The College of Physicians and Surgeons of Ontario

Annual Financial Meeting of Council

May 30 and 31, 2016

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Monday May 30th and Tuesday May 31st, 2016 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

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

Rocco Gerace, MD
Registrar

April 28, 2016

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

ANNUAL FINANCIAL MEETING OF COUNCIL

May 30th and 31st, 2016 at 9:00 a.m.
Council Chamber, 3rd Floor, 80 College Street, Toronto

Monday May 30, 2016

CALL TO ORDER		
9:00 a.m.	**President's Announcements**	
Motion	**Council Meeting Minutes of February 26th, 2016**	**1**
	Executive Committee's Report to Council – April 2015 to March 2016	**48**
Motion	**Physician Behaviour in the Professional Environment – Consultation Report and Revised Draft Policy** Council is provided with a report on the draft Physician Behaviour in the Professional Environment policy consultation and the proposed revisions made to the policy in response to the feedback received. Council is asked whether the revised draft policy can be approved. *For Final Approval*	**53**
Motion	**Proposed Changes to OHPIP Standards – Accountability of Medical Director, Staff Qualifications, Infection Control and Quality Assurance** Council is provided with proposed changes to the Out-of-Hospital Premises Inspection Program (OHPIP) Standards that are intended to increase the accountability of Medical Directors in Out-of-Hospital Premises (OHPs), and is being asked whether the document can be released for external consultation. *For Approval to Consult*	**64**

Motion	**Compensation of Public Members** The Briefing Note considers the issue of public member compensation and the legislative change that would be required for the College to fund or top up the public member per diem. Council is asked whether it supports the development of a formal request for legislative change. *For Decision*	**103**
BREAK		
Motion	**Transparency Initiative: Proposed By-Law Amendment re Posting QAC SCERPs** The proposed by-law that would make QAC SCERPs public has been circulated for comment as required. This briefing note asks Council to approve the proposed by-law and provides a general update on the transparency initiative. *For Final Approval*	**118**
Motion	**By-law Amendments for Register Content** Amendments to the register provisions in the By-law are proposed to reflect College practices and to make corrections and minor improvements of a housekeeping nature. *For Approval to Consult*	**124**
COUNCIL AWARD PRESENTATION		
11:30 a.m.	**Council Award Winner -** Dr. Amanda Bell of Port Colborne, Ontario	**133**
LUNCH		
MEMBER TOPICS		

1:00 p.m.	**Continuity of Care Planning and Proposal** At its March 2014 meeting the Executive Committee asked staff to undertake preliminary work on the issue of continuity of care, including an analysis and recommendation regarding the development of a new policy. Preliminary work related to continuity of care began in early 2016 and has culminated in the development of a *Continuity of Care Planning and Proposal* which is presented to Council for review and feedback. *For Discussion and Feedback on Proposal*	**134**
Motion	**Physician-Assisted Death / Medical Assistance in Dying: Federal Activity and College Policy** *Materials will be made available at the time of the meeting.*	**140**
	Annual Fire Drill and Evacuation Procedures The College is required to complete annual testing of fire drill procedures. Council will be participating in this evacuation process during the meeting.	**141**
Motion	**Planning for and Providing Quality End-of-Life Care – Post Approval Amendments** The College's *Planning for and Providing Quality End-of-Life Care* policy was approved by Council in September 2015 and at that time, there was significant controversy regarding the policy expectations pertaining to no-CPR orders. Feedback was recently received about these expectations from two critical care physicians. This feedback and proposed policy amendments are outlined for Council. As well, some housekeeping amendments are proposed to policy content relating to physician-assisted death. Council is asked whether it approves these amendments. *For Final Approval*	**143**

Tuesday May 31, 2016

CALL TO ORDER		
9:00 a.m.	**President's Announcements**	
Motion	**Governance Committee Report** **Items for Decision:** **i. 2017 Executive Committee Vote** **Items for Information:** **ii. Completion of 2017 Committee Interest Forms *(for submission at Council meeting)***	**172**
REGISTRAR'S REPORT		
	Strategic Update - Dashboard	**207**
BREAK		
DIVISIONAL ANNUAL REPORTS		
	Corporate Services Information Technology Investigations, Resolutions, Hearings, Compliance Monitoring and Supervision Legal Policy and Communications Quality Management Research and Evaluation	**213** **225** **235** **269** **272** **289** **299**
	Opioid Update	**311**

11:00 a.m.	**PRESENTATION**	
	Karen McKibbin Director Ontario Public Health Integrated Solutions (OPHIS) **Status Update:** **Comprehensive Drug Profile Strategy, Digital Health Drug Repository**	**317**
	LUNCH	
1:00 p.m. **Motion**	**Audited Finance Statements – 2015 and Appointment of the Auditor for 2016** The spring meeting of Council is called the Annual Financial Meeting for the College of Physicians and Surgeons of Ontario. At this meeting the College's auditor presents the audit report along with the audited financial statements for the year 2015. After the report, the auditor departs and Council appoints the external auditors for the year 2016. *For Decision* **Report of the Finance Committee** The Committee's issues and activities for 2016 are included for review by the Chair, Mr. Pierre Giroux. *For Information*	**318** **337**
	FOR INFORMATION	
1.	Government Sexual Violence and Harassment Initiatives	**345**
2.	Grey Areas – Commentary on Legal Issues Affecting Professional Regulation	**350**
3.	Policy Report	**352**
4.	Government Relations Report	**378**
5.	Discipline Committee – Report of Completed Cases, May 2016	**381**

