canadian MRA Steering Committee

Mr. Dan Faulkner provided Council with a progress report for this pan-Canadian project. Medical regulatory authorities from six provinces have joined together on a project to identify, understand and use empirically defined factors of practice that support physician performance or that suggest a risk of poor performance.

Potential integration with the CPSO's existing objective to conduct more physician assessments ("every doctor every ten years") was discussed.

MOTION TO GO IN CAMERA

08-C-12-04 (9:07 a.m.)
It is moved by Ms. Dianne Doherty and seconded by Dr. Marc Gabel that:
The Council exclude the public from the part of the meeting immediately after this motion is passed under clause 7(2)(b) and (e) of the Health Professions Procedural Code.

CARRIED

Returned to open discussion at 9:30a.m.

FOR DECISION

Sexual Abuse Initiative – Update on College's Initiative

Dr. Carol Leet provided a progress report on the work that has been undertaken as part of the College's Sexual Abuse Initiative since the September 2015 Council meeting.

Council directed staff to pursue legislative change to expand the scope of funding the College provides as part of its current program. Council also directed staff to explore the creation of a separate College fund for these costs in the interim.pending

Council also reviewed the consultation feedback received on the draft Rights and Responsibilities document–(now entitled What to Expect During Medical Encounters) Council considered the revisions to the draft document proposed in response to the consultation feedback and directed that additional changes be made and approved by the Executive Committee before distribution to patients and the public.

Council was also updated on the College's Education and Training Project Plan related to sexual abuse and maintaining boundaries for a wide range of audiences/learners: physicians, medical trainees, and Council and Committee members.

09-C-12-04

It is moved by Dr. Peter Tadros and seconded by Ms. Debbie Giampietri that:
The College seek amendments to the legislation governing the College program for providing funding for therapy/counselling for individuals who have been sexually abused by physicians as set out in the Health Professions Procedural Code, to achieve the following:

i) expand the College program to provide funding for costs associated with accessing therapy/counselling;

ii) allow funding for these costs to be paid directly to the eligible applicant; and

iii) expand the Discipline Committee's authority to order physicians to pay for these costs as part of the College program.

CARRIED

10-C-12-04

It is moved by Mr. Pierre Giroux and seconded Dr. Steven Bodley that:

The College explore the creation of a separate College fund for costs associated with accessing therapy/counselling for individuals who have been sexually abused by physicians, a copy of which forms Appendix Eto the minutes of this meeting.

CARRIED

11-C-12-04

It is moved by Dr. John Lang and seconded by Dr. Joel Kirsh that:

The Council approves the document "What to Expect During Medical Encounters", (a copy of which forms Appendix E to the minutes of this meeting), for distribution to the public.

CARRIED

PRESENTATION

Dr. Laura Molnar, practicing Psychiatrist and Adjunct Professor with Western University in London and Dr. Jim Silcox, presented the following topic, "Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship Program".

FOR DECISION

Transparency Initiative

Council considered a proposed by-law to make SCERPs ordered by the Quality Assurance Committee (QAC)available to the public.

The proposed by-law would result in a consistent approach to SCERPs by the ICRC and QAC. The by-law proposes making public only the elements of the SCERP. The information considered by the QAC would remain confidential.

12-C-12-04

It is moved by Dr. Eric Stanton and seconded by Ms. Diane Doherty that:

Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 109, after circulation to stakeholders:

By-law No. 109

Subsection 49(1) of By-law No. 1 (the General By-Law) is amended by adding the following paragraphs:

> 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:
>
> 22.1 In respect of a decision of the quality assurance committee that includes a disposition of a specified continuing education or remediation program (a "SCERP"), if the decision is made on or after June 1, 2016, the elements of the SCERP.
>
> 22.2 In respect of the elements of a SCERP referred to in paragraph 22.1 above, a notation that all of the elements have been completed, when so done.
>
> 22.3 Where a decision referred to in paragraph 22.1 above is overturned on review, the information referred to in that paragraph shall be removed from the Register.

CARRIED

FOR DECISION

Physician Behaviour in the Professional Environment – Draft Policy for Consultation

Dr. Peeter Poldre provided an overview of the revisions made to the draft policy'Physician Behaviour in the Professional Environment' which sets out expectations for physician behaviour grounded in the principles of medical professionalism.

13-C-12-04

It is moved by Dr. Eric Stanton and seconded by Dr. El-Tantawy Attia that:

The College engage in the consultation process in respect of the draft policy "Physician Behaviour in the Professional Environment", a copy of which forms Appendix F to the minutes of this meeting.

CARRIED

Report of the Finance Committee

Mr. Pierre Giroux presented the report of the activities of the Finance Committee.

14-C-12-04

It is moved by Mr. Sudershen Beri and seconded by Mr. Peter Pielsticker that:

The Council approve the "Budget for 2016" authorizing expenditures for the benefit of the College during the year 2016, a copy of which forms Appendix G to the minutes of this meeting.

CARRIED

15-C-12-04

It is moved by Dr. El-Tantawy Attia and seconded byMs.Joan Powell that;
Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 107, after circulation to stakeholders:

By-law No. 107

Subsection 4(a) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted:

Annual Fees

4. Annual fees for the year beginning June 1, 2016, are as follows:

   (a) $1595 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;

CARRIED

16-C-12-04

It is moved by Mr. Sudershen Beri and seconded by Ms. Dianne Doherty that:
The Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 108:

By-law No. 108

Paragraphs 20(3)(a)(i),(ii), and (iii) of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked and the following are substituted, effective January 1, 2016:

Council and Committee Remuneration

20.-(3) The amount payable to members of the council and a committee is, subject to subsection (4),

(a) for attendance at, travel to, and preparation for, meetings to transact College business,

(i) $612 per half day for the president,

(ii) $504 per half day for the vice-president, and

(iii) $475.50 per half day for the other members

CARRIED

17-C-12-04

It is moved by Dr. Peeter Poldre and seconded by Dr. Peter Tadros that:

The Council of the College of Physicians and Surgeons of Ontario amends the Discipline Committee's Tariff Rate for Costs and Expenses for the College to Conduct a Day of Hearing, increasing the Tariff Rate to $5,000, effective January 1, 2016, a copy of which forms Appendix G to the minutes of this meeting.

CARRIED

GOVERNANCE COMMITTEE REPORT PART 1

Dr. Marc Gabel presented the first part of the Governance Committee report relating to Council's performance assessment report for 2015.

ANNUAL COMMITTEE REPORTS

Reports were pre-circulated with the agenda materials and received by the members with no further commentary.

TOPICS FOR INFORMATION

2015 District Council Elections
Discipline Committee – Table of Completed Cases
Evaluation of Registration Pathways and Policies – Update
Government Relations Report
Marijuana for Medical Purposes – Data
Peer Assessment Redesign – External Feedback and Implementation Plans
Policy Report

PRESIDENT'S ADDRESS

Dr. Carol Leet delivered her Presidential address to Council and reflected on the accomplishments of Council and the challenges that lay ahead.

Induction of New President:

Dr. Carol Leet presented Dr. Joel Kirsh with his presidential pin and the chain of office.

Dr. Joel Kirsh acknowledged the contributions of members leaving council: Dr. Andrew Falconer, Dr. Wayne McCready, Dr. Wayne Spotswood and Dr. Michael Franklyn.

Induction of New Members of Council

Dr. Joel Kirsh introduced the new members, provided them with their CPSO Pin and invited them to take their seats at the Council Table: Dr. John Rapin, Dr. Judith Plante, Dr. Andrew Turner and Dr. Robert Smith.

FOR DECISION

Governance Committee Report Part II

2015-2016 Governance Committee Election

One nomination for the single physician member position was received for Dr. Peeter Poldre. Ms. Lynne Cram and Ms. Diane Doherty were elected to the two public member positions.

18-C-12-04

It is moved by Dr. Eric Stanton and seconded by Mr. Ron Pratt, that:

The Council appoints Dr. Peeter Poldre (as physician member), Ms. Lynne Cram (as public member) and Ms. Diane Doherty (as public member), to the Governance Committee for 2015-16.

CARRIED

ELECTION OF COMMITTEE MEMBERSHIP

19-C-12-04

It is moved by Mr. Sudershen Beri and seconded by Dr. El-Tantawy Attia that the Council appoints the following people to the following committees:

Council Award Selection Committee:

Dr. El-Tantawy Attia *(PhD)*
Dr. Marc Gabel
Dr. Joel Kirsh
Dr. Carol Leet
Dr. Eric Stanton

Discipline Committee:

Dr. El-Tantawy Attia *(PhD)*
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Paul Casola
Dr. Pam Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Ms. Diane Doherty
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Major Abdul Khalifa
Dr. William L.M. King
Dr. Danny Kraftcheck
Mr. John Langs
Dr. Barbara Lent
Dr. Cheryl Levitt
Dr. Richard Mackenzie
Dr. Bill McCready
Dr. Tracey Moriarity
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Dr. John Rapin
Mr. Arthur Ronald
Dr. Harvey Schipper
Dr. Hugh Scully
Dr. Robert Sheppard
Dr. Alan Simpson
Dr. Fay Sliwin
Dr. Eric Stanton
Dr. Peter Tadros
Dr. Andrew Turner

Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Sheila-Mae Young
Dr. Paul Ziter

Education Committee:

Dr. Brenda Copps
Ms. Diane Doherty
Dr. John Jeffrey
Dr. Joel Kirsh
Dr. Barbara Lent
Dr. Akbar Panju
Dr. Karen Smith
Dr. Robert Smith
Dr. James Watters

Finance Committee:

Dr. Charles Chan
Mr. Harry Erlichman
Mr. Pierre Giroux
Dr. Joel Kirsh
Mr. Peter Pielsticker
Dr. Jerry Rosenblum
Dr. David Rouselle

Fitness to Practice Committee:

Dr. El-Tantawy Attia *(PhD)*
Dr. Steven Bodley
Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Ms. Diane Doherty
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Major Abdul Khalifa
Dr. William L.M. King
Dr. Barbara Lent
Dr. Richard Mackenzie
Dr. Bill McCready
Dr. Tracey Moriarity
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. John Watts
Dr. Paul Ziter

Governance Committee:

Dr. Joel Kirsh
Dr. Carol Leet
Dr. David Rouselle
Dr. Peeter Poldre (physician member of Council)
Ms. Lynne Cram(public member of Council)
Ms. Diane Doherty(public member of Council)

Inquiries, Complaints and Reports Committee:

Dr. Scott Allan
Dr. George Arnold
Dr. Haig Basmajian
Dr. Amanda Black
Dr. Harvey Blankenstein
Dr. Brian Burke
Dr. Bob Byrick
Dr. Angela Carol
Dr. Anil Chopra
Dr. Nicholas Colapinto
Ms. Lynne Cram
Dr. Nazim Damji
Dr. Naveen Dayal
Dr. William Dunlop
Dr. James Edwards
Mr. Harry Erlichman
Dr. Karen Fleming
Dr. Bernard Goldman
Dr. Michael Gordon
Dr. Robert Gratton
Dr. Christine Harrison
Dr. Keith Hay
Dr. Elaine Herer
Dr. Robert Hollenberg
Dr. Nasimul Huq
Dr. Francis Jarrett
Dr. John Jeffrey
Dr. Wayne Johnston
Dr. Carol Leet
Dr. Edith Linkenheil
Dr. Haidar Mahmoud
Dr. Jack Mandel
Dr. Edward Margolin
Dr. J. Neil Marshall
Dr. Bill McCauley
Dr. Robert McMurtry
Dr. Patrick McNamara
Dr. Dale Mercer
Dr. Lawrence Oppenheimer
Dr. Akbar Panju

Dr. Eugenia Piliotis
Dr. Judith Plante
Dr. Joan Powell
Mr. Ron Pratt
Dr. Peter Prendergast
Dr. Jerry Rosenblum
Dr. Nathan Roth
Dr. David Rouselle
Dr. Leonard Schwartz
Dr. Ken Shulman
Dr. Wayne Spotswood
Dr. Marina Straszak-Suri
Dr. Michael Szul
Ms. Peggy Taillon
Mr. Emile Therien
Dr. Lynne Thurling
Dr. Donald Wasylenki
Dr. Ron Wexler
Dr. Stephen White
Dr. Stephen Whittaker
Dr. Lesley Wiesenfeld
Dr. Jim Wilson
Dr. Preston Zuliani

Methadone Committee:

Dr. Steven Bodley
Ms. Diane Doherty
Dr. Michael Franklyn
Dr. Trevor Gillmore
Dr. Kumar Gupta
Dr. Karen Jones
Dr. Barbara Lent
Dr. Meredith MacKenzie

Outreach Committee:

Ms. Lynne Cram
Dr. Marc Gabel
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Eric Stanton
Dr. Ron Wexler

Patient Relations Committee:

Dr. Philip Cheifetz
Dr. Timothy Frewen
Ms. Julie Kirkpatrick
Ms. Lisa McCool-Philbin

Premises Inspection Committee:

Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Bob Byrick
Dr. Wayne Carman
Dr. John Davidson
Dr. Bill Dixon
Dr. James Forrest
Dr. Hugh Kendall
Dr. Norman Hill
Dr. Gillian Oliver
Mr. Peter Pielsticker
Dr. Dennis Pitt
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watson
Dr. Michael Zitney

Quality Assurance Committee:

Dr. El-Tantawy Attia *(PhD)*
Mr. Sudershen Beri
Dr. Brenda Copps
Ms. Debbie Giampietri
Dr. Natasha Graham
Dr. Steven Bodley
Mr. Pierre Giroux
Dr. Anil Joseph
Dr. Hugh Kendall
Major Abdul Khalifa
Mr. John Langs
Dr. Bill McCready
Dr. Rami Mozes
Dr. Deborah Robertson
Mr. Peter Pielsticker
Dr. Patrick Safieh
Dr. Bernard Seguin
Dr. Robert Smith
Dr. Leslie Solomon
Dr. Eric Stanton
Dr. Smiley Tsao
Dr. James Watters

Registration Committee:

Mr. Sudershen Beri
Dr. Bob Byrick
Mr. Harry Erlichman

Dr. John Jeffrey
Dr. Barbara Lent
Dr. Akbar Panju
Ms. Joan Powell
Dr. Jay Rosenfield
Dr. John Watts

CARRIED

ADJOURNMENT

As there was no further business, the President adjourned the meeting 4:00 pm.

_____
Dr. Carol Leet, President

_____
Maureen Boon, Recording Secretary

DRAFT PROCEEDINGS OF THE
SPECIAL MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

January 26th, 2016 at 3:00 p.m

Attendees:

Dr. Joel Kirsh (President)
Dr. El-Tantawy Attia (PhD)
Mr. Sudershen Beri (via telephone)
Dr. Steven Bodley
Dr. Brenda Copps (via telephone)
Ms. Lynne Cram
Ms. Diane Doherty (via telephone)
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Major Abdul Khalifa
Mr. John Langs (via telephone)
Dr. Carol Leet
Dr. Barbara Lent (via telephone)
Dr. Rick Mackenzie
Dr. Haider Mahmoud
Dr. Peter Pielsticker
Dr. Dennis Pitt (via telephone)
Dr. Judith Plante (via telephone)
Dr. Peeter Poldre
Ms. Joan Powell (via telephone)
Mr. Ron Pratt (via telephone)
Mr. Arthur Ronald (via telephone)
Dr. Jerry Rosenblum (via telephone)
Dr. Akbar Panju (via telephone)
Dr. David Rouselle
Dr. Robert Smith
Dr. Eric Stanton
Mr. Peter Tadros (via telephone)
Mr. Emile Therien (via telephone)
Dr. Andrew Turner (via telephone)
Dr. James Watters (via telephone)
Dr. Ronald Wexler (via telephone)

Non-voting Academic Representatives on Council: Dr. Akbar Panju, Dr. John Jeffrey, Dr. Robert Smith

Regrets: Ms. Peggy Taillon, Dr. Harry Erlichman, Dr. John Rapin, Dr. John Jeffrey, Dr. Robert Smith

Physician Assisted Death (PAD):

The purpose of this special council meeting is to discuss Physician Assisted Dying and the critical role that the College plays in providing guidance to the profession about how to assist patients who wish to die. Dr. Carol Leet provided an overview of the work that has been done with respect to the guidelines for patients who are suffering and for physicians who care for them. Key revisions to the guidelines were highlighted in the presentation.

01-C-January 26-2016

It is moved by Dr. Marc Gabel and seconded by Lynne Cram, that Council approves the 'Interim Guidance on Physician-Assisted Death' (a copy of which forms Appendix A to the minutes of this meeting).

CARRIED

Adjournment

As there was no further business, the President adjourned the meeting at 4:15 pm.

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Dr. Joel Kirsh, President

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Franca Mancini, Recording Secretary

February 2016

COUNCIL BRIEFING NOTE

TOPIC: Physician Treatment of Self, Family Members, or Others Close to Them – Revised Draft Policy for Final Approval

FOR DECISION

ISSUE:

- The draft *Physician Treatment of Self, Family Members, or Others Close to Them* policy was circulated for external consultation between June and August 2015.

- At its December 2015 meeting, Council reviewed the consultation report and the proposed revisions made to the draft policy in response to the feedback received. Council directed that some additional revisions be made to the draft policy.

- Council's feedback has been incorporated and Council is asked whether the revised draft policy can be approved as a policy of the College.

BACKGROUND:

- The College's current *Treating Self and Family Members* policy was reviewed in accordance with the policy review cycle. The current policy articulates expectations for physicians who wish to treat themselves or family members and assists physicians in identifying situations where a personal, non-professional relationship makes it inappropriate to treat an individual.

- With the assistance of Dr. Mara Goldstein and Dr. Keith Hay (medical advisors), Carolyn Silver (legal counsel), and Dr. Barbara Lent, the research and consultation feedback[1] obtained during the initial stages of the review was used to help inform the development of an updated draft policy, entitled *Physician Treatment of Self, Family Members, or Others Close to Them*.

- The draft policy was approved by Council for external consultation at the May 2015 meeting. The consultation was held from June 10th until August 7th, 2015.

- At its December 2015 meeting, Council reviewed the consultation report and the proposed revisions made to the draft policy in response to the feedback received.

[1] This included a comprehensive literature review, consideration of the positions taken by other key stakeholders, and an external consultation soliciting feedback on the College's current policy.

Council directed that some additional revisions be made to the draft policy and that it return to Council for final approval.

CURRENT STATUS:

- Council is provided with a summary of the feedback it provided at its December 2015 meeting, along with the key revisions undertaken in response.

- All of the feedback has been carefully reviewed and used to make further revisions to the draft policy. The revised draft policy is attached as **Appendix A**, and a track changes version is attached as **Appendix B** for Council's information. Revisions were also made to the draft Frequently Asked Questions (FAQs) (attached as **Appendix C**).

- All revisions have been undertaken with the assistance of Dr. Keith Hay, Carolyn Silver, and Dr. Barbara Lent.

Council's Feedback	Proposed Revisions
1) 'Others close to them' Definition • The definition of 'Others close to them' in the policy should be revised to: o Ensure the language is consistent with the FAQs (e.g. "*would* reasonably affect" vs. "*could* reasonably affect"). o Clarify that the examples provided *may* include, but are not limited to, friends, colleagues, and staff.	• The definition of 'Others close to them' in the policy was changed to "*could* reasonably affect". • Revisions were also made throughout the FAQs to ensure "would" and "could" are used consistently. • The examples provided in the definition of 'Others close to them' in the policy were changed to "this *may* include, but is not limited to, friends, colleagues, and staff".
2) Referrals • Including "requesting or accepting referrals" in the definition of 'Treatment' in the policy should be reconsidered because it: o Appears to be inconsistent with the *Professional Obligations and Human Rights* policy. o Does not distinguish "formal" referrals from "informal" referrals (i.e. recommending a specific physician and/or facilitating contact between the individual and a specific physician).	• To eliminate any confusion, "requesting or accepting referrals" was removed from the definition of 'Treatment' in the policy. • The FAQ on referrals (Question 8) has been revised to: o Describe "formal" referrals and clarify that they would be captured by this policy, but are outside of the scope of care that the policy permits. o Describe the distinction between "formal" referrals and "informal" referrals (i.e. making informal

• The FAQ on referrals should be revised to: o Distinguish "formal" referrals from "informal" referrals. o Clarify that "formal" referrals are captured by this policy.	recommendations about a specific physician the individual might consider seeing and/or facilitating contact between the individual and that physician).
3) Rural and Isolated Communities • The FAQ on rural and isolated communities should be revised to acknowledge that "isolation" could be based on geography, culture, language, etc.	• The following footnote was added to the FAQ (Question 6): "Isolation could be based on geography, culture, language, etc.".

NEXT STEPS:

- Should Council approve the draft policy, as revised, it will be published in *Dialogue* and will replace the current *Treating Self and Family Members* policy on the College's website.

- In addition, the companion Frequently Asked Questions document will be published to help communicate the policy expectations.

- All stakeholders who responded to the consultation will receive a copy of the new policy, along with a letter thanking them for their participation.

- A webpage will be created to highlight for stakeholders the steps that took place following the consultation, how stakeholder feedback helped to shape the final policy, and the final decision made by Council.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the revised draft *Physician Treatment of Self, Family Members, or Others Close to Them* policy or the revised draft FAQ document?

2. Does Council approve the revised draft *Physician Treatment of Self, Family Members, or Others Close to Them* policy as a policy of the College?

CONTACT: Michelle Cabrero Gauley, ext. 439

DATE: February 1, 2016

Attachments:

Appendix A: Revised Draft *Physician Treatment of Self, Family Members, or Others Close to Them* Policy – Clean Version

Appendix B: Revised Draft *Physician Treatment of Self, Family Members, or Others Close to Them* Policy – Track Changes Version

Appendix C: *Physician Treatment of Self, Family Members, or Others Close to Them: Frequently Asked Questions*

Physician Treatment of Self, Family Members, or Others Close to Them

Policy Number: #7-06
Policy Category: Practice
Approved by Council: November 2001; February 2007
Reviewed and Updated:
Publication Date:
College Contact: Advisory Services

Introduction

Physicians may find themselves in circumstances where they must decide whether it would be appropriate to provide treatment for themselves, family members, or others close to them[1]. While physicians may have the best intentions in providing treatment in this context, a growing body of literature[2] indicates that personal or close relationships can compromise the physician's emotional and clinical objectivity. This may make it difficult for the physician to meet the standard of care and potentially affect the quality of the treatment provided.

This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.

The College's expectations, as set out in this policy, are grounded in the values and principles of medical professionalism as articulated in the *Practice Guide* and are based on the best available evidence pertaining to the risks involved with such treatment.

Purpose and Scope

This policy applies to all physicians who are considering providing treatment for themselves, family members, or others close to them, and describes the circumstances in which physicians

[1] The term "others close to them" is defined later in this policy; please see the *Terminology* section.
[2] In this policy, the term "literature" includes empirical evidence as well as articles on professionalism and medical ethics.

may provide such treatment. The policy sets out the College's expectations for physicians in meeting their professional obligations to practice medicine safely and effectively in this context.

Terminology

Family member – an individual with whom the physician has a familial connection **and** with whom the physician has a personal or close relationship, where the relationship is of such a nature that it could *reasonably affect* the physician's professional judgment. This includes, but is not limited to: the physician's spouse or partner, parent, child, sibling, members of the physician's extended family, or those of the physician's spouse or partner (for example: in-laws).

Others close to them – *any other* individuals who have a personal or close relationship with the physician, whether familial or not, where the relationship is of such a nature that it could *reasonably affect* the physician's professional judgment. This may include, but is not limited to, friends, colleagues, and staff.[3]

Treatment – anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose. This includes: the performance of any controlled act[4]; ordering and performing tests (including blood tests and diagnostic imaging); and providing a course of treatment, plan of treatment, or community treatment plan.[5]

Minor condition – a non-urgent, non-serious condition that requires only short-term, episodic, routine care and is not likely to be an indication of, or lead to, a more serious, complex or chronic condition, or a condition which requires ongoing clinical care or monitoring.[6] Some examples of minor conditions may include, but are not limited to: otitis externa; acute conjunctivitis; uncomplicated cystitis in an adult female; mild impetigo; and contact dermatitis. Complex or chronic conditions are not considered minor conditions, even where their management may be episodic in nature.

[3] Physicians are encouraged to contact the College's Physician Advisory Services or the Canadian Medical Protective Association (CMPA) for further guidance as to which individuals may be included in this term.
[4] Controlled acts for physicians, as set out in s. 4 of the *Medicine Act,* S.O. 1991, c. 30.
[5] The definition of "treatment" in this policy has been adapted, and modified, from the definition of "treatment" as set out in the Ontario *Health Care Consent Act*, S.O. 1996, c. 2, sched. A, at s. 2(1) (*HCCA*). Physicians should note that the exceptions to "treatment" under the *HCCA* do not apply to this policy.
[6] Physicians are advised that minor conditions do not include providing sick notes or completing insurance claims for themselves, family members, or others close to them.

Emergency – an "emergency" exists where an individual is apparently experiencing severe suffering or is at risk of sustaining serious bodily harm if medical intervention is not promptly provided.

Principles

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

1. Always acting in the best interests of the individual requesting or receiving treatment and putting those interests before those of the physician;
2. Practising medicine with the objectivity and professional judgment required to meet the standard of care;
3. Establishing and maintaining appropriate professional boundaries; and
4. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

Policy

While physicians may have a genuine desire to deliver the best possible care when providing treatment for themselves, family members, or others close to them, the literature indicates that a physician's ability to maintain the necessary amount of emotional and clinical objectivity may be compromised.[7] Physicians may then have difficulty meeting the standard of care.

[7] Please see the following articles:
- Katherine J. Gold, et al. "No Appointment Necessary? Ethical Challenges in Treating Friends and Family" (2014) N Engl J Med 2014; 371:1254-1258.
- Carolyne Krupa, "The limits of treating loved ones" Amednews.com (6 February, 2012), online: Amednews.com.
- F. Chen et al., "Role conflicts of physicians and their family members: rules but no rulebook" (2001) 175(4) West. J. Med. 236–239.
- American Academy of Pediatrics Committee on Bioethics, "Pediatrician-Family-Patient-Relationships: Managing the Boundaries" (2009) Pediatrics Vol. 124 No. 6, 1685 -1688.
- Kathy Oxtoby, "Doctors' Self Prescribing" BMJ Careers (10 January 2012), online: BMJ Careers.
- Ruth Chambers & John Belcher, "Self-reported health care over the past 10 years: a survey of general practitioners" (1992) 42 British J. Gen. Practice 153-156.
- Richard C. Wasserman et al., "Health Care of Physicians' Children" (1989) 83 Pediatrics 319.
- Edward J. Krall, "Doctors Who Doctor Self, Family, and Colleagues" (2008) 107 Wisconsin Med. J., No. 6, 279-284.

The CMPA also advises against physicians providing treatment for "family and friends, as well as self-treatment". See the CMPA's "Know the rules, avoid the risks: Treating family and friends" (April 2014), online.

Consequently, the individual may not receive the best quality treatment, despite the physician's best intentions.

In order to meet their professional obligations to practise medicine safely and effectively, physicians must only provide treatment for themselves and family members in limited circumstances, as set out below. These are circumstances where the risks associated with treatment in this context are either minimal or are outweighed by the benefits of providing the treatment.

Physicians must not provide treatment for themselves or family members except:

- For a minor condition or in an emergency situation,
  and
- When another qualified health care professional is not readily available.[8]

Physicians must not provide recurring episodic treatment for the same disease or condition, or provide ongoing management of a disease or condition, even where the disease or condition is minor. Another physician must be responsible for ongoing management.

Physicians are advised that, depending on the nature of the relationship, physicians who provide treatment for *others close to them* may also attract the same risks of compromised objectivity and difficulty meeting the standard of care. Therefore, the College recommends that physicians carefully consider whether it is appropriate to provide treatment to *others close to them*. Where a relationship could reasonably affect the physician's professional judgment, the physician must not provide treatment to that individual, except in accordance with the circumstances set out above.[9]

As relationships may change over time, physicians may need to re-evaluate the nature of the relationship they have with either family members or others close to them to determine whether the physician can still be objective. If the physician's professional judgment has been reasonably affected by changes in the relationship, the physician must transfer care of the individual to another qualified health care professional as soon as is practical.

[8] The Canadian Medical Association (CMA) advises physicians to "limit treatment of yourself or members of your immediate family to minor or emergency services, and only when another physician is not readily available; there should be no fee for such treatment." (CMA *Code of Ethics*, section 20).

[9] For further guidance on evaluating whether it is appropriate to treat a particular individual, please see the Frequently Asked Questions (FAQ) document attached to this policy.

1. Providing Treatment

When physicians provide treatment for minor conditions or emergencies, where no other qualified health care professional is readily available, they must comply with the following expectations[10]:

a) Scope of Treatment and Transfer of Care

Physicians must always act within the limits of their knowledge, skill and judgment.[11] However, the College recognizes that in emergency situations, or public health crises, it may be necessary for a physician to provide treatment outside of his or her area of expertise.[12]

Providing treatment in accordance with this policy is limited to addressing the immediate medical needs associated with treating a minor condition or emergency. Where additional or ongoing care is necessary, physicians must transfer care of the individual to another qualified health care professional as soon as is practical.

b) Expectations about Documenting Care and Maintaining Confidentiality

Documentation of medical treatment is essential to safe, quality health care.[13] When physicians provide treatment for themselves, family members, or others close to them, there is a risk that the individual receiving the care will not have a complete and accurate medical record unless that individual's primary health care professional is made aware of the treatment. Physicians must therefore advise the individual to notify his/her primary health care professional of the treatment that the physician has provided.

Where it is impractical for the individual receiving treatment to inform their own primary health care professional of the treatment the individual received (e.g. children), the physician is advised to inform the individual's primary health care professional, with the individual's consent[14], of the treatment he or she provided. Where the individual does not have a primary health care professional, the physician is advised to explain to the individual the importance of informing their next health care professional, where practical, of the treatment received from the physician.

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[10] The Ontario Health Insurance Plan (OHIP) does not permit billing for treatment of immediate family; see Ministry of Health's *Resource Manual for Physicians*, section 4.11 Explanatory Codes, p. 4-27, (Feb 2014).

[11] Sections 2(1)(c), 2(5), O.Reg. 865/93 (Registration), enacted under the *Medicine Act*, 1991, S.O. 1991, c.30.

[12] For more information, please the College's policy entitled *Physicians and Health Emergencies*.

[13] Complete and accurate medical records are also essential to continuity of care, facilitating and enhancing communication in collaborative health care models, and identifying problems or patterns that may help determine the course of health care.

[14] The individual's consent is required where the individual has the capacity to consent to disclosure of his/her personal health information. Otherwise, consent is required from the individual's substitute decision maker. For more information, please see the College's *Confidentiality of Personal Health Information* policy.

Physicians must maintain the confidentiality of the personal health information of any individual they treat.[15]

c) *Spouses or Sexual/ Romantic Partners*

Physicians must not provide treatment to a spouse, partner, or anyone else with whom they are sexually or romantically involved, beyond the circumstances of a minor condition or emergency, and where no other qualified health care professional is readily available. In addition, physicians must be mindful that providing treatment that exceeds the circumstances set out in this policy may give rise to a physician-patient relationship[16] and, as a result, the sexual abuse provisions of the *RHPA* would apply.[17]

For further guidance, physicians are advised to contact the Canadian Medical Protective Association (or other professional liability provider) or obtain independent legal advice.

2. Prescribing or Administering Drugs

Minor conditions or emergencies may, in some instances, require the prescription of drugs. When prescribing drugs, physicians must comply with the expectations and guidelines for prescribing that are set out in the College's *Prescribing Drugs* policy.

In addition, the literature indicates that some physicians may feel obligated or pressured to prescribe narcotics[18] or controlled drugs or substances[19] for family members or others close to them.[20] While these drugs or substances may be a legitimate treatment, regulations under the *Controlled Drugs and Substances Act (CDSA)*[21] prohibit physicians from prescribing or administering such drugs or substances for anyone other than a *patient* whom the physician is

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[15] Physicians must abide by their legal obligations under the Ontario *Personal Health Information Protection Act, 2004,* S.O. 2004, c. 3 Sched. A *(PHIPA),* as well as the expectations set out in the College's *Confidentiality of Personal Health Information* policy.

[16] For information on the nature of the physician-patient relationship, please see the College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy section "Determining Whether A Physician-Patient Relationship Exists".

[17] Legislative provisions relating to sexual abuse are set out in sections 1(3) and 51(1)(2), and (5) of the *Code* under the *RHPA.* Physicians are advised that the passing of Bill 70, the *Regulated Health Professions Amendment Act (Spousal Exception), 2013,* has not changed the law with respect to physicians, as the College has not opted to exempt physicians who treat their spouses from the sexual abuse provisions.

[18] Narcotics are defined in s. 2 of the *Narcotic Control Regulations,* C.R.C. c. 1041, enacted under the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereafter the *CDSA*): the term 'narcotics' includes opioids.

[19] Controlled drugs and substances are defined in s. 2(1) of the *CDSA* and mean a drug or substance included in Schedule I, II, III, IV or V of the Act.

[20] Please see note 7.

[21] The *Controlled Drugs and Substances Act,* S.C. 1996, c. 19.

treating in a *professional capacity*.[22] There are no exceptions under the *CDSA* for prescribing or administering these drugs or substances to non-patients, even in emergencies.

Accordingly, this means that physicians must never prescribe or administer, for themselves, family members, or others close to them, any of the following: narcotics[23]; controlled drugs or substances[24]; monitored drugs[25]; marijuana for medical purposes[26]; or any drugs or substances that have the potential to be addicting or habituating. Physicians must not prescribe or administer these drugs or substances even when another health care professional is in charge of managing the treatment of the disease or condition.

[22] See s. 53(2) of the *Narcotic Control Regulations* C.R.C. c. 1041, and s. 58 of the *Benzodiazepines and Other Targeted Substances Regulations,* SOR/2000-217, under the *CDSA*.
[23] Please see note 18.
[24] Please see note 19.
[25] The Ontario Ministry of Health and Long-Term Care (Ministry) monitors a number of prescription narcotics and other controlled substance medications as part of its Narcotics Strategy. A list of monitored drugs is available on the Ministry's website http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx. See also s. 2 of the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 for a definition of 'monitored drug'.
[26] The Government of Canada's *Marihuana for Medical Purposes Regulations* (MMPR) establish the legal framework that enables patients to obtain authorization to possess dried marijuana for medical purposes. See Marihuana for Medical Purposes Regulations, SOR/2013-119. Please see the College's *Marijuana for Medical Purposes* policy.

Physician Treatment of Self, Family Members, or Others Close to Them

Policy Number: #7-06
Policy Category: Practice
Approved by Council: November 2001; February 2007
Reviewed and Updated:
Publication Date:
College Contact: Advisory Services

Introduction

Physicians may find themselves in circumstances where they must decide whether it would be appropriate to provide treatment for themselves, family members, or others close to them[1]. While physicians may have the best intentions in providing treatment in this context, a growing body of literature[2] indicates that personal or close relationships can compromise the physician's emotional and clinical objectivity. This may make it difficult for the physician to meet the standard of care and potentially affect the quality of the treatment provided.

This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.

The College's expectations, as set out in this policy, are grounded in the values and principles of medical professionalism as articulated in the *Practice Guide* and are based on the best available evidence pertaining to the risks involved with such treatment.

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This policy applies to all physicians who are considering providing treatment for themselves, family members, or others close to them, and describes the circumstances in which physicians

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may provide such treatment. The policy sets out the College's expectations for physicians in meeting their professional obligations to practice medicine safely and effectively in this context.

Terminology

Family member – an individual with whom the physician has a familial connection **and** with whom the physician has a personal or close relationship, where the relationship is of such a nature that it ~~w~~could *reasonably affect* the physician's professional judgment. This includes, but is not limited to: the physician's spouse or partner, parent, child, sibling, members of the physician's extended family, or those of the physician's spouse or partner (for example: in-laws).

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Treatment – anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose. This includes: the performance of any controlled act[4]; ordering and performing tests (including blood tests and diagnostic imaging); and providing a course of treatment, plan of treatment, or community treatment plan~~; and requesting or accepting referrals~~.[5]

Minor condition – a non-urgent, non-serious condition that requires only short-term, episodic, routine care and is not likely to be an indication of, or lead to, a more serious, complex or chronic condition, or a condition which requires ongoing clinical care or monitoring.[6] Some examples of minor conditions may include, but are not limited to: otitis externa; acute conjunctivitis; uncomplicated cystitis in an adult female; mild impetigo; and contact dermatitis. Complex or chronic conditions are not considered minor conditions, even where their management may be episodic in nature.

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[8] The Canadian Medical Association (CMA) advises physicians to "limit treatment of yourself or members of your immediate family to minor or emergency services, and only when another physician is not readily available; there should be no fee for such treatment." (CMA *Code of Ethics*, section 20).

[9] For further guidance on evaluating whether it is appropriate to treat a particular individual, please see the Frequently Asked Questions (FAQ) document attached to this policy.

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b) Expectations about Documenting Care and Maintaining Confidentiality

Documentation of medical treatment is essential to safe, quality health care.[13] When physicians provide treatment for themselves, family members, or others close to them, there is a risk that the individual receiving the care will not have a complete and accurate medical record unless that individual's primary health care professional is made aware of the treatment. Physicians must therefore advise the individual to notify his/her primary health care professional of the treatment that the physician has provided.

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[11] Sections 2(1)(c), 2(5), O.Reg. 865/93 (Registration), enacted under the *Medicine Act*, 1991, S.O. 1991, c.30.

[12] For more information, please the College's policy entitled *Physicians and Health Emergencies*.

[13] Complete and accurate medical records are also essential to continuity of care, facilitating and enhancing communication in collaborative health care models, and identifying problems or patterns that may help determine the course of health care.

[14] The individual's consent is required where the individual has the capacity to consent to disclosure of his/her personal health information. Otherwise, consent is required from the individual's substitute decision maker. For more information, please see the College's *Confidentiality of Personal Health Information* policy.

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For further guidance, physicians are advised to contact the Canadian Medical Protective Association (or other professional liability provider) or obtain independent legal advice.

2. Prescribing or Administering Drugs

Minor conditions or emergencies may, in some instances, require the prescription of drugs. When prescribing drugs, physicians must comply with the expectations and guidelines for prescribing that are set out in the College's *Prescribing Drugs* policy.

In addition, the literature indicates that some physicians may feel obligated or pressured to prescribe narcotics[18] or controlled drugs or substances[19] for family members or others close to them.[20] While these drugs or substances may be a legitimate treatment, regulations under the *Controlled Drugs and Substances Act (CDSA)*[21] prohibit physicians from prescribing or administering such drugs or substances for anyone other than a *patient* whom the physician is

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[15] Physicians must abide by their legal obligations under the Ontario *Personal Health Information Protection Act, 2004,* S.O. 2004, c. 3 Sched. A *(PHIPA),* as well as the expectations set out in the College's *Confidentiality of Personal Health Information* policy.

[16] For information on the nature of the physician-patient relationship, please see the College's *Maintaining Appropriate Boundaries and Preventing Sexual Abuse* policy section "Determining Whether A Physician-Patient Relationship Exists".

[17] Legislative provisions relating to sexual abuse are set out in sections 1(3) and 51(1)(2), and (5) of the *Code* under the *RHPA.* Physicians are advised that the passing of Bill 70, the *Regulated Health Professions Amendment Act (Spousal Exception), 2013,* has not changed the law with respect to physicians, as the College has not opted to exempt physicians who treat their spouses from the sexual abuse provisions.

[18] Narcotics are defined in s. 2 of the *Narcotic Control Regulations,* C.R.C. c. 1041, enacted under the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereafter the *CDSA*): the term 'narcotics' includes opioids.

[19] Controlled drugs and substances are defined in s. 2(1) of the *CDSA* and mean a drug or substance included in Schedule I, II, III, IV or V of the Act.

[20] Please see note 7.

[21] The *Controlled Drugs and Substances Act,* S.C. 1996, c. 19.

treating in a *professional capacity*.[22] There are no exceptions under the *CDSA* for prescribing or administering these drugs or substances to non-patients, even in emergencies.

Accordingly, this means that physicians must never prescribe or administer, for themselves, family members, or others close to them, any of the following: narcotics[23]; controlled drugs or substances[24]; monitored drugs[25]; marijuana for medical purposes[26]; or any drugs or substances that have the potential to be addicting or habituating. Physicians must not prescribe or administer these drugs or substances even when another health care professional is in charge of managing the treatment of the disease or condition.

[22] See s. 53(2) of the *Narcotic Control Regulations* C.R.C. c. 1041, and s. 58 of the *Benzodiazepines and Other Targeted Substances Regulations,* SOR/2000-217, under the *CDSA*.
[23] Please see note 18.
[24] Please see note 19.
[25] The Ontario Ministry of Health and Long-Term Care (Ministry) monitors a number of prescription narcotics and other controlled substance medications as part of its Narcotics Strategy. A list of monitored drugs is available on the Ministry's website http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx. See also s. 2 of the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 for a definition of 'monitored drug'.
[26] The Government of Canada's *Marihuana for Medical Purposes Regulations* (MMPR) establish the legal framework that enables patients to obtain authorization to possess dried marijuana for medical purposes. See Marihuana for Medical Purposes Regulations, SOR/2013-119. Please see the College's *Marijuana for Medical Purposes* policy.

Physician Treatment of Self, Family Members, or Others Close to Them: Frequently Asked Questions

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

A physician's ability to maintain the necessary amount of emotional and clinical objectivity required for professional judgment can be compromised in this context, as the physician may unconsciously hold preconceived notions about the individual's health and behaviour, or make assumptions about the individual's medical history or personal circumstances. Similarly, the physician may assume that he/she is privy to all the relevant information about the individual and that taking a full history or conducting a medically indicated examination is therefore unnecessary. For example, a physician providing treatment for his/her child may assume the child has not engaged in sexual activity or high risk behaviour, and therefore may not consider all of the possible clinical indications for treatment.

2. *If my objectivity is compromised, how could that affect my ability to meet the standard of care?*

The literature indicates that physicians who provide treatment for individuals when their emotional and clinical objectivity is compromised may have difficulty meeting the standard of care. This can occur in a number of ways, including, but not limited to:

- Physician discomfort in discussing sensitive issues or taking medical histories;
- Discomfort amongst family members and others close to the physician in discussing sensitive issues with the physician. This can be especially true with children receiving treatment, and particularly with respect to sexual health and behaviour, drug use, mental health issues, or issues of abuse or neglect;
- Pressure on physicians to treat problems that are beyond the physician's expertise or training, or to prescribe drugs to family members that are addicting/habituating;
- Difficulty for the physician to recognize the need to obtain informed consent in this context and to respect the individual's decision-making autonomy;
- Difficulty for the physician to recognize that the duty of confidentiality applies in this context, just as it would for a patient. The physician may also experience difficulty in appreciating that the individual's information must be kept confidential, even if other

family members or others close to the physician insist on knowing 'what is going on' in relation to the individual's health; and

- Physician reluctance to make a mandatory report (e.g. an impairment affecting the individual's ability to drive, or a suspicion of child abuse).[1]

When the standard of care has been adversely impacted, this can result in poorer quality health care for the individual receiving the treatment.

3. *How do I know which family members would fall under the scope of this policy?*

Many of us have family members with whom we are very close, and others with whom we may not maintain as close a relationship, or have no relationship at all. The risks associated with physicians providing treatment to family members arise where the nature of the relationship is personal or close enough that the physician's feelings toward that individual (positive or negative) could *reasonably affect* the physician's emotional and clinical objectivity and impair his/her professional judgment. Which members of a physician's family this will include will vary with every physician. They may include members of the physician's immediate or extended family, in-laws, or members of a non-traditional family unit. Some examples include, but are not limited to: the physician's spouse or partner; ex-spouse or ex-partner; parent; step-parent; child; step-child; adopted or foster child; sibling or half-sibling; step-sibling; grandparent or grandchild; aunt; uncle; niece or nephew; or those of the physician's spouse or partner.

4. *Who else, other than family members, would fall under the scope of this policy?*

Personal or close relationships with other individuals, who are not family members, could also compromise the physician's emotional and clinical objectivity in the same way. These individuals ~~can~~may include friends, colleagues, and staff, among others. Not every relationship the physician has would necessarily impair the physician's objectivity. However, when a physician's relationship with an individual is of such a nature that the physician's professional judgment could *reasonably be affected*, that individual would fall under the scope of this policy as defined by the term 'others close to them'.

[1] Please see the literature articles cited in the *Physician Treatment of Self, Family Members, or Others Close to Them* policy.

5. *How can I evaluate the nature of a relationship, whether familial or not, and whether my professional judgment ~~w~~could reasonably be affected if I provided treatment for a particular individual?*

When evaluating the nature of a relationship with an individual, if you can answer "yes" to any of the questions below, the individual probably falls within the scope of having a personal or close relationship with you, as set out in this policy. Consequently, this may reasonably affect your professional judgment, and your objectivity may be compromised in providing treatment to that individual.

a. ~~W~~Could I be uncomfortable asking the questions necessary to take a full history, performing a medically indicated examination, or making a proper diagnosis, particularly on sensitive topics?

Relationships with family members or others close to the physician can give rise to the physician unconsciously holding preconceived notions about the individual's health and behaviour, or making assumptions about the individual's medical history or personal circumstances. Consequently, the physician may not ask questions or seek information that could inform the diagnosis or subsequent care. Similarly, physicians may feel uncomfortable taking a comprehensive medical history, or assume that they are privy to all the relevant information about the individual and that therefore taking a full history or conducting a medically indicated examination is unnecessary. This in turn compromises the physician's ability to meet the standard of care.

b. C~~W~~ould this individual be uncomfortable discussing sensitive topics or disclosing high risk behaviours with me?

Family members and others close to the physician may feel uncomfortable discussing these issues with a physician with whom they have a personal or close relationship. They may also fear judgment or other consequences in the relationship. This can be particularly true with respect to the individual's sexual health and behaviour, drug use, mental health issues, or issues of abuse or neglect; especially if the individual is a child. Consequently, the individual may withhold information which is vital to a diagnosis or subsequent care.

c. ~~W~~Could I have difficulty allowing this individual to make a decision about his/her own care with which I disagree?

Respect for an individual's autonomy is central to the provision of ethically sound health care. Individuals must be able to make free and informed decisions about their health care, as well as

question or refuse treatment options.[2] Family members and others close to the physician, particularly children, may be unduly influenced by the physician's opinions, or feel unable to refuse treatment or seek alternative opinions.

d. Could the personal or close relationship with this individual make it more difficult for me to maintain confidentiality or make a mandatory report?

Confidentiality may be harder to maintain and may be at greater risk of being breached, such as when other family members or others close to the physician insist on knowing 'what is going on' in relation to the individual's health. Conversely, a physician may be more reluctant to make a mandatory report (e.g. an impairment affecting the individual's ability to drive, or a suspicion of child abuse) where a personal or close relationship exists.

6. *Does this policy apply in rural or isolated communities?*

Yes, the expectations set out in this policy apply in rural and isolated[3] communities. While the College recognizes that physicians in these communities often have relationships with many or all of the individuals seeking treatment, the risks associated with compromised objectivity and professional judgment apply in rural and isolated settings just as they do in other settings.

In keeping with the policy, the care that the physician can provide to an individual will be dependent on the nature of the personal relationship between the physician and the individual. Where the nature of the relationship with that family member or other individual close to the physician ~~w~~could *reasonably affect* the physician's professional judgment, then the physician is limited to providing treatment only within the context of a minor condition or emergency, and where no other qualified health care professional is readily available, as set out in this policy.

If the personal relationship between the physician and the individual is not close, and therefore does not fit either the definition of 'family member' or 'others close to them', the physician will be able to act as that individual's treating physician.

Regardless of the practice setting (e.g. rural, isolated, urban, etc.), physicians may encounter an individual, for whom they are providing treatment, in a non-clinical context, such as at the grocery store or at a social event. In order to maintain their objectivity and professional judgment when providing treatment, physicians may find it helpful to keep their personal relationships and social interactions separate by, for example, avoiding medical discussions in

[2] For more information please see the College's *Consent to Medical Treatment* policy.

[3] Isolation could be based on geography, culture, language, etc.

non-clinical settings, and requesting that clinical questions be limited to office hours where the physician has access to the individual's chart.