6.	Draft Revised: IHF Clinical Practice Parameters and Facility Standards for Sleep Medicine	**404**
Motion	**Motion to go In-Camera**	
IN CAMERA SESSION		
ADJOURNMENT		

COUNCIL MEETING MINUTES OF FEBRUARY 26, 2016

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MAY 30, 2016

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

The Council accepts as correct the minutes of the meeting of the Council held on February 26, 2016

- OR -

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

1.

PHYSICIAN BEHAVIOUR IN THE PROFESSIONAL ENVIRONMENT –
Revised Draft Policy for Final Approval

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 30 or 31, 2016

It is moved by .....,

and seconded by ....., that:

The Council approves the revised policy "Physician Behaviour in the Professional Environment" (a copy of which forms Appendix " " to the minutes of this meeting).

PROPOSED CHANGES TO OHPIP STANDARDS – ACCOUNTABILITY OF MEDICAL DIRECTOR, STAFF QUALIFICATIONS, INFECTION CONTROL, AND QUALITY ASSURANCE

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 30-31, 2016

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

The College engage in the consultation process in respect of the draft "Out-of-Hospital Premises Inspection Program (OHPIP) Standards" (a copy of which forms Appendix " " to the minutes of this meeting).

PUBLIC MEMBER COMPENSATION

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 30 or 31, 2016

It is moved by .....,

and seconded by ....., that:

The College seek amendments to the Health Professions Procedural Code to permit it to provide compensation to members of Council appointed by the Lieutenant Governor in Council.

TRANSPARENCY INITIATIVE: Proposed By-Law Amendment re Posting QAC SCERPs

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 30, 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. 109:

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:

25.1 In respect of a decision of the QAC that includes a disposition of a SCERP, if the decision is made on or after June 1, 2016, the elements of the SCERP.

25.2 In respect of the elements of a SCERP, referred to in paragraph 25.1 above, a notation that all of the elements have been completed, when so done.

25.3 Where a decision referred to in paragraph 25.1 above is overturned on review, the summary shall be removed from the Register.

BY-LAW AMENDMENTS FOR REGISTER CONTENT

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 30, 2016

It is moved by _____, and seconded by _____ that the Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 110, after circulation to stakeholders:

By-law No. 110

1. Paragraphs 1, 6, 7, 8, 12, 14, 16, 23, 24, 25 and 27 of subsection 49(1), of By-Law No. 1 (the General By-Law) are revoked and the following are substituted:

1. Any changes in the member's name since his or her undergraduate medical training that is used or to be used in his or her practice, and the date of such change, if known to the College.

6. A description of the member's postgraduate training in Ontario.

7. If the member is certified by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada,

    i. that fact,
    ii. the date of the certification, and
    iii. the discipline or sub-discipline in which the member is certified.

8. The classes of certificate of registration held by the member and the date on which each certificate was issued and, if applicable, the revocation, suspension or expiration date, or date of removal of a suspension.

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

14. If the result of a disciplinary proceeding in which a finding was made by the discipline committee in respect of the member is in the register,

    i. the date on which the discipline committee made the finding, and

    ii. the date on which the discipline committee ordered any penalty.

16. If the result of an incapacity proceeding in which a finding was made by the fitness to practise committee in respect of the member is in the register,

    i. the date on which the fitness to practise committee made the finding,

    ii. the effective date of any order of the fitness to practise committee,

    iii. where the finding is under appeal, a notation to that effect, and

    iv. when an appeal of a finding of incapacity is finally disposed of, the notation added under subparagraph iii of this paragraph 16 shall be removed.

23. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a Specified Continuing Education or Remediation Program ("SCERP"), if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file is dated on or after January 1, 2015, a summary of that decision, including the elements of the SCERP, and, where applicable, a notation that the decision has been appealed.

24. In respect of the elements of a SCERP referred to in paragraph 23 above, a notation that all of the elements have been completed, when so done.

25. Where a decision referred to in paragraph 23 above is overturned on appeal or review, the summary shall be removed from the register.

27. Where a member is currently registered or licensed to practice medicine in another jurisdiction, and such licence or registration has been made known to the College as of or after September 1, 2015, the fact of that licensure or registration.

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

7.1 If the member is formally recognized as a specialist by the College,

i. that fact,

ii. the date of recognition, and

iii. the discipline or sub-discipline in which the member is recognized.

29. If the terms, conditions and limitations (other than those required by regulation) are imposed on a member's certificate of registration or if terms, conditions and limitations in effect on a member's certificate of registration are amended,

i. the effective date of the terms, conditions and limitations imposed or of the amendments, and

ii. a notation as to the committee or the member, as applicable, that imposed or amended the terms, conditions and limitations on the member's certificate of registration.