7. *Can I refill a prescription for myself, my family members or others close to me?*

Regardless of whether physicians are prescribing a drug for the first time or whether they are refilling an existing prescription; physicians are still prescribing. Consequently, when providing treatment for a minor condition or emergency necessitates a refill for a drug, physicians are expected to comply with the College's *Prescribing Drugs* policy. Physicians are reminded that, under the *Physician Treatment of Self, Family Members, or Others Close to Them* policy, physicians are prohibited from prescribing for themselves, family members, or others close to them, any of the following: narcotics; controlled drugs or substances; monitored drugs; marijuana for medical purposes; or any drugs or substances that have the potential to be addicting or habituating; regardless of whether the prescription is a new prescription or a refill.

8. *Does this policy apply to referrals?*

Yes, referrals for yourself, family members, or others close to you would be captured by this policy.

Making a referral requires the referring physician to assess the individual, which may include taking a history, conducting an appropriate examination and/or arranging investigations, to identify a clinical indication for a referral. The steps involved would exceed the scope of care that the policy permits physicians to undertake in relation to themselves, family members or others close to them.

For the purposes of this policy, referrals are considered to be distinct from making informal recommendations to family members or others close to you about a specific physician they *might consider* seeing, and from facilitating contact between the individual and that physician. To ensure continuity of care, physicians must advise the individual to discuss any recommendations with his/her primary health care professional.

~~**8. *Can I request or accept a referral for myself, family members, or others close to me?***~~

~~Neither requesting nor accepting referrals are permitted in the context of this policy. The standard of care required in determining the appropriateness of requesting or accepting a referral for yourself, family members, or others close to you, exceeds what is permitted with respect to providing treatment for a minor condition, and is not applicable in emergencies.~~

February 2016

COUNCIL BRIEFING NOTE

TOPIC: Prescribing Naloxone for Opioid Overdose Emergency Kits.

FOR DECISION

ISSUE:

- Naloxone is a prescription medication that can reverse the life-threatening effects of an opioid overdose.
- With opioid-related fatalities rising in Ontario, the College has received requests from both Toronto Public Health and the Municipal Drug Strategy Co-Ordinator's Network of Ontario to permit physicians to prescribe naloxone for distribution in opioid overdose emergency kits.
- Currently, the College's Prescribing Drugs policy prohibits physicians from prescribing naloxone outside of an established physician-patient relationship.
- Council is asked whether an exception should be added to the Prescribing Drugs policy that would permit physicians to prescribe naloxone for opioid overdose emergency kits.
- Council is also asked whether the College should release a public statement articulating support for the wider availability of naloxone as part of the emergency treatment of opioid overdose.

BACKGROUND:

- As has been widely reported in the media and elsewhere, the prevalence of opioid overdose is increasing across Canada.
- Those at risk of accidental opioid overdose include both individuals who are using opioids as prescribed by their physicians, as well as those using opioids for non-medical reasons.
- Naloxone is a highly effective opioid antagonist that can reverse the life-threatening respiratory depression associated with an opioid overdose.
- Naloxone is administered via an intramuscular injection, and can begin to reverse the effects of an opioid overdose within 2 – 5 minutes.

- Currently, naloxone is available in Canada by prescription only. This means that, in accordance with normal prescribing practices, naloxone can only be obtained by an individual following a direct physician-patient interaction.

- This requirement is seen by some stakeholders to be a barrier, as some opioid users do not have a physician. It would also prevent physicians from pro-actively prescribing naloxone to be kept on-site in non-medical settings, such as homeless shelters, where overdoses may occur.

- In an effort to address this barrier, initiatives are underway in several provinces to make naloxone available outside of a conventional physician-patient interaction. These proposed initiatives are focused on promoting the availability of "take-home" naloxone kits for opioid users, as well as ensuring the on-site availability of naloxone in settings where overdoses are likely to occur.

- Health Canada is also now in the process of re-considering the prescription-only status of naloxone; however, should a decision be made to make naloxone available without a prescription, it is not clear as of when this decision would take effect.[1]

- Currently, Ontario's naloxone distribution program is limited to Public Health Units that manage a core needle exchange program, community-based organizations that have been contracted to manage such a program, and ministry funded Hepatitis C Teams. In addition, a limited "take-home" naloxone program is available through Toronto Public Health.

- Despite the existence of these programs, there is general agreement in current literature and among relevant stakeholders that there are missed opportunities to ensure access to this potentially life-saving drug during emergencies that occur outside of a hospital setting.

CURRENT STATUS:

- In recent months, the College has received requests from two stakeholders to promote the availability of naloxone, specifically by encouraging physicians to prescribe it for distribution in opioid overdose emergency kits (i.e. outside of a direct physician-patient interaction).

Requests

1) The Municipal Drug Strategy Co-Ordinator's Network of Ontario:

   - On June 1, 2015, the College received a report from the Municipal Drug Strategy Co-Ordinator's Network of Ontario entitled *Prescription for Life* (Appendix A). This report included numerous recommendations directed at

[1] http://news.gc.ca/web/article-en.do?nid=1027679

multiple stakeholders aimed at reducing the harms associated with prescription medications and other drugs.

- With respect to naloxone, the report argued in favour of ensuring wider availability both in terms of ensuring access to at-risk opioid users, as well as promoting its availability in locations where overdoses may occur (including non-healthcare settings, such as homeless shelters).

- Among those recommendations specifically directed at the College was a recommendation to "identify, communicate and eliminate barriers that prevent prescribing, dispensing and administration."

- The report was presented to the College's Methadone Committee at their August 25, 2015 meeting, where its recommendations were well received. More specifically, the Committee expressed support for the recommendation that naloxone be made available in emergency kits.

2) Toronto Public Health

- On October 1, 2015, the College received a letter from the Medical Officer of Health, Toronto Public Health (Appendix B), expressing the view that naloxone should be made available for emergency use by trained staff in high-risk settings, particularly via opioid overdose emergency kits.

- The Medical Officer of Health specifically recommended that the College encourage physicians to prescribe naloxone for inclusion in emergency kits.

Current policy expectations

- The College's Prescribing Drugs policy sets expectations for safe and effective prescribing. Key among these expectations is that physicians will prescribe in the context of an established physician-patient relationship, and following an appropriate clinical exam.

- Three specific exceptions to this requirement are set out in the policy:

  a. When prescribing for the sexual partner of a patient with a sexually transmitted infection (STI) who, in the physician's determination, would not otherwise receive treatment and where there is a risk of further transmission of the STI;

  b. Prescribing prophylaxis (e.g., oseltamivir) as part of public health programs operated under the authority of a Medical Officer of Health; and

  c. Prescribing post-exposure prophylaxis for a health-care professional following potential exposure to a blood borne pathogen.

- None of these exceptions would encompass (i.e. permit) the prescribing of naloxone for an emergency kit.

ANALYSIS:

- The proposed responses that are set out below have been informed by input from College staff and other stakeholders, including Nanci Harris, Manager in the Quality Management Division who supports the Methadone Committee, and Dr. Angela Carol, a CPSO Medical Advisor.

- Based on this input as well as the additional research undertaken to date, it would appear that – from a clinical and practice perspective – the benefit of making naloxone available in emergency kits outweighs the risks.

- This view has been informed by a number of considerations, including that naloxone is known to have a strong safety profile:

    - There is effectively no risk of harm should an individual accidentally receive "too large" a dose (i.e. one cannot "overdose" on naloxone);

    - Naloxone is not known to negatively interact with other substances, such as alcohol or other drugs;

    - Naloxone causes no harm should it mistakenly be administered to someone not experiencing an overdose (i.e. it has no pharmacologic effect in the absence of opioids);

    - Naloxone has no known addictive or abusive potential, and consequently no "street value".

- The potential adverse effects of naloxone are generally considered minor, and may include nausea, tachycardia, and tremulousness, however, more serious effects will arise, including:

    - Acute withdrawal syndrome: Naloxone will lead opioid-dependent patients, with or without non-malignant pain, into a state of acute withdrawal, which, while not life-threatening, may include vomiting and other highly distressing symptoms, which will require immediate medical attention.

    - Secondary overdose: The effects of naloxone will wear off before the effects of opioids, leaving some individuals at risk of going back into overdose following a period of apparent recovery.

- Despite their potentially serious nature, these effects can be mitigated in a number of ways:

    - Individuals who receive a kit must have appropriate instruction in its use (including dosage);

    - Emergency kits must contain detailed written instructions with respect to use; and

    - All instructions, whether given in-person or contained in the kit, must stress the importance of *always* obtaining emergency medical care in the event of an overdose or a suspected overdose, even where naloxone has been administered. This is because serious complications can arise following administration that will require appropriate medical care.

- Taking into account both the risks and benefits outlined above, and weighing those risks against the life-threatening nature of an opioid overdose, a strong rationale emerges for the College to support the availability of naloxone for the emergency treatment of opioid overdose.

Proposed Response

- Should Council be satisfied that the College should support the prescription of naloxone for emergency kits, two proposed steps are presented for consideration.

- First, that the College post a statement on its website expressing support for the prescription of naloxone in emergency kits, and second, that the College make a minor amendment to its Prescribing Drugs policy to enable physicians to prescribe naloxone for emergency kits.

- It should be noted that at its January meeting, the Executive Committee considered Health Canada's plan to re-reconsider the prescription-only status of naloxone, and debated whether to postpone any proposed changes until the outcome of that consultation was known. After careful consideration, the Executive Committed wished to proceed with the following proposed steps in the interim:

    1) Proposed statement

        - In keeping with the College's mandate to serve and protect the public interest, and in alignment with past work undertaken by the College regarding opioid-related harm, a public statement is proposed that would formally articulate the College's support for the wider availability of naloxone as part of the emergency treatment of opioid overdose (Appendix C).

2) Proposed policy revision

- Given the strong public health interest, naloxone's favourable risk-benefit ratio, and in keeping with the spirit of the three exceptions already set out in the Prescribing Drugs policy, it is proposed that an additional exception be added to the policy that would specifically permit physicians to prescribe naloxone for opioid overdose emergency kits:

    d. Prescribing naloxone for inclusion in an opioid overdose emergency kit.

- Additionally, it is proposed that a footnote be added to the policy that would signal that physicians who choose to prescribe naloxone must be satisfied that the kits will only be distributed to those individuals who have received appropriate instruction in its use, and that recipients understand that even where naloxone has been administered, emergency care must still be sought.

- Proposed footnote:

    - Where a physician prescribes naloxone for inclusion in an emergency kit, they must be satisfied that the kit will only be distributed to those who have received appropriate instruction in its use, and that measures will be in place to identify and replace expired medication. Physicians must also be satisfied that every recipient of a kit will be informed of the complications and risks that can arise following administration of naloxone, and be advised that emergency care *must always* be sought in the event of an overdose, even where naloxone has been administered. This advice must also be communicated in the written instructions contained in the kit.

CONSIDERATIONS:

Status of naloxone in other jurisdictions

- Initiatives are underway in several provinces to promote the availability of naloxone, including British Columbia, Alberta, Manitoba, and Quebec. To date, only Quebec has formally enabled physicians to prescribe naloxone outside of a direct physician-patient relationship.[2]

Health Canada's consultation

- On January 14, 2016, Health Canada announced a consultation to re-consider the prescription-only status of naloxone.

[2] Naloxone may be prescribed to non-medical staff, friends of patients, families, and opioid users, provided they have received appropriate training.

- This consultation will be open until March 19, 2016, after which (barring new evidence) Health Canada will amend the prescription drug list to allow non-prescription use of naloxone specifically for opioid overdose outside of hospital settings.

- Health Canada has stated that it will waive the usual six-month implementation period that follows such decisions so that the change in status can occur as quickly as possible.

Wider issue of prescribing for emergency kits

- In the course of undertaking this review, staff have become aware that a number of other drugs are sometimes "prescribed" for inclusion in emergency kits in various settings, including at schools and on airplanes.

- As is the case with naloxone, the College's Prescribing Drugs policy does not clearly allow for this type of prescribing.

- While naloxone has been prioritized given its favourable risk benefit ratio and the growing prevalence of opioid-related harm, the broader issue of prescribing for emergency kits will be addressed when the Prescribing Drugs policy is next reviewed.

NEXT STEPS:

- Should Council recommend that the College release a statement of support for naloxone, the draft statement will be posted on the College's website, captured in *Dialogue*, and communicated to relevant stakeholders.

- Should Council recommend that the Prescribing Drugs policy be revised, the current policy will be updated, and any changes will be communicated to the membership and the public via *Dialogue,* the College's website, and the College's social media properties.

- The College will monitor the activities of Health Canada in relation to its proposed plans to allow non-prescription use of naloxone specifically for opioid overdose outside of hospital settings. Council will be updated on Health Canada's activities in this regard.

- Should Health Canada proceed with its proposed plans regarding non-prescription naloxone, the proposed policy revisions would be rescinded; Council would additionally be asked for direction on whether it wished to retain the proposed statement.

DECISIONS FOR COUNCIL:

1. Does Council support enabling physicians to prescribe naloxone for emergency kits?

2. If so, does Council accept the Executive Committee's recommendation to proceed with the draft policy amendment and statement as proposed, or would Council prefer to wait for the outcome of Health Canada's consultation?

3. If Council wishes to proceed with the draft policy amendment and statement as proposed, is there any feedback on the two measures being proposed: the supporting statement and the policy revision?

CONTACTS: Cameron Thompson, ext. 246

DATE: February 3, 2016

Attachments:

Appendix A: Letter from the Municipal Drug Strategy Co-Ordinator's Network of Ontario
Appendix B: Letter from Toronto Public Health
Appendix C: Draft Statement

Municipal Drug Strategy Co-ordinator's Network of Ontario
www.drugstrategy.ca

June 1, 2015

Dr. Rocco Gerace, Registrar
The College of Physicians and Surgeons of Ontario
2 Carlton Street, Suite 1306
Toronto, Ontario
M5B 1J3
rgerace@cpso.on.ca

Dear Dr. Gerace,

On behalf of the Municipal Drug Strategy Co-ordinator's Network of Ontario, we are pleased to present the attached guidance report, *Prescription for Life.*

The Municipal Drug Strategy Co-ordinator's Network of Ontario (MDSCNO) was formed in 2008 and members work in more than 155 municipalities, counties, townships and First Nations communities across Ontario in multi-sectoral initiatives to reduce the harms of alcohol, prescription medications and other drugs.

Ontario has witnessed 13 years of rising prescription opioid overdose fatalities resulting in 5,000 deaths (2000-2013). Accidental opioid overdoses are now the 3rd leading cause of unintentional death and someone in Ontario dies every 14 hours. Those at risk of an accidental opioid overdose include people using medications as prescribed as well as people using prescription and illicit opioids non-medically. Improving access to the opioid antagonist naloxone will reduce deaths and injuries in communities across Ontario. The evidence-based recommendations contained in the attached report represent key components of a comprehensive overdose prevention strategy and are efficacious, safe, cost-effective and relatively quick to implement.

Communities across Ontario are concerned about persistent barriers that prevent access to the lifesaving emergency medicine naloxone. While some action has been taken, more needs to be done and there is a clear role for governments, regulators, professional associations and others. Several networks of concerned medical and non-medical expertise already exist in the province to provide immediate assistance to expedite the recommendations in this report.

We invite you to review the recommendations in advance of a public release. We trust you will find the evidence of harms unacceptable, and the recommendations compelling. On behalf of the MDSCNO and external partners across the province, we thank you for considering your essential role in saving lives and reducing harm in Ontario.

Inquiries are welcome and may be directed to the Network at: ontariodrugstrategies@gmail.com.

Sincerely,

Kerri Kightley
Strategy Coordinator
Peterborough Drug Strategy

Susan Shepherd
Manager, Toronto Drug Strategy Secretariat
Toronto Drug Strategy

Municipal Drug Strategy Co-ordinator's Network of Ontario

Prescription for Life

This report provides key actions urgently needed to improve opioid safety and reduce accidental opioid overdose fatalities and injuries by expanding access to the emergency medicine naloxone.

Massive increases[1] in opioid prescribing have made Canada a world leader in per-capita prescription opioid consumption[2] and Ontario a leading province in opioid prescribing[3] and high dose opioid dispensing.[4] Ontario has witnessed 13 years of increasing and record-setting opioid overdose fatalities,[5,6] which now rank as the third leading cause of accidental death,[7] and more than double the number of drivers killed in motor vehicle collisions.[8] More than 5000 Ontarians have died of an opioid overdose since 2000, the vast majority unintentionally.[9] Non-fatal opioid overdoses have been estimated at 20-25 times the number of fatal overdoses and can be a significant contributor to morbidity[10] however, data on prevalence and injury burden are limited.[11,12] Opioid-related hospital emergency department (ED) visits in Ontario have increased significantly,[13] and hospital stays across Canada are up 23%.[14]

It is critical to understand that people who are at-risk of an accidental overdose[15] include individuals who are taking opioids as prescribed,[16-20] in addition to people using opioids non-medically.[21] Effective opioid overdose prevention and intervention targets both opioid-using populations- and potential witnesses.

Naloxone is the opioid antagonist that has been used to effectively revive victims of opioid overdose for decades, in hospital emergency rooms and by select paramedics. A limited "take-home" naloxone program was recently launched in Ontario,[22] however, barriers prevent dispensing to most Ontarians at risk of experiencing or witnessing an opioid overdose; an opioid overdose victim cannot save themselves. Considered as an essential part of the First Aid toolbox, expanded low-barrier naloxone access will reduce injuries, save lives,[23-30] and begin to provide similar levels of care that are dedicated to reducing other preventable deaths.

We can do much better at responding to the thousands of opioid-related medical emergencies that are certain to occur. As Peterborough Police Chief Murray Rodd noted when speaking of opioid overdoses and naloxone, "It could be anybody's mother or father, anybody's brother or sister - we have to respond appropriately".[31]

Recommendations

The Municipal Drug Strategy Co-ordinator's Network of Ontario recommends the following actions to reduce accidental opioid overdose fatalities and injuries in our communities:

1. **Add naloxone to Provincial, Federal and Veterans Affairs Formularies**
    a. Ontario Formulary Ontario Drug Benefit Plan (ODB), General Benefits
    b. Federal Formulary and
    c. Veterans Affairs Canada Formulary

    The emergency medicine naloxone is a post-patent, World Health Organization (WHO) recommended[32] Essential Medicine[33] that (temporarily) reverses an opioid overdose. Naloxone should be on all government drug formularies for the same reason that epinephrine (e.g. EpiPen®, Allerject™) is: it is the emergency medicine of choice and a proven lifesaver. More than 150 opioid

formulations are on the Ontario Drug Formulary (ODB, General Benefits),[34] but not the essential lifesaver naloxone. The absence of Formulary standing is a barrier to patient safety and for physicians who wish to prescribe naloxone alone or with opioids for at-risk patients and potential Good Samaritans (witnesses).

2. **Increase onsite naloxone access**

   a. **The Ministry of Health and Long Term Care to expand naloxone and kits beyond select Public Health Units and Hepatitis C programs**
   Ontario has a 'take home' naloxone program with onsite access that is limited to participants of select HIV and HCV programs and has helped to successfully reverse opioid overdoses. The existing administrative arrangement precludes equitable and expanded access as per the Minister's promise of 2012.[35] All Ontarians at risk for an opioid overdose, and potential Good Samaritans such as parents and friends, should have access to this essential lifesaver. For example, targeted onsite dispensing via medical staff, including Registered Nurses, as well as non-medical staff providing outreach, shelter, withdrawal management, and addiction treatment services, and in primary care settings are among the priority options.

   b. **The Ministry of Health & Long-Term Care to provide naloxone and kits to patients receiving Opioid Substitution Therapy (OST)**
   The MOHLTC should provide naloxone and kits to OST patients given that portions of the patient roster at OST clinics are considered high-risk for an accidental overdose.[36-40] Methadone-related fatalities have been increasing for several years[41] and physicians and other care providers are willing to dispense naloxone onsite to their patients.

   c. **The Ministry of Health & Long-Term Care and area Local Health Integration Networks to ensure naloxone and kits are provided at Ontario hospitals**
   Ontario hospitals treat thousands of overdose victims each year. A major predictor of an accidental opioid overdose is having experienced a non-fatal overdose in the past.[42,43] Frequency of ED visits are a predictor of fatal overdose.[44] The Canadian Paediatric Society's "Emergency Treatment of Anaphylaxis in Infants and Children"[45] provides a discharge protocol relevant for people at risk of experiencing or witnessing an overdose. Naloxone dispensing is a promising practice at select hospitals in the United States,[46-50] and currently three Canadian hospitals dispense naloxone through inpatient and ED services.[51]

   d. **The Ministry of Community Safety and Correctional Services, Corrections Canada, and Public Safety Canada to provide naloxone and kits to high-risk prisoners leaving correctional institutions**
   People released from correctional facilities are at an exceptionally elevated risk for accidental overdose death upon release.[52-59] Forty-three percent of opioid-related deaths amongst Ontario inmates occurred within 7 days of release.[60] Scotland's national naloxone program has cut the fatality rate by almost half in just a few years.[61] England's N-ALIVE program was a proven success for discharged inmates exiting 15 prisons.[62] New York State's Department of Corrections provides one example of a formal naloxone program in the U.S.A.[63] Correctional Services Canada noted the importance of naloxone access in discharge planning and transfer guidelines provided in 2014.[64]

e. **Health Canada to provide naloxone and kits to Aboriginal, Inuit and Metis nations as requested**

In 2007, opioid per capita prescribing in Ontario's First Nations was over 52% higher than the rest of Ontario[65]. In 2009, the Nishnawbe Aski Nation declared a State of Emergency due to an epidemic of opioid addiction and death in 49 northern communities,[66] as did Eabametoong and Cat Lake.[67] In 2014-15, Alberta's Blood Tribe witnessed a serious rise in fentanyl-related deaths[68], for which Health Canada, possibly for the first time, provided naloxone kits[69] that enabled the community to successfully reverse several overdoses.[70]

3. **Ensure health professionals and others can be lifesavers**

a. **The Ministry of Health & Long-Term Care work with the Ontario College of Pharmacists, the College of Nurses of Ontario, the Ontario Pharmacists Association and the Registered Nurses Association of Ontario to add naloxone to the list of medicines these health professionals can prescribe**

Pharmacists and nurses have key roles in opioid safety. Pharmacists have unique pharmacological expertise, access to patient history, frequent interaction with physicians regarding opioids[71] and a high level of patient trust.[72,73] An Ontario study revealed that 56.1% of fatal opioid overdose victims had filled a prescription for opioids in the month preceding their death (66.4% had seen a physician).[74] Pharmacists, associations and legislators in several U.S. states are already providing patients with improved opioid safety via naloxone.[75-81] The Ontario pharmacists' Scope of Practice recently changed to include flu vaccines and tobacco cessation products[82], and naloxone should be included in this expansion too. The Registered Nurses' Association of Ontario recently released best practice guidelines on engaging clients who use substances[83] and have advocated for expanded naloxone distribution.[84] In British Columbia, Registered Nurses and Nurse Practitioners are permitted to "*compound, dispense or administer Schedule 1 drugs autonomously for the purpose of treating opiate overdose*".[85] Naloxone should be added to the Scope(s) of Practice for nurses and pharmacists.

b. **The Ministry of Community Safety and Correctional Services, Corrections Canada, Public Safety Canada, the Ontario Provincial Police and the Royal Canadian Mounted Police to provide naloxone and training to select jail, correctional centre, detention centre and policing staff**

Federally, 80% of incarcerated males have an identified 'substance abuse disorder.[86] No prison is 'drug-free'[87,88] and officials from Public Safety, the Correctional Service and the Parole Board of Canada conclude drug-free prisons are "an aspirational goal, just as is achieving drug-free societies".[89] In Ontario, overdose deaths while in custody have been the subject of several (mandatory) Coroner's Inquests.[90] Twenty percent of opioid-related inmate deaths in Ontario (2006-2008) occurred while in custody.[91] Risky drug use, specifically opioid use, is significant inside both provincial[92,93] and federal[94,95] facilities. Staff in correctional institutions, detention centres and other custodial facilities should be trained in overdose prevention generally, have naloxone in their first aid kit, and be trained to administer it. The U.S. National Commission on Correctional Health Care supports increased access to and use of naloxone in correctional facilities.[96] The College of Physicians and Surgeons of Ontario (CPSO) recommends naloxone on site.[97] Even the best response times from Emergency Medical Services can be too slow to avert injuries or death.

4. **Develop Overdose Policies**

   a. **The Province of Ontario and the Government of Canada to Develop Real Time and Online Monitoring and Surveillance**
   Throughout the United States data exists from surveillance and monitoring to inform policy and programming that is simply not collected and available in Canada, including Ontario. Health Canada cannot provide a national snapshot of drug-related deaths for any year; data from the Office of the Chief Coroner for Ontario is at least a year behind; the Ontario Ministry of Community Safety & Correctional Services does not track overdoses occurring in its correctional facilities; the Ontario Health Minister's promise of 2012 to implement "real-time surveillance of opiate overdose and withdrawal in 73 emergency departments"[98] has yet to be realized; the MOHLTC's Public Health Division has yet to implement monitoring and surveillance; and the Ontario Narcotics Monitoring System appears limited in functionality. There is no early warning system with evidence from real-time monitoring and surveillance – critical in a post-OxyContin era of non-pharmaceutical bootleg fentanyl[99,100] and, in spite of clinical prescribing guidelines, increased high-dose opioid prescribing.[101] These are persistent, systemic problems[102] that limit efforts to understand, address and evaluate opioid-related harms.

   b. **The Ministry of Health & Long-Term Care and the College of Physicians & Surgeons of Ontario to provide clear third-party liability guidance and eliminate any identified barriers**
   An opioid overdose victim cannot save themselves. Potential third party liability concerns could arise when naloxone i) is administered by a bystander/Good Samaritan when the victim does not have a prescription, and/or ii) is prescribed to a person not using opioids (e.g. concerned parent). The concern for prescribers and administrators may be real or perceived. We request the MOHLTC and the CPSO to provide clear third-party liability guidance, and if necessary, to identify, communicate and eliminate any barriers that prevent third-party prescribing, dispensing and administration.

   c. **The Province of Ontario and the Government of Canada to develop Overdose Prevention and Intervention Plans**
   U.S. governments and agencies at all levels have shown leadership on reducing opioid-related deaths via strategic plans with defined overdose reduction targets, dedicated funding and regulatory-legislative changes as required.[103-105] In Canada, no provincial or federal plan exists despite similar opioid consumption rates and opioid overdose rates at record levels. A "leading public health and safety concern"[106] and a "public health crisis"[107] merits a strategic plan not unlike what is in place for other significant causes of accidental death and injury such as motor vehicle collisions and infectious diseases.

   d. **The Government of Canada to create Good Samaritan Legislation**
   At most accidental overdose emergencies involving illicit substance use, a witness is present.[108-113] In an Ontario study of barriers to calling 911 during an (illicit) overdose emergency, respondents reported that 911 was called just 46% of the time at the last witnessed overdose,[114] the primary barrier cited being fear of police presence and the potential for criminal charges.[115] By contrast, call rates for cardiac arrest are above 90%.[116] Good Samaritan Laws that provide limited immunity from prosecution for witnesses and victims and have been passed or are pending in more than 27 U.S. states,[117] often with bi-partisan support and alongside bills that expedite improved naloxone access. In Canada, a Good Samaritan Law is a federal responsibility.

e. **Health Canada to reschedule naloxone**
Naloxone should be rescheduled in Regulations under Canada's Food and Drugs Act to ensure that health care professionals other than physicians can provide naloxone for clients without a physician's prescription. For example, pharmacist-prescribed naloxone is an increasingly common practice in several U.S. states[118] and entirely appropriate in the Canadian context for reasons outlined in recommendation 3b.

f. **Health Canada to encourage additional naloxone formulations**
The sole format approved in Canada is intra-muscular, requiring an injection. Although typically more expensive, auto-injectors similar to an EpiPen®, and intra-nasal devices are available in the USA and Europe but not in Canada.

Conclusion

The Municipal Drug Strategy Co-ordinator's Network of Ontario calls on the Province of Ontario, the Government of Canada, and others with a critical role in these recommendations to take action now to prevent deaths due to accidental opioid overdose. Expanded naloxone access can be quick to implement and is a WHO Essential Medicine because it is the "safest, most efficacious and cost effective medicine for priority conditions".[119]

Members of the Municipal Drug Strategy Co-ordinator's Network of Ontario (MDSCNO) work in more than 155 municipalities, counties, townships and First Nations communities across the province. These multi-sectoral initiatives aim to reduce the harms of alcohol and other drugs, including prescription medications. Strategies are tailored to each community, and based on the integrated components of prevention, harm reduction, treatment and enforcement/justice.

The MDSCNO has no conflicts to declare and receives no funding.

The MDSCNO endorsed these recommendations in May 2015 (2 abstentions).

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Item 2

TORONTO

Dr. David McKeown
Medical Officer of Health

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Oct 1, 2015

Rocco Gerace
Registrar
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, Ontario M5G 2E2
rgerace@pso.on.ca

Re: Naloxone Exemption for Physicians

Dear Dr. Gerace,

As the prevalence of overdose increases across Ontario, we are being asked more frequently to support community service agencies with non-medical staff who wish to include naloxone in their first aid kits as an emergency response tool to opiate overdoses. Naloxone is an extremely safe and effective opioid antagonist used to reverse opiate overdoses both in hospital and in the community.

Thanks to the Ministry of Health and Long-Term Care, naloxone is being provided to people using drugs across Ontario via community harm reduction services. To date, Toronto Public Health's POINT program has trained and distributed over 1700 kits to opiate users and kits have been successfully used in over 300 situations. However, high-risk clients attend many other agencies, including drop-in services, shelters, and other programs not currently able to provide naloxone for onsite overdoses.

The following are real situations exemplifying the need:

- A man died in a local homeless shelter following an opiate overdose. Shelter staff had no naloxone. This gentleman had a naloxone kit in his pocket. Even if staff had been aware of it, they would have had no training in what to do with it.
- A man overdosed at a busy downtown drop-in centre. Staff did not have naloxone, and the gentleman died before EMS could reach him.
- A research project involving opiate users was in progress at a local program. One of the participants went into overdose. Another participant had a naloxone kit, and used it.

Staff did not have naloxone. The person survived. The researcher has since requested and received a prescription from her own physician in case this should happen again.

We believe that naloxone should be available for emergency use by trained staff in high-risk settings. One way to achieve this is to have it available in first aid kits. Our reading of both the Delegation of Medical Acts Policy and the Prescribing Policy would support this use outside of a specific patient-physician relation as dictated by consideration of patient safety and best interests. It would however be helpful in encouraging physicians to prescribe naloxone for first aid kits, if the College would explicitly endorse this practice.

Therefore in order to more immediately reduce both the risk of adverse client outcomes we are writing to request that the CPSO give explicit support to the prescribing of naloxone to be kept onsite in first aid kits to be used by trained staff in the case of a client overdose. Should you require further information or have any questions, please contact Dr. Rita Shahin, Associate Medical Officer of Health at rshahin@toronto.ca or 416-338-7924. I look forward to receiving your reply.

Sincerely,

Dr. David McKeown
Medical Officer of Health
Toronto Public Health

Dr. Leslie Shanks
Medical Director,
Inner City Health Associates

Draft position statement:

In keeping with the College of Physicians and Surgeons of Ontario's mandate to serve and protect the public interest, and building upon our public policy efforts to date with respect to reducing opioid-related harm, the College recognizes that action is needed to address the rising prevalence of opioid overdose in Ontario.

While opioid overdose is now the third leading cause of accidental death in Ontario, this risk of death can be significantly reduced through the timely administration of the prescription drug naloxone.

The College strongly supports efforts to increase the availability of naloxone as part of the emergency treatment of opioid overdose.

To help achieve this goal and eliminate barriers to access, the College has formally revised its Prescribing Drugs policy to permit physicians to prescribe naloxone for inclusion in opioid overdose emergency kits.

February 2016

COUNCIL BRIEFING NOTE

TOPIC: **APPROVAL OF FEES BY-LAW #107 (MEMBERSHIP FEE)**

FOR DECISION

ISSUE:

At its December meeting, Council proposed a 1.6% increase to the membership fee for independent practice certificates. The proposed increase was determined to be necessary after careful consideration of the 2016 budget submissions that were reviewed in detail by the Finance Committee.

The proposed change to the Fees By-law sets the membership fee at $1,595 (an increase of $25 from the current fee of $1,570) for the year beginning June 1, 2016.

BACKGROUND:

- The College sought feedback on a draft amendment to the Fees and Remuneration By-Law that, if passed, would increase the annual membership fee for the year beginning June 1, 2016.
- At its December meeting, after reviewing the proposed budget for 2016, Council proposed a 1.6% increase in membership fees. This increase would bring the fee that a physician pays to renew a certificate of registration from $1,570 to $1,595.
- A number of channels were used to garner participation in this consultation, including:
    - an article in in Vol. 11, Issue 4 of Dialogue;
    - a newsletter to the OMA;
    - various calls to participate through our three social media properties (Twitter, Facebook, and LinkedIn);
    - a posting in the consultation section of the CPSO website; and
    - a notice in the Council Update e-newsletter.
- Stakeholders could submit their feedback via:
    - Email
    - The feedback form provided on the consultation's web page
    - Regular mail or fax
- The following report provides Council with an overview of this consultation.

Draft By-Law Amendment: Fee Increase

i. Timeline

- The consultation ran from December 4, 2015 to February 12, 2016.

ii. Rate of Response

- At the time of drafting these briefing materials, a total of **594 written responses** have been received: 532 from physicians, 24 from members of the public, and 38 anonymous submissions.
- 91 comments were submitted via email; 502 were submitted via the online feedback forum; and one was submitted via regular mail.

iii. Feedback

- All stakeholder feedback has been posted publicly on the consultation discussion page. Written feedback was posted on our website in keeping with regular consultation processes and posting guidelines.
- A summary of the major themes advanced in the feedback to date is set out below.

General Comments

- Broadly speaking, the nature and tone of the feedback received in response to the proposed by-law amendment to increase fees by $25 was negative.
- All 594 comments from the stakeholders were strongly opposed to the fee increase.
- The three main arguments against the fee increase were:
    - The optics of increasing fees while physicians' remuneration were being clawed back was poor
    - The need for the CPSO to reduce expenses and staff before proposing a fee increase; and
    - The high cost of CPSO fees in comparison to medical regulatory authorities, primarily in the United States.

Fee Increase during provincial claw backs to Physicians' remuneration

- The majority of stakeholders weren't opposed to the dollar amount of the fee increase, but to the optics of a fee increase at all. The government of Ontario is reducing physician fees and it makes the CPSO appear "insensitive" toward its membership.
- A few stakeholders suggested that CPSO annual fee changes "should be commensurate with those imposed on physicians by the government of Ontario for medical services rendered."

The CPSO has too many staff and too many staff benefits

- A few stakeholders commented on the staff size of the CPSO and recommended that a reduction in the number of employees to save on costs.
- Two of stakeholders listed out some of the benefits CPSO employees have suggesting that the CPSO is wasting money on staff benefits.
- A number of stakeholders suggested an independent audit of CPSO expenses.
- Two stakeholders suggested the CPSO relocate from downtown Toronto to another cheaper location.

Medical regulators in the United States have smaller fees

- A few stakeholders mentioned that the CPSO has one of the highest membership fees in Canada. (Note: CPSO fees are fourth lowest in Canada)
- Other stakeholders mentioned that membership fees in the United States, such as in California and Pennsylvania, were significantly lower and they had more physicians to regulate.

Two-tiered membership fees

- A small number of stakeholders suggested a two-tier membership fee; one fee for regular, full-time members, and another for semi-retired and retired members who wish to hold onto their license.

DECISION FOR COUNCIL:

Does Council approve By-Law #107 that sets the membership fee for an independent certificate of registration beginning June 1, 2016 at $1,595?

CONTACT: Nawaz Pirani ext. 765
Jill Hefley, ext. 445
Douglas Anderson, ext. 607
Leslee Frampton, ext. 311

DATE: February 3, 2016

February 2016

COUNCIL BRIEFING NOTE

Topic: Strategic Update - Dashboard

FOR INFORMATION

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

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

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

Progress towards the goals set out in the Strategic Plan is reflected in the attached Strategic and Operational Dashboards. The Dashboards provide an overview of performance against targets sets for each area.

This is the final dashboard for 2015. A revised 2016 dashboard will be provided to Council at its February 2016 meeting.

The Strategic Initiatives were defined as follows: Quality Management Partnership, Education, Transparency and Information Management. These initiatives have not yet generated dashboard indicators.

The Dashboard will be presented as part of the Registrar's Report at Council.

CONTACT: **Rocco Gerace**
Maureen Boon, extension 276

DATE: February 4, 2016

Appendix A: Strategic Framework
Appendix B: Strategic Update Q4 2015

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

VISION

QUALITY PROFESSIONALS, HEALTHY SYSTEM, PUBLIC TRUST

PRIORITIES

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

STRATEGIC INITIATIVES

- QUALITY MANAGEMENT PARTNERSHIP
- EDUCATION
- TRANSPARENCY
- INFORMATION MANAGEMENT

PRINCIPLES

- INTEGRITY
- ACCOUNTABILITY
- LEADERSHIP
- COLLABORATION

Strategic Dashboard – Final 2015

Strategic Priority	Objective	Measure/Target	Mar 2015	Jun 2015	Dec 2015	FINAL	Comments
Optimize Registration	No strategic objective identified for 2015						
Assure/Enhance Physician Competence	CPD Compliance	98% compliance					Q4- As of December 31, 2015 – 8 physicians of all registered physicians have indicated they are not tracking CPD with any of the 3 approved bodies – over 99% compliance
	Every physician assessed every 10 years	2600 assessments/year					Q4 – 2,349 assessments completed – representing 90% of target. *Note: Total volume was 2,501 (96% of target) but 152 of these assessments were commenced and exemptions were eventually issued due to various reasons (i.e. unreported retirement, no practice to assess, agreement to undertake to cease practice as alternative to pursuing assessment/re-assessment activity).*
Optimize Investigations, Discipline and Monitoring	Schedule discipline hearings more quickly	Time from referral to hearing date Target: 1 year					Jan 1 – Dec 31, 2015: 90% of hearings (31) began on average, 351.2 days (11.5 months) from the NOH date

Operational Dashboard – Final 2015

Strategic Priority	Objective	Measure/Target	Mar 2015	Jun 2015	Dec 2015	FINAL	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 4 wks b) 5 wks					Credentials – 4,442 (98%) applications assessed within 4 weeks Registration Committee – 1,247 (95%) assessed within 5 weeks
Assure/Enhance Physician Competence	Increase input in policy/reg/program	130 responses/policy					Consultation responses received as of end of 2015: Blood Borne Viruses (42), Rights and Responsibilities (138), Block Fees and Uninsured Services (117). Interim Guidance on Physician-Assisted Death (391) but this consultation extended into 2016. The average for Q4 is 172. The overall average for 2015 is 155.
	Existing policies current/relevant	2 policies/Council					3 policies considered by Council: Blood Borne Viruses (final approval), Physician Treatment of Self, Family and Others Close to them (final approval), and Physician Behaviour in the Professional Environment (consultation).

Strategic Priority	Objective	Measure/Target	Mar 2015	Jun 2015	Dec 2015	FINAL	Comments
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high profile and/or high risk investigations completed in **243** days.					Jan 1 – Dec 31, 2015: 90% of high profile investigations were completed in an average of 299 days (197 investigations involving 89 physicians). 90% of high risk investigations were completed in an average of 225 days (42 investigations involving 35 physicians).
Operational Excellence	Improve service level targets	80% live answer (PPAS, A&C)					A&C: 26,005/30,127 calls (86%) answered live PPAS: 50,230/54,607 calls (92%) answered live Combined: (89%) of calls answered live
	Improve service level targets	15% call abandonment					A&C: 4,122 (14%) of calls abandoned PPAS: 2,626 (5%) of calls abandoned Combined: (10%) abandonment rate
	Media coverage	85-100% positive or neutral					Q4: 149 news items were analyzed. The overall tone of the news coverage was good: 31% Positive (46 news items); 51% Neutral (76 news items); and 18% Negative (27 news items).

Dashboard Legend

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
Optimize Registration	Meets processing time for Registration Applications	Time from application received by College to (a) first application contact for non-registration committee cases; (b) first applicant contact for registration committee cases	90% of applications meet process time of (1) 4 weeks (b) 5 weeks	= > 90%	70-89%	<70%
Assure and Enhance Physician Competence	Physician compliance with CPD requirements	% of registrants participating in, and reporting CPD to a CPSO-approved organization	98% compliance	= > 98%	90-97%	<90%
	Every physician assessed every 10 years	# of physician assessments in College programs	2600 to be assessed in 2014	Tracking to >= 2600	Tracking 2400-2599	Tracking <2400
	Develop, implement and evaluate IEPs for physicians in need	% of IEPs developed with (1) specified interventions (2) target outcomes (3) outcome measures	75% of IEPs contain all elements	>75% IEPs meet expectations	60-75% IEPs meet expectations	<60% IEPs meet expectations
	Increase participation in development of major policy, regulation and program development.	Average # of responses/policy	130 responses/policy	>130 responses	75-129 responses	50-75 responses

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
	Existing policies are current and remain relevant.	# of policies considered/Council meeting	6-8 policies in active review/development	>= 2 policies/Council	1 policy/Council	0 policies/Council
Optimize Investigations, Discipline and Monitoring Processes	Reduce time for completion of high risk investigations	# days of investigation	90% of High Profile and/or High Risk investigations are completed in an average of ***243 days or less*.**	90% of High Profile and/or High Risk investigations are completed in an average of ***243 days or less*.**	90% of High Profile and/or High Risk investigations are completed in an average of ***between 244 and 256 days***.	90% of High Profile and/or High Risk Investigations are completed in an average of ***257 days or more***.
	Schedule discipline hearings more quickly	Time from referral to hearing date	Target: 1 year	90% of hearings began **within** 365 days (12 months) on average from the NOH date	90% of hearings began **within** 457 days (15 months) on average from the NOH date)	90% of hearings began **more than** 457 days (15 months)on average from the NOH date
Operational Excellence	Improve service level targets	Live answer for PPAS and A&C	80% live answer	80% or greater	70-79%	Less than 70%
	Improve service level targets	Call abandonment rate	15% call abandonment	15% or less	16-20%	Greater than 20%
	Media coverage	Positive or neutral media coverage	85%+ positive/neutral media coverage	80-100%	60-80%	<60%

February 2016

COUNCIL BRIEFING NOTE

TOPIC: Regulatory Models

FOR DISCUSSION

ISSUES:

In light of the Ministry of Health's 'regulatory modernization' strategy, preliminary research has been conducted on regulatory models in several jurisdictions where regulatory change has occurred.

The purpose of this discussion is to review governing, discipline and oversight structures in other jurisdictions to inform future direction.

BACKGROUND:

- The Ministry of Health and Long Term Care (MOHLTC) has signalled its intention to convene a Health Regulatory Modernization Advisory Table. The mandate of this group has not yet been articulated, and no decisions have been made, however, it seems clear that regulatory structures are likely to be the subject of discussion.

- The MOHLTC has also expressed considerable interest in the oversight model that exists in the UK via the Professional Standards Authority.

- Given these factors, information from other jurisdictions, particularly those that have experienced significant regulatory change over the past several years, seems particularly relevant. An overview of governing, discipline and oversight structures is included at Appendix A.

DECISIONS FOR COUNCIL: This item is for discussion.

CONTACT: Vicki White, ext 433
Maureen Boon, ext 276

DATE: February 9, 2016

Appendix A: Regulatory Models summary chart

GOVERNING BODY

	Ontario (Doctors)	Ontario (Lawyers)	Quebec (Doctors)	UK (Doctors)	Australia (Doctors)	New Zealand (Doctors)
Background:						
Name		Law Society of Upper Canada	Collège des Médecins du Québec (the "Collège")	General Medical Council (the "GMC")	National governing body: • Medical Board NSW governing body: • Medical Council	Medical Council
Composition:						

Members		Benchers run the affairs of the Law Society. They include:
		• Honorary benchers
		  o Honorary benchers before 1970
		  o all former Treasurers
		  o everyone who has held position of elected bencher for 12 or more years
		• Benchers by virtue of their office
		  o Minister of Justice
		  o Attorney and Solicitor Generals of Canada
		  o current and all previous Attorney Generals of Ontario
		  o longstanding elected benchers
		• Elected benchers
		  o 40 lawyers
		  o 5 paralegals
		• Lay benchers
		  o 8 persons
			Board of Directors:
			• 28 directors (including a president)
			
			Of these:
			• 4 are laypersons
			• 24 are physicians
				The GMC is governed by 12 individuals:
				• 1 Chair (who is a doctor)
				• 5 doctors
				• 6 laypersons
					Medical Board:
					• 1 chair (who is a doctor)
					• at least 50% of the remaining are doctors but no more than 2/3 of Board can be doctors
					• at least 2 community members
					
					Medical Council:
					• 19 members
					
					Of these:
					• 1 is a lawyer
					• 12 are doctors nominated by various organizations
					• 5 are persons nominated by the Minister
					• 1 is a doctor nominated by the Minister
						The Medical Council is comprised of 12 members:
						• 8 doctors
						• 4 laypersons

Selection Process for Members		Honorary benchers and benchers by virtue of the office: • appointed by government • years of service Elected benchers: • elected by lawyers or paralegals (depending on profession) • elected at large and by region Lay benchers: • appointed by the Lieutenant Governor	• 20 are elected doctors, chosen by doctors on a regional basis • 4 are appointed by the Office des Professions du Québec • 4 are appointed by the faculties of medicine in Québec	• appointed by the Privy Council	Medical Board: • appointed by the Ministerial Council Medical Council: • appointed by the Governor o but many members nominated by various organizations or the Minister	• 4 doctors elected by doctors • 4 doctors appointed by the Minister of Health • 4 laypersons appointed by the Minister of Health
Special Categories of Representation		• regional representation • representation by profession (lawyer, paralegal, layperson, government officer etc.)	• regional representation • medical faculty representation	• regional representation	Medical Board: • regional representation Medical Council: • representation of specialties • representation of some organizations, such as: o the Australian Medical Association o Multicultural NSW	• majority of Council must be doctors

DISCIPLINE BODY						
	Ontario (Doctors)	**Ontario (Lawyers)**	**Quebec (Doctors)**	**UK (Doctors)**	**Australia (Doctors)**	**New Zealand (Doctors)**
Background:						
Name		Law Society Tribunal (consists of two divisions: Hearing Division and Appeal Division)	Disciplinary Council	Medical Practitioner Tribunal Service ("MPTS")	Civil and Administrative Tribunal	Health Practitioners Disciplinary Tribunal (for conduct/competence issues) *Medical Council (for competence/capacity issues)*
Hearing Panels:						

Composition of Body		Hearing Division:
		• Chair of the Law Society Tribunal
		  ○ a lawyer but not a bencher
		• 1 Vice-Chair
		  ○ an elected bencher
		• 90 individuals
		  ○ laypersons and lawyers
		  ○ over half are benchers
			• 1 President/Chair
			  ○ a lawyer
			• 7 Substitute Chairs
			  ○ lawyers
			• 51 doctors
				280 laypersons and doctors ewer doctors than laypersons
				
				Panel members:
				• cannot be members of the GMC governing body
				• cannot take part in the investigation process
					N/A (see composition of panels)	• 1 Chairperson
						• 2 Deputy Chairpersons

Selection Process		Chairs: • appointed by benchers Members of the Hearing Division: • appointed by benchers	Chairs: • appointed by the government Other members: • appointed by the Collège's Board of Directors	MPTS appoints: • lay members • registrant members • makes a list of eligible Chairs from the lay and registrant members	Judges: • judges of the Supreme Court or District Court Medical Practitioners: • selected by the Medical Council Layperson: • selected by the Medical Council from a panel nominated by Minister	The Minister of Health appoints all members of the Tribunal

Composition of Individual Panels		Panels have three members
		
		If person subject to proceeding is a lawyer:
		• at least 1 elected lawyer bencher
		• at least 1 lay bencher or a person approved by the Attorney General of Ontario
		
		If person subject to proceeding is a paralegal:
		• 1 paralegal
		• 1 lawyer
		• 1 lay bencher or a person approved by the Attorney General of Ontario
		
		Chair or Vice-Chair appoints members to each panel
			Panels have 3 members:
			• a chair
			  ○ designated by the President
			• 2 doctors
			  ○ selected by the Council secretary
				Panels have 3 members, including a Chair, at least one of whom is:
				• a lay member
				• a registrant member
					Panels have 4 members:
					• 1 judge
					• 2 doctors
					• 1 layperson
					
					For an appeal restricted to a point of law, the panel is one judge
						Panels have 5 members:
						• the Chairperson of the Tribunal or a deputy Chairperson of the Tribunal
						• 4 persons selected by the Chairperson or the deputy Chairperson from the panel maintained by the Minister of Health, of whom:
						  ○ 3 are doctors
						  ○ 1 is a layperson

Role of Lawyers		At least one lawyer sits on each Hearing Panel	8 members of the Council are lawyers 1 lawyer sits on each panel	Each hearing will have either: • a legal assessor; or • a legally qualified Chair	Each panel includes a judge and for appeals of points of law, only a single judge decides the matter *Also: one member of the Medical Council is a lawyer*	The Tribunal's Chairperson and two deputy Chairpersons are lawyers Either the Chairperson or a deputy Chairpersons sits on each hearing panel
Independence Mechanisms:						
Separate hearing location		Yes	Yes	Yes	Yes	[information not available']
Governing body appoints majority of members:		Yes	No	No	Yes (except for appeal of point of law alone)	No

Majority of adjudicators part of governing body:		Yes	No	No	No	No
Other		• Tribunal Chair is not a bencher • Tribunal members must apply to be members of the Tribunal (merit based selection process) • Chair reviews performance of all adjudicators, and determines reappointments	• Chair and Substitute Chairs are not doctors • No members of the Disciplinary Council can sit on the Board of Directors	• the GMC and the MPTS are separate bodies • no membership cross-over except for the Chair of the MPTS, who is a member of the GMC by virtue of appointment as Chair • MPTS tracks private interests of members	• Every panel includes a judge • No members of the Medical Council can sit on the Tribunal • The Tribunal is completely separate and adjudicates a wide range of matters in the state	• hears cases from all regulated health professions • two individuals out of five on a hearing panels are not doctors
Appeals:						
Body		Law Society Tribunal: Appeal Division	Professional Tribunal (hears cases for all Professions)	relevant Court	• Civil and Administrative Tribunal • relevant Court (questions of law)	High Court

Composition		• Chair of the Tribunal
		• Vice-Chair
		  ○ a bencher appointed by benchers
		• 22 members
		  ○ vast majority are benchers
		  ○ some are laypersons approved by the Attorney General of Ontario
			11 judges	Judges presiding	As described above	Judges presiding

Other		The Chair or Vice-Chair assigns members to individual Appeal Division hearings Appeal Division hearings are heard by panels of 3 or 5 Appeals from the Appeal Division are to the Divisional Court	Professional Tribunal decisions can be judicially reviewed on questions of jurisdiction to the Superior Court	The GMC is permitted to appeal decisions of the MPTS, where it considers that the decision is not sufficient for the protection of the public	Tribunal hears "internal appeals" following its own inquiries and "external appeals" from decisions of the Professional Standards Committee A party to an appeal before the Tribunal may, with leave, appeal on a question of law to the Court	
Other Information of Note:						
Who has ultimate responsibility for actions of discipline body		The Law Society, through the benchers, controls who is appointed to the Law Society Tribunal All members of the Hearing and Appeal Division hold their appointments at the pleasure of the benchers	Reports to: • the Collège's Board of Directors • the Office des Professions du Québec o who provides a copy to the Minister, who tables it in Parliament Bureau des Présidents des Conseils de Discipline: • takes measures to promote the expeditious nature of complaint processing and decision-making • evaluates chairs	GMC: • the Chair of the MPTS reports to the GMC Profession Standards Authority for Health and Social Care: • reviews all final decisions of the MPTS • reports to Parliament Privy Council: • has the power to step in and take over the duties of the GMC where it fails to meet them	The Tribunal reports on referrals, applications and appeals to the Medical Council and gives the Medical Council its decisions	It does not appear that an external body has responsibility for the Disciplinary Tribunal It does not appear that the Disciplinary Tribunal is required to report to the Medical Council or any other party The decisions of the Tribunal are posted on the Tribunal website along with summaries and statistical information

OVERSIGHT BODY						
	Ontario (Doctors)	**Ontario (Lawyers)**	**Quebec (Doctors)**	**UK (Doctors)**	**Australia (Doctors)**	**New Zealand (Doctors)**
Background:						
Name		• Advisory Council • Attorney General of Ontario	• the Office des Professions du Québec • the Commissioner for Complaints Concerning Mechanisms for the Recognition of Professional Competence • the Interprofessional Council	• Privy Council • Professional Standards Authority for Health and Social Care ("PSA")	• Advisory Council	There is no oversight body for the Medical Council. However, the New Zealand Parliament (the Minister of Health) plays an oversight role (see below)

Composition		Advisory Council:
		• the chair and vice-chair of each standing committee
		• the president of each county or district law association (or a nominee)
		• one person who is a lawyer in an Ontario law school and who is also a full-time teacher at an Ontario and who is appointed by law school faculty
			Office:
			• four members of a regulated profession
			  ○ chosen by the Council, from a list furnished by the government
			• one non-professional
			
			Commissioner:
			• nominated by the Office
			
			Council:
			• Presidents (or other delegate) from each regulated profession in Québec, including the Collège
				Privy Council:
				• senior politicians, who are present or former members of the House of Commons or the House of Lords
				
				PSA:
				• has a staff and board of directors
					• 7 members, including:
					  ○ chair who is not a health practitioner
					  ○ of 6 others, 3 have expertise in health and/or education
					
					Members are appointed by Ministerial Council	

Powers		Advisory Council: • assesses how lawyers in Ontario are discharging their obligations to the public • assesses general matters affecting the practice of law as a whole Attorney General of Ontario: • guardian of the public interest in all matters concerning the practice of law in Ontario • power to require the production of any document or thing pertaining to the Law Society at any time	Office: • monitors Collège • approves regulations drafted by the Board of Directors • recommends that the government adopt the regulations • suggests amendments to regulations and by-laws • establishes the Bureau des Présidents des Conseils de Discipline Commissioner: • receives and examines complaints against the Collège concerning the operations for reviewing professional competence • monitors the Collège's mechanisms for recognizing professional competence Council: • advises the relevant Minister on matters regarding professionals • examines problems encountered by governing bodies • proposes to the relevant Minister objectives to be pursued to protect the public • carries out studies on protecting the public	Privy Council: • can require the GMC to act • assumes powers of GMC where it fails to act PSA: • oversees the UK's health care professional regulatory bodies, including the GMC • reviews performance of the GMC • reviews all decisions of the MPTS • reports to Parliament	Advisory Council reports to Ministerial Council about matters relating to national scheme	

RELATIONSHIP TO GOVERNMENT AND INDEPENDENCE						
	Ontario (Doctors)	**Ontario (Lawyers)**	**Quebec (Doctors)**	**UK (Doctors)**	**Australia (Doctors)**	**New Zealand (Doctors)**
Relationship to government		The benchers have a standing committee dedicated to working with government • the mandate is to develop and maintain an effective working relationship with the government	Disciplinary Council Chairs are appointed by government The Collège reports annual to the Office, who sends the report to the relevant Minister The Minister of Justice oversees the application of the *Professional Code* and the *Medicine Act* • The Minister can direct the profession or convene the Interprofessional Council	The Privy Council: • sets the number of registrant versus lay members of the GMC • appoints members to the GMC • reviews the conduct of the GMC and can assume the powers of the GMC, where the GMC fails to fulfil its mandate	Australian Health Workforce Ministerial Council: • comprised of health ministers of participating jurisdictions and commonwealth • provides high level decision-making and ministerial oversight	The Medical Council is required to report annually to the Minister of Health The Minister of Health may: • request statistical information from the Medical Council • audit the Medical Council on compliance with legislation • convene a conciliation conference to address concerns in the audit • address jurisdictional disputes between different regulated professions

Robert G.W. Lapper, Q.C., Chief Executive Officer

Robert G.W. Lapper, Q.C., joined The Law Society of Upper Canada as Chief Executive Officer on February 1, 2012.

Robert was formerly the Deputy Minister of Labour for the Province of British Columbia, a post he held since 2009. From 2007 to 2009, he served as the Deputy Cabinet Secretary and Associate Deputy Minister, Cabinet Operations and Intergovernmental Relations, in the Office of the Premier.

For seven years, beginning in 2001, Robert was the Assistant Deputy Attorney General, Legal Services Branch, for the Province of British Columbia. He oversaw a complete organizational and service transformation in the Legal Service Branch during his tenure there. He was honoured with a Queen's Counsel appointment in December 2002.

After clerking with the British Columbia Supreme Court, he practised law as an associate and later partner in a firm in Sidney, British Columbia, for 10 years. During that time, his practice included a variety of areas. One — emerging aboriginal law issues — engaged his interest in particular. Robert joined the Province of British Columbia, in 1994, as a lawyer in the Legal Services Branch, Ministry of Attorney General, to focus on aboriginal law issues. His work included acting as one of the counsel to the Nisga'a Treaty negotiations, which concluded the first "modern" treaty in British Columbia. In 1998, he was appointed to head the Aboriginal Law Practice Group in the Legal Services Branch.

Robert has a passion for legal and justice issues and wide-ranging experience in legal policy and operations, and is a frequent speaker, lecturer and writer on public law, aboriginal law, commercial law and related issues. He also has a long history of volunteer engagements with community organizations.

The Law Society of Upper Canada regulates the lawyers and paralegals of Ontario in the public interest. The Law Society ensures that lawyers and licensed paralegals meet standards of learning, professional competence and professional conduct that are appropriate for the legal services provided. The Law Society has a duty to protect the public interest, to maintain and advance the cause of justice and the rule of law, to facilitate access to justice for the people of Ontario, and to act in a timely, open and efficient manner.

March 2015

Feb 2016

COUNCIL BRIEFING NOTE

TOPIC: COUNCIL AWARD

BACKGROUND:

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

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

At the February 26th meeting of Council, **Dr. Stephen Feder** of Ottawa, Ontario will receive his Council Award

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DECISION FOR COUNCIL:

No decisions required

CONTACT: Patricia Santana, ext. 257

DATE: February 1, 2016

Appendices: N/A

February 2016

COUNCIL BRIEFING NOTE

TOPIC: Physician-Assisted Death - Update

FOR DISCUSSION

ISSUES:

Since the approval of the Interim Guidance on Physician-Assisted Death at the January 2016 meeting of Council, work has continued with various stakeholders. Council will be provided with an overview of the current status of various Physician-Assisted Death initiatives at the provincial and federal level.

BACKGROUND:

- The Interim Guidance on Physician-Assisted Death was approved at the special meeting of Council on January 26, 2016. It has been distributed broadly and is now available on the CPSO website along with a physician-only link to drug protocol examples.

- The Guidance was passed after the Supreme Court of Canada extended the period for the federal and provincial governments to pass legislation governing physician-assisted death to June 6, 2016. Between February 6 and June 6, applicants who seek physician-assisted death can go to the Superior Court of their jurisdiction to obtain judicial authorization.

- On January 29, 2016, the Chief Justice of the Ontario Superior Court issued a Practice Advisory - Application for Judicial Authorization of Physician-Assisted Death (attached as Appendix A). The Practice Advisory sets out both the procedural requirements for making an application as well as evidence the advisory said should be included from the applicant, the applicant's attending physician, a consulting psychiatrist and a physician proposed to be the physician authorized to assist death (who could also be the attending physician).

- The College's Interim Guidance does not call upon those seeking physician-assisted death (or the physicians who propose to assist them) to provide some of the evidence that is recommended in the Superior Court Practice Advisory.

- Between February 6 and June 6, 2016, the College will be actively monitoring the landscape for any relevant developments in order to inform any action the College may take following June 6, 2016 to provide guidance to the membership.

- CPSO staff has continued to work with the Ministry of Health and Long Term Care as it considers the government's response to *Carter*, including possible legislation, moving toward June 6, 2016 and beyond.

- The federal government's Special Joint Committee on Physician Assisted Dying was appointed to review the report of the External Panel on Options for a Legislative Response to *Carter v. Canada* and, following consultations, make recommendations on the framework of a federal response on physician assisted dying. It is expected to submit its report by the end of February.

- Activity at the federal level is being monitored closely and the CPSO will participate fully in the legislative process. It is anticipated that the federal government will introduce legislation in the spring.

- Various physician organizations have issued statements on Physician Assisted Death. In addition, both Continuing Professional Development – Ontario (CPD-O) and the Centre for Effective Practice (CEP), in collaboration with the College and others, have begun the development of educational tools relating to Physician Assisted Death.

- Further information on the status of various Physician Assisted Death initiatives will be provided at the Council meeting.

DECISIONS FOR COUNCIL: This item is for discussion.

CONTACT: Rocco Gerace

DATE: February 9, 2016

Appendix A: Practice Advisory – Application for Judicial Authorization of Physician Assisted Death

Practice Advisory – Application for Judicial Authorization of Physician Assisted Death

January 29, 2016

Heather J. Smith
Chief Justice
Superior Court of Justice (Ontario)

In *Carter v. Canada (Attorney General)*, 2016 SCC 4, the Supreme Court of Canada directed that applications may be brought to provincial superior courts for exemptions from the *Criminal Code* prohibition against physician assisted death, in accordance with the criteria set out in *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter* (2015)].

This Practice Advisory is intended to provide guidance to counsel and parties who intend to bring applications to the Superior Court for an exemption to the *Criminal Code* prohibition against physician assisted death. The direction provided in this advisory is always subject to any orders made by the presiding judge on the application. In addition, this Practice Advisory refers to the types of evidence discussed in *Carter* (2015) to assist counsel and parties. However, the onus rests with the applicant to confirm and meet the evidentiary requirements set out in *Carter* (2015).

Commencement of Application

1. An application to the Superior Court of Justice for authorization for a physician assisted death shall be commenced by notice of application under Rule 14 of the Rules of Civil Procedure and be in accordance with this Practice Advisory.

Content of Notice of Application

2. The notice of application shall state that the application shall be heard by a judge on a date to be fixed by the registrar at the place of hearing, such date not being earlier than fifteen days after the application is commenced and not being later than thirty days after the application is commenced. Depending upon the circumstances, certain applications may be heard sooner on an emergency basis. The nature of the relief sought on the application must be brought to the attention of the registrar by the applicant at the time of filing so that a hearing date within these time periods, or sooner, can be fixed.

3. The notice of application shall state,

    a. that the applicant is seeking authorization for a physician assisted death;

b. the date of the hearing as set by the registrar;

c. the place of the hearing; and

d. the documentary evidence to be used at the hearing of the motion.

4. In addition, the notice of application should set out if the applicant intends to seek a publication ban, an order under s. 135 of the *Courts of Justice Act* to have the application heard in the absence of the public, or an order to seal the file, as well as the grounds upon which any such orders are sought.

Application Record and Factum

5. As required under Rule 38,

   a. the applicant shall serve and file an application record and factum at least seven days before the hearing;

   b. the respondent(s) shall serve and file a factum and respondent(s)'s application record (if any), at least four days before the hearing.

Proof of Service

6. Proof of service of the notice of application, application record, and factum shall be filed at least seven days before the hearing date in the court office of the place of hearing.

Service of Application

7. The notice of application shall be served on,

   a. the Attorney General of Canada; and

   b. the Attorney General of Ontario.

8. In addition, depending upon the circumstances of the applicant, the Court may require that notice of the application be served on the applicant's spouse/partner, children, parents, grandparents, siblings, and any other person who will be affected by the order sought.

Evidence about the Applicant

9. The application record should include an affidavit from the applicant concerning,

   a. the applicant's birth date;

   b. the applicant's place of residence and the duration of that residency;

   c. the applicant's medical condition (illness, disease, or disability);

   d. whether as a result of his or her medical condition, the applicant is suffering enduring intolerable pain or distress that cannot be alleviated by any treatment acceptable to the applicant;

   e. the reasons for the applicant's request for an authorization of a physician assisted death;

   f. whether the applicant commenced the application after having been fully informed about his or her medical condition (illness, disease, or disability),

diagnosis, prognosis, treatment options, palliative care options, the risks associated with the treatment and palliative care options, and the risks associated with a physician assisted death;

g. the manner and means and timing of the physician assisted death for which the applicant seeks an authorization;

h. whether the applicant is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time; and

i. whether the applicant is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the applicant's decision to make.

Evidence of the Attending Physician

10. The application record should include an affidavit from the applicant's attending physician addressing whether,

    a. the applicant has a grievous irremediable medical condition (illness, disease, or disability) that causes suffering;

    b. as a result of his or her medical condition, the applicant is suffering enduring intolerable pain or distress that cannot be alleviated by any treatment acceptable to the applicant;

    c. the applicant was fully informed about his or her medical condition (illness, disease, or disability), diagnosis, prognosis, treatment options, palliative care options, the risks associated with the treatment and palliative care options, and the risks associated with a physician assisted death;

    d. the applicant has the mental capacity to make a clear, free, and informed decision about a physician assisted death;

    e. the applicant is or will be physically incapable of ending his or her life without a physician assisted death;

    f. the applicant consents without coercion, undue influence, or ambivalence to a physician assisted death;

    g. the applicant is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time;

    h. the applicant makes the request for authorization for a physician assisted death freely and voluntarily; and

    i. the applicant is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the applicant's decision to make.

Evidence of the Consulting Psychiatrist

11. The application record should include an affidavit from the applicant's consulting psychiatrist addressing whether,

    a. the applicant has a grievous irremediable medical condition (illness, disease, or disability) that causes the applicant to suffer;

b. the applicant has the mental capacity to make a clear, free, and informed decision about a physician assisted death;

c. the applicant consents without coercion, undue influence, or ambivalence to a physician assisted death;

d. the applicant is aware that his or her request for an authorization for a physician assisted death may be withdrawn at any time;

e. the applicant makes the request for authorization for a physician assisted death freely and voluntarily; and

f. the applicant is aware that if the authorization is granted, the decision to use or not use the authorization is entirely the applicant's decision to make.

Evidence of Physician Proposed to Assist Death

12. The application record should include an affidavit from the physician who is proposed to be the physician authorized to assist death, who may be the applicant's attending physician or another physician, addressing,

    a. the manner and means and timing of the physician assisted death;

    b. whether the physician providing assistance is willing to assist the applicant in dying if that act were authorized by court order;

    c. whether the physician believes that his or her providing assistance would be clearly consistent with the applicant's wishes; and

    d. whether the physician understands that the decision to use or not use the authorization is entirely the applicant's decision to make.

Disposition of Application

13. On the hearing of the application, the judge may grant the relief sought, dismiss or adjourn the application for further evidence to be filed, or make such other order as is just.

February 2016

COUNCIL BRIEFING NOTE

TOPIC: Policy Report

ITEMS FOR INFORMATION

External Consultation Responses:

1. Health Professions Regulatory Advisory Council Consultation on Registered Nurse Prescribing

Updates:

2. Right and Responsibilities/What to Expect During Medical Encounters – Revised Document Approved

3. Policy Consultation Update: *Physician Behaviour in the Professional Environment policy*

4. Policy Status Table

1. Health Professions Regulatory Advisory Council Consultation on Registered Nurse Prescribing

- On November 4, 2015, the Minister of Health directed the Health Professions Regulatory Advisory Council (HPRAC) to conduct broad consultations with key partners within the nursing and health care community to assess three models for Registered Nurse (RN) prescribing.

- The Minister noted that the decision had already been made to proceed with expanding RN's scope of practice to include prescribing, and therefore HPRAC was not asked to consider whether the expansion should occur. Rather, HPRAC was asked to provide recommendations to the Minister on the most suitable model under which RN prescribing would occur in Ontario.

- The three models of RN prescribing that HPRAC consulted on are as follows:

    - *Independent prescribing*: RNs may prescribe medications under their own authority, either without restrictions (i.e. they can prescribe any drug), OR from a limited or pre-defined formulary within a regulated scope of practice (i.e. they can only prescribe certain drugs found on a list). As independent

prescribers, RNs would be similar to physicians in terms of ability to prescribe. However, RNs would not have access to prescribing controlled drugs and substances.

- *Use of protocols*: This model appears to reflect the status quo, in which RNs are permitted to prescribe via delegation (under direct orders or medical directives). The use of protocols would allow RNs to prescribe specific medications under specific circumstances, and supply and administer medications within the strict terms of a predetermined protocol.

- *Supplementary prescribing*: This is a hybrid of independent prescribing and use of protocols where after an initial assessment of the patient's needs by the physician, a nurse may prescribe medication within a limited or pre-defined formulary or by class of drugs within their clinical competency area.

- The consultation period ran from December 14, 2015 until January 22, 2016, with a four day extension granted to the CPSO so that the Executive Committee could review the draft response at its January 26th meeting.

- The Executive Committee considered the draft response at this meeting and directed that the response (attached as **Appendix A**) be submitted to HPRAC. Key comments and issues identified in the response include the following:

  - The CPSO values initiatives that encourage the inter-professional and collaborative delivery of health care and ensure that every health care professional can work to their full scope of practice.

  - The CPSO is supportive, in principle, of RN prescribing as long as RNs have the appropriate knowledge, skill and judgment to prescribe in a safe and effective manner.

  - With respect to independent prescribing, the CPSO believes that RNs should be required to prescribe in a manner that is consistent with the CPSO's expectations for physicians.

    - As set out in the CPSO's Prescribing Drugs policy, this includes conducting an appropriate clinical assessment prior to prescribing (which may include diagnostic and/or laboratory testing), and making a diagnosis and/or having a clinical indication; however, RNs currently do not have the authority to order diagnostic/laboratory tests and to communicate a diagnosis.

    - Additional education and training would be required to ensure that RNs possess the competencies to practice safely within their expanded

scope and to minimize or prevent the risks inherent to independent prescribing.

- RN prescribing through use of protocols appears to reflect the status quo, where RNs currently prescribe via delegation (direct orders or medical directives). The CPSO believes that prescribing in this manner can and does currently work safely and effectively, and questions whether changes could be made to the existing delegation framework to achieve the Ministry's objectives in enabling RN prescribing.

- As supplementary prescribing is a hybrid of the other two models, the comments offered on this model include the already noted points.

- The response also highlights impacts the models could have on patients and the health care system more broadly, and comments on the impacts of RN prescribing in general.

- The Executive Committee and Council will be kept apprised of any developments.

2. What to Expect During Medical Encounters – Revised Document Approved

- As a part of the College's Sexual Abuse Initiative, Council provided direction to enhance the information and resources on the College's website regarding sexual abuse. This included creation of a document to educate patients about what to expect during medical encounters.

- At its September 2015 meeting, Council considered the draft Rights and Responsibilities document and approved it for external consultation. The consultation was held from September 22nd until November 20th, 2015.

- At its December 2015 meeting, Council requested that some additional revisions to be made to the draft document, and directed that the revised draft document be forwarded to the Executive Committee for final approval once these changes had been incorporated.

- After the December 2015 Council meeting, the Ontario Medical Association (OMA) submitted its feedback on the draft document. The OMA acknowledged that a number of concerns it initially had with the draft document were addressed by the revisions that were made post-consultation and considered by Council at its December 2015 meeting.

- In its response, the OMA provided general support for the spirit of the draft document, but expressed some concern over the tone and clarity of it. The OMA also provided some specific suggestions on how to enhance the draft document.

- In response to feedback from Council and the OMA, a number of revisions were made to the draft document to improve the tone and clarity. Some of the key revisions included:

    - Adding a statement to the introduction to reinforce that the responsibilities set out within are not new, and to highlight that links to relevant College policies where these existing responsibilities can be found have been included in the revised draft document.

    - Reducing the use of the term "right" throughout the revised draft document and replacing it with alternate wording (e.g. patients are "entitled" to certain things, and can "expect" that their doctor will fulfill certain responsibilities) to address concerns about the document's tone.

    - Acknowledging the importance of patients being actively involved in their health-care, of *mutual* communication and collaboration, and of *mutual* trust, respect, and honesty.

- At its January 2016 meeting, the Executive Committee reviewed the revisions made to the draft document, now titled 'What to Expect During Medical Encounters', and thought the revisions addressed the feedback that had been provided. The revised draft document was approved for distribution to the public.

- The final version of the document has been posted on the College's website and will be communicated broadly in keeping with our communications strategy.

- All stakeholders who responded to the consultation will receive a copy of the final document, along with a letter thanking them for their participation.

3. Policy Consultation Update

I. Physician Behaviour in the Professional Environment

- The College's Physician Behaviour in the Professional Environment policy is currently under review. Following an initial review period in the summer of 2014, a new draft policy has been developed.

- The draft Physician Behaviour in the Professional Environment policy was approved for external consultation by Council at their December 2015 meeting. The consultation period began on December 9th, 2015 and will conclude on February 12th, 2016.

- As of Feburary 3, 2016, the College has received 71 consultation feedback responses: 28 comments posted on the consultation specific discussion page (16

comments from physicians, 6 from the public, 5 posted anonymously, and 1 from an organization[1]) and 43 online surveys (30 submitted by physicians, 7 by members of the public, 4 other health care professionals, and 2 respondents who preferred not to identify themselves).

- Broadly speaking, feedback has been more negative than in the initial consultation. Although a strong majority of survey respondents think the policy as a whole, and the definition of disruptive behaviour specifically, is clear and comprehensive, respondents on the discussion page have been largely critical of the policy.

- On the discussion page, some physician respondents have expressed concern that the policy will be used to unfairly target physicians, others have said it is disconnected from the stressful conditions that physicians work under, and some physicians have commented that the policy should set expectations for patient behaviour.

- All written feedback can be read in its entirety on the consultation homepage of the College's website.

- All feedback received will be carefully reviewed and used to evaluate and revise the draft policy.

- The revised draft policy will be presented to the Executive Committee and Council for its consideration for final approval later this year.

4. 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 B**. This table will be updated at each Council meeting.

- For further information about the status of any policy issue, please contact Andréa Foti, Manager, Policy, at extension 387.

DECISIONS FOR COUNCIL: For information only.

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[1] The organization respondent is the Canadian Medical Protective Association.

CONTACTS: Andréa Foti, ext. 387

DATE: February 3, 2016

Appendices:

Appendix A: Response to the Health Professions Regulatory Advisory Council (HPRAC) Regarding Registered Nurse Prescribing.

Appendix B: Policy Status Table.

January 26, 2016

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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Thomas Corcoran
Chair
Health Professions Regulatory Advisory Council
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Toronto, ON M5S 2S3

Dear Mr. Corcoran:

Thank you for requesting the College of Physicians and Surgeons of Ontario's (the College) feedback on Registered Nurse (RN) Prescribing in Ontario. The College appreciates the invitation to participate in the Health Professions Regulatory Advisory Council's (HPRAC) consultation on this issue.

Our understanding is that HPRAC is looking for comment on three models of RN prescribing for Ontario, in principle, as a specific objective or challenge that motivated consideration of RN prescribing hasn't been identified. Overall, this response expands on the informal comments on RN prescribing the College provided to the Ministry of Health and Long-Term Care (Ministry) at a meeting on July 14, 2015, and the College's preliminary position on RN prescribing that was submitted to the Ministry on August 24, 2015.

The College values initiatives that encourage the inter-professional and collaborative delivery of health care and ensure that every health care professional can work to their full scope of practice. The College is supportive in principle of RN prescribing, as long as RNs have the appropriate knowledge, skill and judgment to prescribe in a safe and effective manner. The College's specific comments on the three models of RN prescribing and the impacts of RN prescribing are set out below.

Independent Prescribing

The College's understanding is that in this model, RNs may prescribe medications under their own authority, either without restrictions (i.e. they can prescribe any drug), OR from a limited or pre-defined formulary within a regulated scope of practice (i.e. they can only prescribe certain drugs found on a list). Independent prescribers are allowed to prescribe any licensed or unlicensed drugs that are within their clinical competency area. As an independent prescriber, the RN would be fully responsible for the assessment of the patient's needs and prescription of medication. As independent prescribers, RNs would be similar to physicians and nurse practitioners (NPs) in terms of ability to prescribe. However, RNs would not have access to prescribing controlled drugs and substances as they are not authorized to do so under the *Controlled Drugs and Substances Act*.

Patient safety considerations are paramount when any regulated health care professional has the authority to independently prescribe drugs. The College's Prescribing Drugs policy sets out expectations for physicians who prescribe drugs. The policy contains a number of requirements physicians are expected to comply with in order to prescribe in a safe and

effective manner. To ensure patient safety is maintained, any health care professional who independently prescribes should do so in a manner that is consistent with the College's expectations for physicians. The College's support for independent RN prescribing would be contingent on this.

Key requirements in the College's policy specify that in order for physicians to prescribe in a safe and effective manner, they must conduct an appropriate clinical assessment prior to prescribing, which may include diagnostic and/or laboratory testing. The physician would also have to make a diagnosis and/or have a clinical indication based on the clinical assessment. Further, patients need follow-up care after prescribing, to monitor whether any changes to the prescription are required, and to manage a response to therapy or its complications. This may require further clinical assessments and/or diagnoses. Currently, it is not clear whether independent RN prescribing would include not only access to the controlled act of prescribing, but also the authority to order and interpret diagnostic and laboratory tests and to communicate a diagnosis. The College is concerned that patient safety and quality of care may be compromised if independent RN prescribing does not include the ability to order and interpret tests and communicate a diagnosis, as they are essential to safe and effective prescribing.

Patient safety must also be considered when any regulated health care professional has the authority to order and interpret diagnostic and laboratory tests. The College's Test Results Management policy sets out expectations for physicians regarding the management of all types of test results. The policy contains a number of requirements physicians are expected to comply with in order to ensure an effective system for managing test results is developed and maintained, and that test results are followed up on appropriately. To ensure patient safety is maintained, any health care professional who orders and interprets tests should do so in a manner that is consistent with the College's expectations for physicians. As such, the College believes that if RNs order tests in the context of independent prescribing, they should also have expectations to track and follow up on test results, as set out in the College's Test Results Management policy.

As RNs currently do not have the authority to prescribe independently, they will require appropriate education and training in order to do so safely and effectively. Appropriate education and training in prescribing is particularly important given the potential risks to patient safety that are inherent in independent prescribing. Prescribing is a complicated clinical act and potentially inappropriate medications or potentially inappropriate prescriptions can lead to adverse drug events, hospitalization, a poorer health-related quality of life, and death.[1] The media has reported[2] that the Government would extend RN prescribing to "minor skin conditions". However, even when prescribing drugs that may seem harmless (such as those

[1] Anderson K, Stowasser D, Freeman C, et al. "Prescriber barriers and enablers to minimising potentially inappropriate medications in adults: a systematic review and thematic synthesis". BMJ Open 2014;4:e006544. doi:10.1136/bmjopen-2014- 006544.
[2] See: http://globalnews.ca/news/1336105/wynne-promises-to-let-nurses-write-basic-prescriptions/

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used for minor conditions), there is potential for patient harm by misdiagnosis and/or inappropriate prescribing. For example, some skin cancers can masquerade as benign appearing skin conditions. We also know that inappropriate prescribing of antibiotics may further increase the development of antibiotic resistant organisms.

The College notes for HPRAC's information that education and training for physicians is significant. For example, physicians receive comprehensive training in pharmacology at the basic sciences level, followed by the application of pharmacotherapeutic principles in clinical practice. In considering independent RN prescribing, HPRAC must be assured that RNs have the appropriate education, training, and clinical judgment to prescribe in a safe and effective manner.

As stated earlier, since safe and effective prescribing also requires the ability to order and interpret tests and communicate a diagnosis, RNs who prescribe independently would also require the authority to perform these other controlled acts. It is essential that RNs be required to complete additional education and training in these areas as well to ensure that RNs possess the competencies to practise safely within their expanded scope.

Although patient safety should be the primary consideration as HPRAC considers independent RN prescribing, HPRAC may also want to consider the fact that providing RNs with the authority to prescribe, order and interpret tests, and to communicate a diagnosis would bring the scope of practice of RNs almost in line with the current scope of NPs, and would likely have a broader impact on the delivery of health care across the province. For example, it may lead to confusion amongst patients regarding scopes of practice for physicians, and nurses (NPs and RNs) and uncertainty as to which health care professional is ultimately responsible for the patient. HPRAC may wish to consider any potential impacts as it considers whether independent RN prescribing is an appropriate model for Ontario.

HPRAC may also want to consider the impacts on patients and other impacts on the health care system more broadly given fact that RNs would not have access to prescribing controlled drugs and substances as they are not authorized to do so under the *Controlled Drugs and Substances Act*. The College strongly supports this restriction, as prescribing controlled drugs and substances, and monitoring patients who are prescribed these drugs and substances, is extremely complex, especially given the associated significant patient and public safety risks. Access to prescribing controlled drugs and substances should not be provided to additional health care professions until prescribers are able to get real-time access to patient medication histories. Having said that, the College questions whether independent RN prescribing with this restriction would benefit patients and the health care system. If patients see an RN but require controlled drugs or substances, the patient would have to also see a regulated health care professional that has the authority to prescribe these drugs. This may not increase access to care or be convenient for patients, and may impact any efficiencies to the health care system that may be gained by adopting independent RN prescribing in Ontario. These potential impacts would also apply if independent RN prescribing is restricted to a limited or pre-defined formulary within a regulated scope of practice.

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Use of Protocols

This model appears to reflect the status quo, in which RNs are permitted to prescribe via delegation (under direct orders or medical directives). The College's understanding is that in this use of protocols model, written instructions from a prescribing physician or regulated health professional with prescribing authority will allow RNs to supply and administer medications within the terms of a predetermined protocol. The use of protocols is used for the supply and administration of named medicines in an identified clinical situation. RNs are only able to supply and administer medications within the strict terms of the predetermined protocol. RNs under this model are responsible for the acceptance of the protocol but the prescribing physician or regulated health professional with prescribing authority is responsible for the assessment of the patient's needs and prescription of any medication. Through the use of protocols, RNs would be able to prescribe specific medications under specific circumstances, similar to how RNs currently prescribe through the use of an order or a medical directive.

HPRAC may be aware that the College's Delegation of Controlled Acts policy enables physicians to delegate controlled acts (under direct orders or medical directives), including prescribing, to health care professionals such as RNs under appropriate circumstances. For example, this could include prescribing oral contraception for family planning purposes or penicillin for confirmed Group A streptococcal pharyngitis. There are safeguards in place for physicians to ensure delegation is done in a safe and effective manner, as articulated in the College's policy. These include the following: only delegating when it is in the bests interests of the patient and in the context of an existing physician-patient relationship (unless patient safety and best interests dictate otherwise); limiting delegation to acts that the physician is competent to perform personally; ensuring the delegate has the appropriate knowledge, skill and judgment to perform the delegated act, and that the delegate is able to accept the delegation; obtaining the patient's informed consent for the act; identifying the risk involved in delegating the act and any resources and equipment necessary to reduce risk; ensuring the appropriate level of supervision to ensure the act is performed safely and appropriately; and ongoing monitoring and evaluation of the act being performed.

Given that the use of protocols model proposes that a regulated health professional with prescribing authority other than a physician can allow RNs to supply and administer medications within the terms of a predetermined protocol, similar safeguards as set out in the College's Delegation of Controlled Acts policy must be in place to ensure this is done in a safe and effective manner. As such, if the Ministry proceeds with the protocols model, it may wish to consider the positions that have been adopted by other Colleges and ensure that there are requirements that are consistent with those set out in the College's Delegation of Controlled Acts policy.

It is the College's view that delegation of prescribing through direct orders or medical directives can and does work effectively. Appropriate delegation of controlled acts can result in more timely delivery of health care, and can promote optimal use of health care resources and personnel. HPRAC may wish to consider whether delegation is being fully utilized in Ontario

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and if not, whether changes could be made to the existing delegation framework that would achieve the Ministry's objectives in enabling RN prescribing.

Supplementary Prescribing

It is the College's understanding that supplementary prescribing is a hybrid of independent prescribing and use of protocols. This model involves a partnership between RNs, physicians and patients, where after an initial assessment of the patient's needs by the physician, a nurse may prescribe medication. In this model a patient-specific clinical management plan (CMP) is developed by the nurse and physician that allows the nurse to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area. The collaborating physician shares the responsibility of prescribing and holds full responsibility for the assessment of a patient. There are no restrictions on the type of patient condition or patient population for which a physician and RN could develop a CMP. As a supplementary prescriber a RN, working within a previously established CMP, would be permitted to prescribe for a variety of patient clinical conditions as long as they are within the RN's clinical competency.

The College's comments above regarding independent RN prescribing and use of protocols apply to this model. Given the potential risks to patient safety when independently prescribing, some of these key comments are highlighted here as well. For example, to ensure patient safety is maintained, RNs who prescribe independently, even if it is only from a limited or predefined formulary or class of drugs, should do so in a manner that is consistent with the College's expectations for physicians as set out in the College's Prescribing Drugs policy. As RNs currently do not have the authority to prescribe independently, they will require appropriate education and training in order to do so safely and effectively. Since safe and effective prescribing also requires the ability to communicate a diagnosis, RNs who prescribe independently under this model would also require the authority to perform this controlled act in order to develop patient-specific CMPs. However, because RNs do not currently have the authority to communicate a diagnosis, they will also require appropriate education and training in this area in order to do so safely and effectively.

Additionally, the College questions whether there would be the potential for confusion regarding which health care professional is ultimately responsible for the assessment, making a diagnosis, obtaining patient consent and writing the prescription under this model.

HPRAC may want to consider the impact this model may have on patients. For example, the fact that the model only allows the RN to prescribe within a limited or pre-defined formulary or by class of drugs within their clinical competency area may not benefit patients and the health care system. If the patient sees an RN and requires a drug that the RN cannot prescribe, they would have to also see a regulated health care professional that has the authority to prescribe that drug. This may not increase access to care or be convenient for patients, and may impact any efficiencies to the health care system that may be gained by RN prescribing under this model in Ontario. Further, it may lead to confusion amongst patients regarding scopes of

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practice for physicians and RNs, and uncertainty as to which health care professional is ultimately responsible for the patient.
HPRAC may also want to consider whether this model will achieve the Ministry's objectives in enabling RN prescribing.

Impacts of RN Prescribing

The College notes that HPRAC's online survey asks specific questions regarding the impact of RN prescribing, the risk of harm and readiness to prescribe. The College has raised potential impacts of RN prescribing throughout this letter, but wanted to specifically comment on a few others.

In regard to the impact of RN prescribing on better access to care in remote and rural areas, the College believes that this can and currently is being achieved in Ontario a number of different ways. For example, some RNs and NPs are physically located in remote and rural areas to provide care to patients either via delegation (RNs) or independently (NPs), and care is also being provided in these areas via telehealth. Information and communication technologies are currently being used, which benefit patients, physicians and other health care providers and the broader health care system by improving access to care, and increasing efficiencies in the delivery of care. HPRAC may want to consider whether delegation, NPs and teleheath are being fully utilized in Ontario and if not, whether changes could be made in these areas to achieve the Ministry's objectives in enabling RN prescribing.

In respect to the impact of RN prescribing on patients, including whether RN prescribing will help patients have a better understanding of the medications prescribed to them, result in patients being more compliant with instructions for medication use, and improve patient well-being, the College cannot predict whether or not these benefits would be realized with RN prescribing. The College understands that HPRAC will be reviewing the preliminary literature reviews on RN prescribing and the effectiveness of RN prescribing, and suggests that this may be the best way to determine the impact of RN prescribing on patients.

In conclusion, the College believes that inter-professional collaboration and coordination of care remain key enablers to safe, effective, high-quality and patient-centred care. The College is supportive of changes that improve these systemic issues and ensure that all health care professionals are working to their full scopes of practice. In regard to the three models of RN prescribing for Ontario, the College is supportive of the use of protocols model as it appears to reflect the status quo, where RNs are able to prescribe via delegation. The College has experience with a delegation model and believes that is strikes an appropriate balance between access to care and patient safety, particularly given the safeguards in place via the College's Delegation of Controlled Acts policy. It is the College's view that delegation of prescribing through direct orders or medical directives can and does work effectively. The College's support of any model that contemplates independent RN prescribing is contingent on whether the patient safety considerations identified are addressed.

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Yours very truly,

Rocco Gerace MD
Registrar

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Re-entering Practice	The current policy sets out expectations for physicians who wish to re-enter practice after a prolonged absence from practice and sets out requirements of physicians in demonstrating their competency in the area of practice they are returning to.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation will be commencing after the February 27 meeting of Council. A joint Working Group consisting of members of the Registration and Quality Assurance Committees will be struck to undertake this review along with the review of the Changing Scope of Practice policy.	2017
Changing Scope or Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice and sets out requirements of physicians in demonstrating their competence in the new area of practice.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation will be commencing after the February 27 meeting of Council. A joint Working Group consisting of members of the Registration and Quality Assurance Committees will be struck to undertake this review along with the review of the Re-entering Practice policy.	2017
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure	This policy is currently under review and the initial stages of the policy review are underway. This review will be coordinated with anticipated	2017

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	work on Continuity of Care which is set to commence this Spring.	
Block Fees and Uninsured Services	The current policy sets out the College's expectations of physicians who charge patients for services not paid for by the Ontario Health Insurance Plan (OHIP).	This policy is currently under review. Initial stages of the review are underway, and a preliminary consultation was undertaken between September and November, 2015. Further updates with respect to the status of this review will be provided at a future meeting.	2016
Accepting New Patients	The current policy provides guidance for physicians on accepting new patients for primary care.	This policy is currently under review. A Joint Working group has been struck to undertake this review along with the review of the *Ending the Physician-Patient Relationship* policy. A preliminary consultation on the current policy was undertaken between June and August, 2015. The working group is developing a revised draft policy informed by preliminary consultation feedback and research findings.	2016
Ending the Physician Patient Relationship	The current policy provides guidance to physicians about how to end physician-patient relationships, including a sample letter.	This policy is currently under review. A Joint Working group has been struck to undertake this review along with the review of the *Accepting New Patients* policy. A preliminary consultation on the current policy was	2016

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		undertaken between June and August, 2015. The working group is developing a revised draft policy informed by preliminary consultation feedback and research findings.	
Treating Self and Family Members	This policy articulates expectations for physicians who wish to treat themselves or family members and assists physicians in identifying situations where a personal, non-professional relationship makes it inappropriate to treat an individual.	At its December 2015 meeting, Council considered the consultation feedback received on the draft policy and the proposed revisions made in response. Council directed that additional revisions be undertaken. These revisions have been made and the revised draft policy is being presented to Council for final approval in February 2016.	2016
Physician Behaviour in the Professional Environment	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.	This policy is currently under review. A draft policy informed by preliminary consultation feedback and research findings has been developed. Council approved the draft policy for external consultation at its December 2015 meeting. This consultation is currently underway, ending February 12, 2016.	2016
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy provides guidance to physicians and to help physicians understand and comply with the legislative provisions of the	A review of this policy is intended to commence in 2016. The review will be informed by the College's Sexual Abuse Initiative and the Minister of Health and Long-Term Care's Task	2017

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	Regulated Health Professions Act, 1991 (RHPA) regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	Force on the Prevention of Sexual Abuse of Patients.	

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015	This policy provides guidance to physicians on disclosing harm to patients.
Fetal Ultrasound for Non-Medical Reasons	2015	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds.
Anabolic Steroids	2016	This policy sets out the expectation that physicians should not prescribe anabolic steroids or other substances and methods for the purpose of performance enhancement in sport.
Female Genital Cutting (Mutilation)	2016	This policy sets out physicians' obligations with respect to female genital cutting/mutilation.
Complementary/Alternative Medicine	2016	This policy articulates expectations relating to complementary and alternative medicine.
Dispensing Drugs	2016	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Practice Management Considerations	2016	This policy explains the practice management measures physicians should take when they cease to practise or will not be practising for an extended period of time. The review of this policy has been de-prioritized to accommodate other more urgent files.
Confidentiality of Personal Health Information	2016	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
		The review of this policy is currently on hold pending the introduction of new legislation by the Ministry.
Third Party Reports	2017	This policy clarifies the College's expectations regarding physicians' roles in and standards of care for conducting medical examinations and/or preparing reports for third parties.
Delegation of Controlled Acts	2017	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Medical Records	2017	This policy sets out the essentials of maintaining medical records.
Mandatory and Permissive Reporting	2017	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.
Criminal Record Screening	2017	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017	This policy sets out the College's expectations of physicians who act as medical experts.
Prescribing Drugs	2017	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.
Social Media – Appropriate Use by Physicians (Statement)	2018	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2019	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest: Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)	2019	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making for the End of Life)	2020	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.

POLICY STATUS REPORT – FEBRUARY 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Blood Borne Viruses	2020	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.

February 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNANCE COMMITTEE REPORT:

1. **Committee Appointment**
   - **Dr. Anita Rachlis, Inquiries, Complaints and Reports Committee**

2. **Resignations - Inquiries, Complaints and Reports Committee**
   - **Dr. Bernard Goldman**
   - **Dr. Wayne Johnston**

FOR INFORMATION

ISSUE:

1. **Committee Appointment**
   - Dr. Anita Rachlis, Inquiries, Complaints and Reports Committee

- The Governance Committee is reporting to Council that Dr. Anita Rachlis was appointed to the Inquiries, Complaints and Reports Committee (ICRC) by the Executive Committee at a meeting held on January 26, 2016 to fill a vacancy for an Internal Medicine specialist.

2. **Resignations - Inquiries, Complaints and Reports Committee**
   - **Dr. Bernard Goldman**
   - **Dr. Wayne Johnston**

- At the same meeting, the Executive Committee accepted committee appointment resignations from Dr. Bernard Goldman and Dr. Wayne Johnston and rescinded their committee appointments on the Inquiries, Complaints and Reports Committee.

DECISION FOR COUNCIL:

FOR INFORMATION ONLY

CONTACT: Carol Leet, Chair, Governance Committee
Debbie McLaren
Louise Verity

DATE: February 3, 2016

February 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNANCE COMMITTEE REPORT

FOR DECISION:

I Committee Appointments

ITEM FOR DECISION:

I Committee Appointments

Dr. Pauline Abrahams – Patient Relations Committee

- The Patient Relations Committee has an outstanding vacancy for a physician with a specified skillset, that includes experience with treating/counselling sexual abuse/sexual assault patients
- Dr. Pauline Abrahams, a Family Physician from Toronto, was identified as a qualified candidate for the position
- Dr. Abrahams is currently a GP Psychotherapist working in the Scarborough Hospital providing psych-oncology consultation and also providing psychosocial palliative care in home hospice
- In the past, Dr. Abrahams participated as a member of the Sexual Assault Care Centre at Women's College Hospital
- Dr. Abrahams was interviewed for the position by the Chair of the Governance Committee, Dr. Carol Leet, and the Chair of the Patient Relations Committee, Ms. Lisa McCool Philbin, on February 18, 2016

Dr. Mary Bell – Inquiries Complaints and Reports Committee

- The Inquiries, Complaints and Reports (ICR) Committee has an outstanding vacancy for an additional Internal Medicine Specialist for the 2016 Committee
- Dr. Mary Bell, an Internal Medicine Specialist with a subspecialty in Rheumatology, was identified as a qualified candidate for the position
- Dr. Bell's current medical experience includes,
    - Associate Professor, Division of Rheumatology, Dept. of Medicine, Faculty of Medicine, University of Toronto
    - Courtesy Staff, Dept. of Medicine, Southlake Regional Health Centre in Newmarket
    - Research Scientist. Arthritis Community Research and Evaluation Unit, The Arthritis and Immune Disorder Research Centre, University Health Network and Associate Scientist, Sunnybrook Research Institute
    - Active Staff, Dept. of Medicine, Sunnybrook Health Sciences Centre in Toronto
- Dr. Bell's, past medical experience includes,
    - Head, Division of Rheumatology, Dept. of Medicine, Sunnybrook Health Sciences Centre
    - Staff Rheumatologist, Dept. of Medicine, St. Joseph's Hospital, Hamilton

- Dr. Bell was interviewed for the position by the Chair of the Governance Committee, Dr. Carol Leet, and the Vice Chair, Internal Medicine Panels, Inquiries, Complaints and Reports Committee, Dr. Wayne Spotswood, on February 22, 2016
- The Governance Committee met by teleconference on February 23, 2016 and considered the chairs' recommendations for both candidates
- The Governance Committee recommends to Council that Dr. Pauline Abrahams be appointed to the Patient Relations Committee, and Dr. Mary Bell be appointed to the Inquiries, Complaints and Reports Committee

FOR DECISION:

Does Council approve the committee appointments as recommended by the Governance Committee?

CONTACT: Dr. Carol Leet, Chair, Governance Committee
Marcia Cooper
Debbie McLaren
Louise Verity

DATE: February 23, 2016

February, 2016

COUNCIL BRIEFING NOTE

TOPIC: Government Support for Public Members

FOR INFORMATION

ISSUES:

- Low level of per diem
- Inadequacy of per diem coverage (does not cover a range of activities)

BACKGROUND:

- The College is concerned with the level of government support for public members of Council.
- We have raised these issues with government in a number of ways and forums over many years.
- Our most recent formal submission on the issues was made November 30, 2015 in correspondence from the College President to the Minister of Health and Long-Term Care (Attachment 2).

CURRENT STATUS:

- We have just received the government's response. The response came from Mike Weir, Chief Administrative Officer and Assistant Deputy Minister January 28, 2016 (Attachment 1).
- The response makes the following points:
    - Government's appreciation for the work of public members of Council;
    - Applicable per diem remuneration rates appointed by a Minister or by Lieutenant Governor in Council are set out in government directives;
    - Public appointees to College Councils must not accept unauthorized remuneration from the College and Colleges should not supplement payments;
    - The basis of all governmental appointments is public service;
    - The Ministry's commitment to ensuring expenses and claims are processed in a timely fashion.
- We have also learned that government is looking at ways of enhancing and expanding coverage of the per diems. Such change will be welcome. This information will be circulated when it is available.

Attachments:

1. January 28, 2016 Letter from Mike Weir, Chief Administrative Officer and Assistant Deputy Minister MOHLTC
2. November 30, 2015 Letter from Dr. Carol Leet, CPSO President to the Minister regarding government support for public members

CONTACT: Louise Verity*:* 416-967-2600 (466)

DATE: February 3, 2016

Ministry of Health
and Long-Term Care

Corporate Services Division

Hepburn Block, 11th Floor
80 Grosvenor Street
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Tel.: 416 327-4266
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Ministère de la Santé
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Ontario

JAN 2 8 2016

HLTC3966MC-2015-478

Dr. Carol Leet
President
The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON M5G 2E2

Dear Dr. Leet:

Thank you for your letter to the Honorable Minister Dr. Eric Hoskins dated November 30, 2015 regarding the level of support provided to publicly appointed members of the College's Council. I have been asked to respond to this letter on behalf of Dr. Hoskins.

I know that the Minister is very appreciative of the work that public members provide for all of the health regulatory colleges. We continue to recognize that this invaluable and important work involves commitment and often a considerable amount of time.

Compensation costs for government appointed individuals must be addressed within Ontario's existing fiscal framework and all public-sector partners need to continue to work together to control current and future compensation costs.

As you are aware, Section 8 of the *Health Professions Procedural Code*, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, provides for the remuneration of College Council members appointed by the Lieutenant Governor in Council:

> *8. Council members appointed by the Lieutenant Governor in Council shall be paid, by the Minister, the expenses and remuneration the Lieutenant Governor in Council determines. 1991, c. 18, Sched. 2, s. 8; 2006, c. 19, Sched. L, s. 10 (1).*

Applicable per diem remuneration rates for individuals appointed by a Minister or by the Lieutenant Governor in Council under the authority of provincial legislation to perform public functions are set out in governmental directives centrally established by the Management Board of Cabinet.

Public appointees to College Councils must not accept unauthorized remuneration from the College or from any health profession body in respect of the individual's appointment. Accordingly, Colleges should not supplement payments to public-

.../2

appointees by making additional payments or "topping-up" payments for honoraria per diem remuneration or out-of-pocket expenses.

While acknowledging the significant level of commitment undertaken by public appointees, the basis of all governmental appointments is public service. Any per diem remuneration that may be paid to an appointee is not expected to be competitive with the marketplace or the appointee's usual rate of occupational compensation. Per diem remuneration is a nominal fee paid to partially off-set the cost of the individual's public service contribution, and is not intended to pay the appointee for services rendered or compensate her/him for lost income or the opportunity to earn income. The ministry informs every public member individually about the remuneration level for their appointment before the appointment is finalized.

We are committed to ensuring that expenses and claims are processed in a timely fashion. The processing of expenses/claims typically takes within four to six weeks to pay and reimburse a college appointee. This is also the length of time that it takes for Ontario Public Service employees.

The Ontario Shared Services (OSS) bi-weekly payment structure requires that the appointee's claims be verified by the Health Boards Secretariat (HBS) with the information provided by the individual College before payment can be approved. As you may know, public member claims hit three different departments including the College for attendance verification, the HBS for payment approval, and finally OSS for payment issuance. Public members are encouraged to claim regularly in an effort to ensure more regular payments to them.

Should you have further questions about the payment/reimbursement process, please feel free to contact Sara van der Vliet, Manager, HBS, at (416) 327-8510. For appointment related matters, please feel free to contact Thomas Boyd, Manager, Agency Liaison and Public Appointments Unit at (416) 327-6108.

Thank you once again for writing to the Minister.

Sincerely,

Mike Weir
Chief Administrative Officer and Assistant Deputy Minister

c: Dr. Eric Hoskins, Minister, Ministry of Health and Long-Term Care (MOHLTC)
Dr. Bob Bell, Deputy Minister, MOHLTC
Denise Cole, Assistant Deputy Minister, Health Workforce Planning Regulatory Affairs Division, MOHLTC
John Amodeo, Director, Corporate Management Branch, Corporate Services Division, MOHLTC
Sara van der Vliet, Manager Health Boards Secretariat, Corporate Management Branch, Corporate Services Division, MOHLTC
Tom Boyd, Manager, Agency Liaison and Public Appointments Unit, Corporate Management Branch, Corporate Services Division, MOHLTC

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

November 30, 2015

The Honourable Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister,

Re: Support for public members of the College Council

Thank you for your response to our September 2014 letter. As you know, the College of Physicians and Surgeons of Ontario has long-standing concerns with the support provided by government to public members of the College Council.

I am encouraged by your response to our correspondence and in particular, your recognition of the importance of the public member role and direction that government will "review our concerns and consider any appropriate amendments."

I write today to offer our full cooperation and assistance to move this work forward and to provide an update on the major issues. I sincerely hope that together, we can take tangible steps to address the long-standing issues facing our public members.

Overview

As you will know, the College has raised concerns regarding government support for public appointees for many years. Despite numerous meetings, conversations and correspondence with predecessors in your role, as well as government staff and Health Board Secretariat staff, the issues remain unresolved. Since our letter last year there has unfortunately not been any significant progress.

Public Council members make a vital contribution to the work of the College of Physicians and Surgeons of Ontario. We would simply not be able to fulfill our legislative mandate without their work. Concrete changes are needed in order to provide public members with the support they require and deserve. The College is eager to work closely with your government to identify short and mid-term solutions to address the issues.

As we have noted previously, there are three main issues of concern: inadequacy of per diem coverage; administration of claims; and per diem rates. The issues together with proposed solutions are identified below.

80 College Street, Toronto, Ontario M5G 2E2 Tel: (416) 967-2600 Toll Free: (800) 268-7096 Fax: (416) 961-3330

Inadequacy of per diem coverage

- Public members are not supported by government for a significant portion of their work as members of Council. For instance:
  - Preparation time is either not paid at all for some Committee work, such as Methadone or Premises Inspection Committees, or when preparation time is paid, the amount covered often falls significantly short of what is required.
  - Not all Committee Chairs are paid the higher per diem.
  - Travel time is not adequately covered.

Proposed solution:

- Ensure that per diem coverage is complete and that it is fairly and consistently applied to public members in a manner that recognizes the range of vital tasks and responsibilities that come with the role.

Administration of Claims

- Public members continue to report long delays getting reimbursed by government for their work, sometimes stretching upwards of three months. Travel expenses can be significant, and covering these sums while awaiting delayed reimbursement is unreasonable.

Proposed solution:

- The government has long recognized the importance of timely reimbursement and has previously committed to addressing the delays. We understand that there are some issues with the government's accounting system and recent changes have created additional challenges. We respectfully ask that more be done to ensure timelines for reimbursement are reasonable and that steps be taken to address the problem. We suggest that government communicate to all public members on this issue.

Per diem rates

- We understand that the per diem rate has not increased in approximately two decades and is not commensurate with the time, responsibility or workload of public members.
- We are discomfited by the significant difference in the public and physician Council members' per diem and believe the public member per diem is inadequate. Public members have equal responsibility and are expected to meet the same expectations as physician members of Council and College committees.

Proposed solution:

- If government is not willing to increase the per diem, legislative change is required. The College is prevented from "topping up" or covering public member per diems. This approach of topping up per diems has been taken by other regulatory authorities within and outside of Ontario.

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I have had the privilege of working closely with public members of Council for many years. Their dedication, competence and commitment to the public interest merit a reciprocal commitment from government.

Attached are our September 2014 letter and your May 2015 response. For further information about these issues please contact Louise Verity. I ask for your assistance to ensure that these issues are resolved.

Yours truly,

Carol Leet MD, FRCPC
President

Attachments:

1. September 2014 Letter to the Minister
2. May 2015 Response from the Minister

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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From the Office of the President
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Facsimile: (416) 967-2618

September 2, 2014

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister,

As you know, public Council members make a vital and important contribution to the work of the College of Physicians and Surgeons of Ontario (CPSO). Lack of government support for their appointees is troubling and I write to bring the issue to your attention.

Despite numerous meetings, conversations and correspondence with Health Board Secretariat staff the issues remain outstanding.

We are concerned with the amount of the per diem, the increasing narrowness of services for which the per diem is applied, the increasingly narrow interpretation of the expense claim guidelines, and the considerable time that it is taking for public members to receive reimbursement by government for travel, per diems and other associated expenses relating to their role as a College Council and committee member.

To help put the workload and role of a Council member into context, the CPSO receives approximately 3,000 complaints each year – the highest volume of any health profession in Ontario. We ask our public members to provide a minimum of 80 days of time per year at the government's $150.00 per diem. This is an unusually large amount of time for a board position. In addition to serving on the College Council which meets approximately 8 days per year, public members of Council also serve on either the Discipline or the ICR (central screening) committee. They are also called upon to serve on other statutory and operational committees. The skill set and technical competencies required of public members are high and the work while rewarding is demanding and can be emotionally draining.

Of particular concern is the fact that public members are not recognized and supported by government for a significant portion of their work as members of Council. This includes:

- Preparation time for some statutory committee meetings fall significantly short of what is required (includes Registration Committee, ICR Committee, and Discipline Committee). For the past five years, the Health Board Secretariat has approved claims for additional preparation time, when a supporting explanation for the claim is provided. This has now ended. For instance in July 2014, the professional and public members of the Discipline Committee reviewed hundreds of pages of documents prior to a challenging case. This work took two days' time and was vital to the role as a Discipline Committee panel member, yet the claim was not supported by Health Board Secretariat.

.../2

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- Preparation time for all non-statutory committees, task forces and policy working groups is not reimbursed (includes the Governance Committee, Outreach Committee, Finance Committee, Methadone Committee, and Education Committee). The Human Rights Policy working group is reviewing approximately 9,000 responses to the public consultation. The public member who is part of the working group will not receive any reimbursement for this activity.

- Compensation for decision writing and deliberation time frequently fall short of what is required.

- The per diem rate has not increased in over a decade and is not commensurate with the time, responsibility or workload of public members.

- Timelines for reimbursement remain long.

Public members are fully engaged in the work of the College and we understand that your government works to attract and appoint dedicated and skilled individuals. These long-standing issues are impacting morale and workload – and will not be sustainable in the long run.

I would be pleased to provide you with further information about these issues and ask for your assistance to ensure that they are resolved in a timely manner.

Yours truly,

Marc Gabel MD, MPH
President

Ministry of Health
and Long-Term Care

Office of the Minister

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Marc Gabel, MD, MPH
President
College of Physicians and Surgeons of Ontario
80 College Street
Toronto ON M5G 2E2

Dear Dr. Marc Gabel:

Thank you for your letter regarding your request for the ministry to consider an increase in the per diem rate for public members of your College. I note your concerns and apologize for the delay in responding.

As I'm sure you are aware, the government is committed to balance the budget by 2017–18 in a fair and responsible way. Compensation costs must be addressed within Ontario's existing fiscal framework. All public-sector partners need to continue to work together to control current and future compensation costs.

With that being said, I value the work of the public members of all of the health regulatory colleges and transitional Councils and we note that at times there can be a considerable about of work. Public members are an essential component in ensuring that Colleges consider the public's interest when dealing with matters of the College and the profession.

The Ministry will review your concerns and consider any appropriate amendments.

Thank you again for taking the time to write. I look forward to continuing to work together with our health care partners to ensure all Ontarians have access to high quality comprehensive health care services.

Yours sincerely,

Dr. Eric Hoskins
Minister

February 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNMENT RELATIONS REPORT

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Legislative Issues of Interest
3. Government Relations Activities

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1. Ontario's Political Environment

- The fall session of the Ontario Legislature rose on December 10th, 2015 and the spring session is scheduled to begin on February 16th, 2016.
- A February 11th by-election was called in Whitby-Oshawa to replace former PC MPP Christine Elliott who resigned last August and has since been appointed Ontario's first Patient Ombudsman. Both the Liberals and PCs nominated Whitby Regional Councilors as their candidates. Lorne Coe was the PC candidate, Elizabeth Roy was running for the Liberals and Niki Lundquist, a labour lawyer, for the NDP.
- The government continues to face challenges.
- Most recently, in December, two former McGuinty staff were each charged with three criminal counts for allegedly wiping the Premier's office hard drives after the cancellation of the gas-fired power plants in 2013.
- The 2015 Sudbury by-election bribery scandal also continues to be in the news following Liberal party organizer, Gerrry Lougheed's criminal charges in this matter and a possible trial that could begin as early as the spring.
- These issues, as well as the ongoing controversy over the majority sale of Hydro One, the government's new cap-and-trade system, and unrest with Ontario's doctors regarding compensation will likely continue to dominate the landscape at Queen's Park in the new session.

2. Legislative Issues of Interest

- The previous session was relatively quiet in regards to legislation that impacts the College, with some exceptions.
- *Bill 33, Safeguarding our Communities Act*, *2015* passed third reading and received Royal Assent on December 10th, however it will not come into force

until a day named by proclamation of the Lieutenant Governor.

- Bill 33 is a private member's bill introduced by PC MPP Vic Fedeli. The Bill's primary intent is to implement a provincial "patch-for-patch" program that aims to combat the abuse of fentanyl.
- The Bill requires a person prescribing fentanyl patches to record on the prescription the name and location of the pharmacy that will fill the prescription and to notify the pharmacy about the prescription. The Bill also contains various rules that apply to persons who dispense fentanyl including a requirement that a new fentanyl patch may only be dispensed if the dispenser collects a used fentanyl patch and one that has not been misused, tampered or is counterfeit.
- The Bill also contains regulation making authority that among other provisions, could allow for exceptions to these requirements to be put in place.
- The development of regulations is being closely monitored and more information will be shared, as it becomes available.
- *Bill 119, Health information Protection Act*, *2015* is the re-introduction of Bill 78, the Electronic Personal Health Information Protection Act.
- Bill 119 makes major revisions to the *Personal Health Information Protection Act*, repeals and replaces the *Quality of Care Information Protection Act*. It also makes amendments to the *RHPA* to require Colleges to collect personal information from members that is necessary for the purposes of developing or maintaining the electronic health record (EHR), and ensuring that members are accurately identified for purposes of the EHR.
- Second reading debate on Bill 119 is currently underway. We expect that the Bill will progress to Committee hearings in the upcoming spring session and that the College will make a formal submission at that point. However, conversations are already been occurring between College staff and the Ministry regarding potential amendments.

3. Government Relations Activities

- The College has frequent contact with all levels of government decision-makers to ensure government and elected officials have accurate and up-to-date information about the College and our activities.
- We have worked particularly closely with government on areas of shared focus including physician assisted dying, prevention of sexual abuse, transparency, and assisted reproduction. We also continue to raise concerns with government support for public members of the College Council.
- We regularly meet with MPPs from all three parties.
- We anticipate that the coming legislative session will be a busy one.

CONTACT: Louise Verity*:* 416-967-2600 x466
Miriam Barna: 416-967-2600 x557

DATE: February 1, 2016

The College of Physicians and Surgeons of Ontario

Memorandum

To: Council

From: Louise Verity

Date: February 22, 2016

Subject: Discussion Paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

As Council may be aware, at the end of 2015 the Minister of Health and Long-Term Care released a discussion paper Patient's First: A Proposal to Strengthen Patient Centred Health Care in Ontario.

The discussion paper followed the release of an earlier report by the Ministry's Expert Advisory Committee on strengthening primary health care in Ontario[1]. The Expert Committee was formed to provide advice to the ministry to assist in the advancement of the primary health care transformation agenda.

The Minister's *Patients First* discussion paper is a high level document that identifies the gaps or short comings with the health care system and proposes significant structural solutions. The central recommendation is the proposal to significantly expand the role of local health networks (LHINs).

The Minister and the Deputy Minister, LHINs and others are seeking feedback on the proposals contained in the paper. The Deputy Minister is speaking at Friday's Council meeting and will likely highlight the areas of focus in the discussion paper.

The paper can be found here http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf and feedback can be submitted to health.feedback@ontario.ca

A high level summary is contained below.

Existing gaps or challenges with the health system include the following:

- Many Ontarians are not as well served as they should be including indigenous peoples, newcomers and persons with mental health and addictions challenges;

[1] *Patient Care Groups: A new model of population based primary health care for Ontario*, A report on behalf of the Primary Health Care Expert Advisory Committee, David Price, Elizabeth Baker, Brian Golden and Rosemary Hannam, May 2015.

- Ontarians have difficulty accessing their primary health care provider when they need to;
- Ontarians have problems accessing home and community care;
- Public health services lack coordination across the health care system and population health planning is lacking; and
- Services are fragmented and inconsistent.

There is a sense that while the system may perform well in certain areas, it does not perform well at a systems level.

Four components or broad areas of change are proposed in the paper.

1. **More effective integration of services and greater equity**. The primary recommendation centres on significantly increasing and expanding the authority of LHINs. Through this approach, work to improve health equity and reduce health disparities over time.
    - Make LHINs responsible and accountable for all health service planning and performance management.
    - Make LHINs responsible for home and community care management and service delivery.
    - Identify smaller sub-regions as part of each LHIN to be the focal point for local planning and service management and delivery.
    - Make LHINs responsible for working with providers across the care continuum to improve access to high quality and consistent care.
    - The model proposes that clinician and patient choice would be maintained.

2. **Timely access to primary care, and seamless links between primary care and other services.**
    - Bring the planning and monitoring of primary care closer to the communities where services are delivered.
    - LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.

3. **More consistent and accessible home and community care.**
    - Strengthen accountability and integration of home and community care.
    - Transfer direct responsibility for service management and delivery from the community care access centres (CCACs) to the LHINs.
    - CCAC boards would be eliminated, CCAC employees would be employed by LHINs, and home care services would be provided by current service providers.

4. **Stronger links between population and public health and other health services.**
    - Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.
    - Closer links between Medical Officers of Health and LHINs to plan population health services.
    - Ministry funding for public health units would be transferred to the LHINs, yet local boards of health would continue to set budgets and public health services would be managed at the municipal level.

Discipline Committee
Report of Completed Cases
February 2016

Covering cases completed between November 12, 2015 and February 3, 2016

Note: This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) since the December 2015 Report to Council. The decisions are organized according to category, and then listed chronologically based on the date of the written decision on finding.

Click on the headings or case names below to access case details:

Sexual Abuse – 3 cases

1. Dr. T. Iqbal

Name:	Dr. Tariq Iqbal
Practice:	Internal medicine, Rheumatology
Practice Location:	Ottawa/Brockville
Hearing:	Contested
Decision / Written Decision Date:	September 24, 2015
Penalty Decision Date:	October 20, 2015
Written Penalty Decision Date:	December 14, 2015

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct - **proved**
- Failed to maintain the standard of practice of the profession - **proved**

Summary

On September 24, 2015, the Discipline Committee of the College of Physicians and Surgeons of Ontario found that Dr. Iqbal committed acts of professional misconduct in that, in respect of four patients, he has engaged in sexual abuse, he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and he has failed to maintain the standard of practice of the profession.

Ms. A
Dr. Iqbal sexually abused Ms. A during an office visit in May 2011 by repeatedly and forcefully moving his fingers in and out of her rectum in a sexual manner and without changing gloves; moved directly to insert his fingers in her vagina and again moved them in and out in a sexual manner; all under the guise of medical examinations. Dr. Iqbal failed to maintain the standard of practice by failing to ensure Ms. A's privacy (failing to leave the room while dressing and not ensuring appropriate draping) by performing examinations in the prone position; by performing intimate examinations that were unnecessary; by performing the intimate examinations in an inappropriate manner.

Ms. B
Dr. Iqbal sexually abused Ms. B by: penetrating her vagina with his finger and moving it in a sexual manner; and having a finger in her vagina and massaging the area without medical justification while performing a cortisone injection. Dr. Iqbal failed to maintain the standard of practice of the profession by failing to respect the privacy of Ms. B,

namely, failing to leave the room while dressing and assisting undressing, and by performing an unjustified examination in an inappropriate manner.

Ms. C
Dr. Iqbal sexually abused Ms. C on an office visit in June 2011 by touching her vagina and clitoris in a sexually stimulating manner under the guise of a medical examination. Dr. Iqbal failed to maintain the standard of practice of the profession by: failing to respect Ms. C's privacy; assisting her in removing her clothing: inappropriately performing a perianal examination; and inappropriately touching her vagina and clitoris during the examination.

Ms. D
Dr. Iqbal sexually abused Ms. D in May 2011 by touching her lower vulva and separating her labia without clinical justification, as well as in June 2011 by inserting his fingers into her rectum and vagina and moving them in a sexual manner under the guise of a medical examination. Dr. Iqbal failed to maintain the standard of practice of the profession by not respecting Ms. D's privacy by remaining in the room while she changed, and by performing inappropriate examinations of her vagina.

Disposition

On October 20, 2015, the Discipline Committee ordered and directed that:

- the Registrar revoke Dr. Iqbal's certificate of registration, effective immediately
- Dr. Iqbal reimburse the College for funding provided to patients under the program required under section 85.7 of the Code by posting a security acceptable to the College to guarantee payment within 60 days of the Order becoming final in the amount of $64,240.00
- Dr. Iqbal appear before the panel to be reprimanded no later than six months from the date the Order becomes final
- Dr. Iqbal pay $49,060.00 in costs to the College in within 60 days of the Order becoming final.

Appeal Notation

On November 17, 2015, Dr. Iqbal appealed the decision of the Discipline Committee to the Divisional Court. On December 3, 2015, Dr. Iqbal abandoned his appeal.

2. Dr. EFG

Name: Dr. EFG
Practice: Obstetrics and Gynaecology
Practice Location: Redacted
Hearing: Contested
Decision / Written Decision Date: December 16, 2015

Allegations and Findings

- Engaged in sexual abuse of a patient - **not proved**
- Disgraceful, dishonourable, or unprofessional conduct - **not proved**

3. Dr. S. Dobrowolski

Name: Dr. Stanley Thomas Dobrowolski
Practice: Psychiatry
Practice Location: London
Hearing: Uncontested Facts and Joint Submission on Penalty
Decision Date: November 30, 2015
Written Decision Date: January 20, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct - **proved**
- Failed to maintain the standard of practice of the profession – **proved**
- Found guilty of offences relevant to his suitability to practice - **proved**

Summary

On November 30, 2015, the Discipline Committee found that Dr. Dobrowolski committed an act of professional misconduct, in that he has engaged in the sexual abuse of patients, has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, has failed to maintain the standard of practice of the profession; and has been found guilty of offences relevant to his suitability to practise. Dr. Dobrowolski did not contest the allegations.

On December 20, 2005, as a result of an appeal of a decision of the Discipline Committee of the College of Physicians and Surgeons of Ontario, the Divisional Court made an order, by which terms, conditions or limitations were imposed on Dr. Dobrowolski's certificate of registration. These terms, conditions or limitations were in place until October 12, 2012 at 12:01 a.m. when his certificate of registration was

suspended on an interim basis by the Inquiries, Complaints and Reports Committee (ICRC) of the College, pending this hearing. The terms, conditions or limitations imposed by the Divisional Court included that:

(a) Dr. Dobrowolski was prohibited from performing any form of physical examination on any of his patients;
(b) Dr. Dobrowolski was required to post signage in his waiting room in a location where it was visible to patients, in an approved form, advising patients of this restriction;
(c) Dr. Dobrowolski was required to advise all female patients of the discipline findings made against him by the Discipline Committee of the College, and that as a result he was restricted from performing any form of physical examinations on any of his patients, and that if a physical examination was necessary, it would have to be performed by another physician;
(d) Dr. Dobrowolski was required to further advise all female patients that it was inappropriate and unacceptable for him to have any form of relationship with his patients outside of the physician-patient therapy relationship; and
(e) Dr. Dobrowolski was required to have all existing and future female patients sign an acknowledgment in a form provided, indicating that they had been advised of all of this information.

Investigation regarding Patient A

Patient A was Dr. Dobrowolski's patient between approximately February 2006 and May 2011, having been referred to him by a friend when seeking treatment for panic attacks and anxiety.

With respect to Patient A, in summary between February 2006 and May 2011, during the doctor-patient relationship:

- Dr. Dobrowolski touched Patient A in a sexual manner, including her breasts, legs, vaginal area and anal area, in the guise of a medical examination;
- Dr. Dobrowolski shaved Patient A's legs and pubic area during medical appointments for a sexual purpose;
- Dr. Dobrowolski took photographs and videos of Patient A during medical appointments, on some occasions without her knowledge, including photographs and videos in which she was fully or partially nude and was being touched by Dr. Dobrowolski;
- Dr. Dobrowolski purchased lingerie for Patient A to wear and photographed her wearing it during medical appointments;

- Dr. Dobrowolski inappropriately showed photographs of other patients' genital areas to Patient A during medical appointments;
- Dr. Dobrowolski hugged and kissed Patient A during medical appointments;
- Dr. Dobrowolski offered to undress during Patient A's medical appointment;
- Dr. Dobrowolski made inappropriate and sexual remarks to Patient A during medical appointments;
- Dr. Dobrowolski gave and lent money and items to Patient A during medical appointments;

- Dr. Dobrowolski breached the terms, conditions or limitations of his certificate of registration and the Divisional Court order in his conduct towards Patient A.

During the entire time period that he treated Patient A, Dr. Dobrowolski was subject to the terms, conditions or limitations on his certificate of registration and the Divisional Court order. He violated these terms, conditions or limitations and the Divisional Court order by conducting what purported to be physical examinations of Patient A. In addition, although he had Patient A sign the acknowledgement required by the Divisional Court's order, Dr. Dobrowolski gave Patient A false and misleading information about the terms on his certificate of registration, and the reasons for them, including his discipline history.

In July 2012, as a result of information received from Patient A and her husband, College investigators attended at Dr. Dobrowolski's office to obtain any computers used in his practice, together with thumb drives, disc drives, storage units, and cameras for inspection and analysis.

The College retained a computer forensics expert, Mr. X, to perform a forensic analysis of the materials obtained from Dr. Dobrowolski's office. Preliminary results of his analysis showed numerous images of Patient A from Dr. Dobrowolski's computer that Mr. X had recovered, including nude and partially nude images. The images were derived from videos taken on a computer camera, from which screen shots were taken and saved by Dr. Dobrowolski. Though Patient A believed Dr. Dobrowolski was performing physical examinations on her, in fact he had been touching her for a sexual purpose and filming himself doing so.

In addition, Mr. X recovered thousands of images of other nude and partially nude women. The images were captured in Dr. Dobrowolski's medical office, in some cases while the women interacted with Dr. Dobrowolski, for example while he handled their breasts, and in some cases without the woman's face being visible. Mr. X also recovered two videos of women in their underwear and/or nude, taken in Dr. Dobrowolski's medical office, in which Dr. Dobrowolski touched the women, including their breasts and vaginal areas. Both videos and many images had been deleted prior to Mr. X's analysis.

Upon the College's receipt of the preliminary results of the computer forensics analysis, on October 10, 2012, the ICRC referred allegations to the Discipline Committee and suspended Dr. Dobrowolski's certificate of registration without notice. At the same time, another investigation was commenced by the College, based on the information obtained in the investigation into Mr. A's complaint, including in particular the videos and images of women other than Patient A that were obtained from Dr. Dobrowolski's computer devices.

Criminal Conviction of Dr. Dobrowolski

After allegations against Dr. Dobrowolski were referred to discipline, Dr. Dobrowolski was arrested in November 2012, and charged with sexual assault of Patient A.

On May 14, 2014, Dr. Dobrowolski was found guilty in the Ontario Court of Justice of the following offences relevant to his suitability to practise:

(i) having sexually assaulted sixteen persons, contrary to section 271, subsection (1) of the Criminal Code of Canada (“sexual assault”);
(ii) having without lawful excuse disobeyed a lawful order by conducting physical examinations on twelve persons, contrary to section 127, subsection (1) of the Criminal Code of Canada (“breach of a court order”); and
(iii) having without lawful excuse, surreptitiously made visual recordings of nine persons, who were in circumstances that gave rise to a reasonable expectation of privacy when those persons were in a place in which they could reasonably be expected to be nude, to be exposing their genital organs or anal region or exposing their breasts or be engaged in explicit sexual activity, namely Dr. Dobrowolski’s office, and thereby having committed an offence under section 162, subsection (1), clause (a) of the Criminal Code, contrary to section 162, subsection (5) of the Criminal Code of Canada (“voyeurism”).

In total, the criminal findings related to Dr. Dobrowolski’s conduct towards 22 female patients, including Patient A.

Misconduct towards Other Patients

The College’s and police investigative processes led to the discovery of misconduct by Dr. Dobrowolski towards other patients who were not the subject of his criminal conviction:

(i) Regarding Patient B, when College investigators attended at Dr. Dobrowolski’s office in October 2012 to serve him with notice of his suspension and of the new investigation, she was present at his office. Investigators identified her as the subject of one of the videos recovered in the forensic analysis. The video shows Dr. Dobrowolski placing a concealed video camera in the area of his desk before Patient B enters the room. It then shows Dr. Dobrowolski touching Patient B’s breasts and vaginal area, including inserting his fingers into her vagina. College investigators advised Patient B of the video that the College had discovered. They learned from her that on numerous occasions during medical appointments Dr. Dobrowolski had conducted what Patient B believed at the time to be physical examinations on her, consisting of Dr. Dobrowolski touching her breasts and her genitals, including inside her vagina. Dr. Dobrowolski had videotaped Patient B without her knowledge, while touching her breasts and her genitals for his own sexual purposes.
(ii) Regarding Patient C, in approximately 2011 or 2012, Dr. Dobrowolski purported to examine a mole at a medical appointment. She removed her top but not her bra for the examination. In doing so, Dr. Dobrowolski breached the terms, conditions or limitations on his certificate of registration and the Divisional Court order prohibiting him from conducting physical examinations, and engaged in inappropriate touching of a sexual nature.
(iii) Regarding Patient D, she was Dr. Dobrowolski’s patient intermittently between 2000 and 2011. Dr. Dobrowolski on one occasion early in her treatment performed what purported to be a physical examination, including feeling around the area of

her breast, while telling her that he had found cancerous spots on other women. In doing so, Dr. Dobrowolski engaged in inappropriate touching of a sexual nature.

(iv) Regarding Patient E, she was Dr. Dobrowolski's patient from November 2005 to March 2006. Dr. Dobrowolski offered to check her breasts to see if she had any moles, and performed what purported to be a breast examination on one occasion during a medical appointment. In doing so, Dr. Dobrowolski engaged in inappropriate touching of a sexual nature.

(v) Regarding Patient F, on approximately five occasions between 2007 and 2008 during medical appointments, Dr. Dobrowolski conducted what purported to be physical examinations, with Patient F's bra off and her underwear on. In doing so, Dr. Dobrowolski engaged in inappropriate touching of a sexual nature and breached the terms, conditions or limitations on his certificate of registration and the Divisional Court order.

(vi) Regarding Patient G, she was Dr. Dobrowolski's patient between February 2005 and May 2012. Dr. Dobrowolski injected vitamin B12 shots into Patient G's buttocks on 1 to 3 occasions during medical appointments, in breach of the terms, conditions or limitations on his certificate of registration and the Divisional Court order. He also inappropriately lent her one hundred dollars during a medical appointment.

(vii) Regarding Patient H, Dr. Dobrowolski injected vitamin B12 shots into her hip once a month between 2005 and 2007. While Dr. Dobrowolski had Patient H sign the acknowledgement required by the terms, conditions or limitations on his certificate of registration and the Divisional Court order, he falsely told her they arose because a patient's husband had overreacted when Dr. Dobrowolski examined his wife for a mole while she was breastfeeding.

(viii) Regarding Patient I, she was Dr. Dobrowolski's patient in approximately 2005 and 2006. Dr. Dobrowolski directed Patient I to disrobe, did not leave the room while she did so, and performed what purported to be physical examinations on her, including touching her legs, abdomen, and breasts. In doing so, he engaged in touching of Patient I of a sexual nature and breached the terms, conditions or limitations on his certificate of registration and the Divisional Court order.

(ix) Regarding Patient J, she was Dr. Dobrowolski's patient from approximately 1998 until June 2012. Dr. Dobrowolski made inappropriate comments to Patient J during medical appointments, including sharing personal information. Dr. Dobrowolski also commenced performing a physical examination on Patient J on one occasion during a medical appointment, inappropriately looking at and touching her back and chest, purportedly while looking for moles. Patient J did not remove her clothes. Dr. Dobrowolski inappropriately offered to perform a breast examination during a medical appointment, but Patient J declined.

Disposition

On November 30, 2015, the Discipline Committee ordered and directed that:

- the Registrar revoke Dr. Dobrowolski's certificate of registration, effective immediately.
- Dr. Dobrowolski appear before the panel to be reprimanded.
- Dr. Dobrowolski reimburse the College for funding provided to those patients in respect of whom this panel has found Dr. Dobrowolski to have engaged in sexual abuse, under the program required under section 85.7 of the Code.
- Dr. Dobrowolski post an irrevocable letter of credit or other security acceptable to the College, to guarantee the payment of any amounts he may be required to reimburse under paragraph 4 of the Order, such security to be posted within 90 days of the date of this Order, in the amount of $449,680.00.
- Dr. Dobrowolski pay costs to the College in the amount of $4,460.00 within 30 days of the date of the Order.

Incompetence – 2 cases

1. Dr. R. Patel

Name:	Dr. Ramesh Patel
Practice:	Independent Practice
Practice Location:	Toronto
Hearing:	Uncontested Facts re Patients A & B; Contested Penalty
Finding Decision Date:	March 9, 2015
Penalty / Written Decision Date:	June 8, 2015

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct: **proved**
- Failed to maintain the standard of practice of the profession: **proved**
- Was incompetent: **proved**

Summary

On March 9, 2015, the Discipline Committee found that Dr. Patel committed an act of professional misconduct by failing to maintain the standard of practice of the profession in his care of 25 patients and that he is incompetent. The Committee also found that Dr. Patel engaged in disgraceful, dishonourable or unprofessional conduct, namely: inadequate supervision of staff; improper delegation of controlled acts; improperly permitting and/or directing staff to prescribe to patients; inappropriately having staff care for and treat patients in his absence; inappropriate billing to OHIP; and breaching his undertaking to the College. Dr. Patel admitted to the allegations.

In addition, Dr. Patel pleaded no contest to and the Discipline Committee found that Dr. Patel committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession and that he engaged in disgraceful, dishonourable or unprofessional conduct regarding his care of Patients A and B.

An investigation into Dr. Patel's practice was initiated after the College received information that Dr. Patel had been allowing staff to perform patient care beyond that which was appropriate for a non-physician staff member to provide. When College investigators attended at Dr. Patel's clinic in April 2011, staff and patients were present. College investigators were advised that Dr. Patel was on vacation.

Dr. Patel inappropriately billed OHIP during the time period that he was on vacation in April 2011. OHIP billings for the time period of Dr. Patel's absence indicated that the total amount billed in his name while he was on vacation was $34,079.14. Dr. Patel was not present in the office while any services were performed during this time. Dr. Patel inappropriately billed OHIP during this time period. Dr. Patel also engaged in other

inappropriate billing practices: billing for a minor assessment when faxing prescription renewals to or receiving them from pharmacies; billing for a minor assessment when a patient's family member dropped off or picked up a document, prescription or testing kit; and billing inappropriately with respect to administration of the Rotateq vaccination.

Dr. X, independent expert, identified a number of areas in which Dr. Patel's practice was unsatisfactory, including that he:

(a) made unsubstantiated diagnoses, including of diabetes.
(b) ordered numerous unnecessary tests that were not appropriate to patients' circumstances, based on the use of templates and routine. Inappropriate blood tests were also ordered as a matter of routine. Decisions were generally made to order tests before Dr. Patel had seen the patient.
(c) inappropriately treated respiratory infections in both adults and pediatric patients with medications that do not meet the standard of practice, and he failed to consider asthma where it would have been indicated to do so. Patients with respiratory infections were sometimes required unnecessarily to come in daily or almost daily for a period of time for a treatment that was not indicated.
(d) failed to address patients' presenting concerns on occasion.
(e) failed on one occasion to follow up appropriately on an abnormal electrocardiogram.
(f) inappropriately prescribed the 'morning sickness' medication Diclectin to a prenatal patient who did not complain of nausea or vomiting.
(g) failed to ensure that information in the patient chart was informative.
(h) failed to appropriately supervise staff and improperly delegated controlled acts. There was no documentation in the charts of instructions by Dr. Patel to his staff, including with respect to assessments and examinations conducted in his absence, nor were there any medical directives provided. Dr. X identified instances in which the care delivered in this manner showed a lack of appropriate clinical decision-making reflective of the lack of supervision.
(i) failed to obtain informed patient consent to the delegation of controlled acts to staff, or to staff involvement in their care.

After a referral to the Discipline Committee, Dr. Patel entered into an undertaking dated May 1, 2014. Among other things, Dr. Patel undertook that, effective immediately, he would not "delegate to any other person any Controlled Act, as that term is defined in the *Regulated Health Professions Act, 1991*." He also undertook to engage a Clinical Supervisor, Dr. Y, who would review his practice. Dr. Patel undertook "to co-operate fully with the supervision of" his practice, and to abide by the recommendations made by his Clinical Supervisor, including but not limited to any recommended practice improvements and ongoing professional development.

Dr. Y reviewed patient charts from Dr. Patel's practice and observed patient encounters in his office as required by the Undertaking. In the course of her duties, Dr. Y found that Dr. Patel continued to delegate controlled acts in breach of his Undertaking.

Dr. Patel failed to abide by practice recommendations made by Dr. Y, in breach of his undertaking, namely:

(a) to cease having staff enter billing codes for visits that were in progress and to begin entering billing codes only upon completion of a patient encounter.
(b) to cease billing for visits at which the patient was not present, including missed appointments and where the patient or family member was dropping off or picking up forms, specialist information, or specimens for testing.
(c) to augment subjective histories documented by staff with his own additional questions.
(d) to obtain informed consent from patients prior to staff documenting patients' subjective histories.
(e) to take steps to ensure that his EMR system clearly indicated which details were entered by which individual.
(f) to take steps to ensure his staff did not make clinical decisions.
(g) to cease ordering unnecessary diagnostic tests.
(h) to cease routinely prescribing Biaxin and Alupent for cough symptoms.

In addition, Dr. Patel failed to abide by patient-specific treatment recommendations made by Dr. Y, in that he did not discontinue a drug, Diabeta, which is associated with hypoglycemia to a patient who had experienced a hypoglycemic episode, continued to prescribe narcotics to a patient without adequate documentation, and continued to prescribe Ventolin to a patient without the suggested addition of another inhaler such as Advair to provide better symptom relief.

With respect to Patient A, she attended at Dr. Patel's office because she was experiencing foot problems and looking for a family physician. A female staff member, whom Patient A believed was a nurse but who was not a nurse, documented Patient A's history in detail, as well as her blood pressure, weight, and height. Patient A expressed to both the staff member and to Dr. Patel that she was being followed by Hospital 1 for a health issue related to her breasts, and did not require a breast examination. During the examination, Dr. Patel made comments that made Patient A feel uncomfortable, did not examine her feet, and conducted a breast examination without her consent.

Dr. X indicated that Dr. Patel's care did not meet the standard of practice of the profession. The history and other information in the chart obtained was contradictory. Patient A was subjected to unnecessary investigations, and did not have her concerns regarding her presenting complaint addressed. She had a breast examination to which she had not consented. There were errors in judgment in not seeking to obtain information from Hospital 1 or ordering appropriate tests, and there was a lack of adequate supervision of the staff member who saw Patient A before Dr. Patel. Dr. Patel's care displayed a lack of knowledge and judgment.

With respect to Patient B, he attended at the office of Dr. Patel complaining of chest pain. He was initially seen by a staff member, who recorded his history and vital signs, and performed an electrocardiogram. Dr. Patel informed Patient B that his electrocardiogram was normal, and that he could not treat him. Dr. Patel advised him that he could go to a hospital emergency department if he wished.

The next day, Patient B was admitted to hospital, where he underwent triple bypass surgery. Patient B was discharged from hospital with instructions to follow up with his family physician. After Patient B voiced concerns regarding post-operative care, he was discharged from Dr. Patel's practice by letter, five days after his discharge from hospital.

Dr. X opined that based on Patient B's account of his patient encounter, Dr. Patel did not meet the standard of practice of the profession and lacked knowledge and judgment in his treatment of Patient B. It would have been appropriate for Dr. Patel to either call the emergency department or send information either separately or with the patient. Patient B's discharge from Dr. Patel's practice also exposed him to harm, as he was not given any time to find a new primary care provider, and the discharge instructions from the hospital had indicated the need to see his primary care provider within the week.

With respect to both Patients A and B, Dr. Patel failed to provide an audit trail for their electronic medical records that accorded with College policy upon request by the College investigator.

In making its decision, the Discipline Committee rejected the submissions that were made by counsel for Dr. Patel in favour of a suspension and detailed program of re-education. The Committee disagreed with the opinion of an expert witness called by Dr. Patel on the structure and implementation of the proposed remediation, instead finding that Dr. Patel was not remediable. The Committee took into account the fact that it had disciplined Dr. Patel on two previous occasions, finding that the cumulative impact of the breadth and pervasiveness of Dr. Patel's clinical misconduct, and its extent, together with his failure to respond to the recommendations of his supervisor, provided evidence of ungovernability and constituted professional misconduct that deserved the most serious sanction. Dr. Patel's delegation practices and billing offences were a serious breach of the public trust. The safety of the public, maintenance of public confidence in the profession and its ability to govern itself, and the maintenance of the integrity of the profession, called for imposition of a penalty of revocation in this case.

Disposition

On May 20, 2015, the Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Patel's certificate of registration, effective immediately.
- Dr. Patel appear before the Committee to be reprimanded, and that the fact of the reprimand be recorded on the register.
- The parties make written submissions with respect to costs payable to the College, to be exchanged and filed with the Hearings Office of the College within 21 days of the date of this order.

On January 29, 2016, the Committee directed that Dr. Patel pay costs to the College in the amount of $22,300.00 within 60 days of the date of this Order.

2. Dr. W. A. Botros

Name: Dr. Wagdy Abdalla Botros
Practice: Psychiatry and FRCPC
Practice Location: Kitchener and London
Hearing: Contested
Decision / Written Decision Date: July 31, 2015
Penalty / Written Decision Date: December 16, 2015

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct - **proved**
- Incompetence - **proved**

Summary

On July 31, 2015, the Discipline Committee found that Dr. Wagdy Abdalla Botros committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Committee also found that Dr. Botros is incompetent.

The Committee found that Dr. Botros failed to maintain the standard of practice of the profession in his care and treatment of 22 patients in his sleep medicine practice between 2007 and 2010, including:

- failing to maintain the standard of practice with regard to his sleep study interpretation regarding all 22 patients;
- failing to triage all patient referrals as required;
- failing to complete a physical examination for one patient, and either did not do a physical examination or did not chart a physical examination with respect to three additional patients;
- prescribing inappropriate Continuous Positive Airway Pressure (CPAP) pressures following CPAP titration with respect to five patients;
- failing to take appropriate steps to treat three patients with severe obstructive sleep apnea within a reasonable time frame;
- allowing two patients to be prescribed CPAP without first being seen by a sleep physician;
- incorrectly or incompletely diagnosing five patients;
- failing to appropriately notify or follow up with the Ministry of Transportation regarding three patients;
- failing to appropriately prescribe supplemental oxygen for one patient who was on CPAP therapy; and

- demonstrating poor knowledge and understanding of CPAP treatment.

The Committee also found Dr. Botros incompetent in that his care of patients showed a lack of knowledge, skill or judgment generally, and specifically in the care of four patients who had severe conditions and one patient who was inappropriately diagnosed and managed.

The Committee also found that Dr. Botros engaged in behaviour that was unprofessional in his treatment of the College investigators. During an office visit, Dr. Botros interfered with the investigators' chart pull and made comments that were derogatory and demeaning to the professionalism of the College investigators.

Following a medical inspector's review of ten of Dr. Botros' charts, Dr. Botros failed to comply with multiple requests for information within a reasonable period of time.

Disposition

On December 16, 2015, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Botros' certificate of registration for a period of six months commencing immediately.
- The Registrar place the following terms, conditions and limitations on Dr. Botros' certificate of registration for an indefinite period:
  a) Dr. Botros is restricted from practising in sleep medicine, including but not limited to:
     i. Ordering, supervising and interpreting any sleep studies, diagnostic, or therapeutic; and
     ii. Assessing, managing, treating or prescribing to any patients in relation to any sleep disorder problems; except that this Order does not preclude Dr. Botros prescribing medication for sleep difficulties associated with a psychiatric disorder.
  b) Dr. Botros shall co-operate with unannounced inspections of his practice and patient charts, conducted at his own expense, by a College representative(s), for the purpose of monitoring and enforcing his compliance with these terms, conditions and limitations.
- Dr. Botros appear before the panel to be reprimanded.
- Dr. Botros pay costs to the College in the amount of $53,520.00, within 60 days of the date of the Order.

Disgraceful, Dishonourable or Unprofessional Conduct – 1 case

1. Dr. M. Varenbut

Name:	Dr. Michael Varenbut
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	November 20, 2015
Written Decision Date:	November 26, 2015

Allegation and Finding

- Disgraceful, dishonourable, or unprofessional conduct - **proved**

Summary

On November 20, 2015, the Discipline Committee found that Dr. Varenbut committed an act of professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Dr. Varenbut admitted to the allegation.

The Committee found that Dr. Varenbut held appointments at various times at six hospitals and a university between 2005 and 2013, during which time Dr. Varenbut failed to disclose that he had been the subject of College investigations, or that restrictions had been imposed on his certificate of registration, where that information was required to be disclosed, in certain applications for renewal of privileges or appointment at a number of different institutions.

Dr. Varenbut was not provided with specific advice on completing these applications or that the scope of disclosure requested can vary from year to year, and from one hospital to another. Dr. Varenbut did disclose the existence of his College Discipline Committee finding in his applications where appropriate. Dr. Varenbut also consented to allow the hospital or institution to obtain information from the College in relation to College matters, where this was sought. Dr. Varenbut did not exercise his hospital privileges during the relevant time period and had no clinical patient responsibility in any of the hospitals/institutions.

He obtained and maintained these appointments as a corollary to his teaching appointments or so that if a patient on methadone in the community required hospitalization, a physician qualified in methadone treatment would be available to provide a prescription for methadone while the patient was hospitalized.

Dr. Varenbut admitted to the allegation that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

Disposition

The Committee ordered and directed that:

- The Registrar suspend Dr. Varenbut's certificate of registration for three months starting November 21, 2015.
- Dr. Varenbut appear before the panel to be reprimanded.
- Dr. Varenbut pay to the College costs in the amount of $4,460.00 within 30 days of this Order.