30. Where a member's certificate of registration is revoked or suspended, the committee that ordered the suspension or revocation of the member's certificate of registration, if applicable.

31. Where a member's certificate of registration is expired, the reason for the expiry.

32. Where a notation of a finding of professional negligence or malpractice in respect of the member is in the register,

i. the date of the finding, and
ii. the name and location of the court that made the finding against the member, if known to the College.

33. The date on which the College issued a certificate of authorization in respect of the member, and the effective date of any revocation or suspension of the member's certificate of authorization.

34. The language(s) in which the member is competent to conduct practice, as reported by the member to the College.

4. Subsection 49(2) of By-Law No. 1 (the General By-Law) is revoked.

5. Subsection 50.1(1) of By-Law No. 1 (the General By-Law) is revoked and the following is substituted:

Public Information

50.1 (1) All information contained in the register, other than:

(a) a member's preferred address for communications from the College,

(b) a member's e-mail address,

(c) a member's date of birth,

(d) a member's place of birth,

(e) any information that, if made public, would violate a publication ban if known to the College, and

(f) information that the registrar refuses or has refused to post on the College's website pursuant to subsection 23(6), (7), (8), (9) or (11) of the Health Professions Procedural Code,

is designated as public except that,

(g) if,

(i) terms, conditions or limitations were directed to be imposed upon a member's certificate of registration by a committee other than the discipline committee, and

(ii) the terms, conditions or limitations have been removed,

the content of the terms, conditions or limitations are no longer public information.

6. Subsection 50.2 of By-Law No. 1 (the General By-Law) is amended by adding the following as a heading preceding the subsection:

Liability Protection

5. Subsection 51(1) of By-Law No. 1 (the General By-Law) is revoked and the following is substituted:

Notification Required by Members

51. (1) A member shall notify the College in writing or electronically as specified by the College of,

(a) the member's preferred address (both mailing and e-mail) for communications from the College;

(b) the address and telephone number of the member's principal place of practice;

(c) the identity of each hospital and health facility in Ontario where the member has professional privileges;

(d) any currently existing conditions of release (not including any information subject to a publication ban) following a charge for a criminal or provincial offence, or subsequent to a finding of guilt and pending appeal, and any variations to those conditions; and

(e) any changes in the member's name since his or her undergraduate medical training that is used or will be used in the member's practice.

Explanatory Note: - This by-law must be circulated to the profession and will return to the Council after the circulation.

PLANNING FOR AND PROVIDING QUALITY END-OF-LIFE CARE – POST APPROVAL AMENDMENTS

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 30 or 31, 2016

It is moved by .....,

and seconded by ....., that:

The Council approves the revised "Planning for and Providing Quality End-of-Life Care" policy, (a copy of which forms Appendix "" to the minutes of this meeting).

2017 EXECUTIVE COMMITTEE VOTE

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May __, 2016

It is moved by .....,

and seconded by ....., that:

The Council appoints _____ (as President), _____(as Vice President), _____ (as physician member), _____ (as public member), _____ (as public member), and Dr. Joel Kirsh (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2016.

MOTION TO APPROVE THE FINANCIAL STATEMENTS

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2016

It is moved by .....,

and seconded by ....., that:

The Council approves the financial statements for the fiscal year ended December 31, 2015 as presented (a copy of which forms Appendix " " to the minutes of this meeting).

MOTION TO APPOINT THE AUDITOR FOR 2016

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

May 2016

It is moved by .....,

and seconded by ....., that:

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

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion to Go In-Camera

May 31, 2016

It is moved by

.....,

and seconded by

.....,

that :

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

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
FEBRUARY 26, 2016

Members:

Dr. Joel Kirsh (President)
Dr. El-Tantawy Attia (PhD)
Mr. Sudershen Beri
Dr. Steven Bodley
Dr. Brenda Copps
Ms. Lynne Cram
Ms. Diane Doherty
Mr. Harry Erlichman
Ms. Debbie Giampietri
Dr. Marc Gabel
Major Abdul Khalifa
Dr. Carol Leet
Dr. Barbara Lent
Dr. Richard (Rick) Mackenzie
Dr. Haidar Mahmoud
Dr. William McCready
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Dennis Pitt
Dr. Peeter Poldre
Ms. Joan Powell
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Eric Stanton
Dr. Peter Tadros
Ms. Peggy Taillon
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watters

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

Regrets: Mr. Pierre Giroux, Dr. John Jeffrey, Mr. John Langs, Mr. Ron Pratt, Dr. John Rapin, and Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

Dr. Joel Kirsh called the meeting to order at 8:30 a.m., and welcomed members of Council and guests.

Council Meeting Minutes of December 3 and 4, 2015

01-C-02-2016

It is moved by Mr. S. Beri and seconded by Mr. E. Therien that:

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

CARRIED

Council Meeting Minutes of January 26, 2016

02-C-02-2016

It is moved by Dr. M. Gabel and seconded by Dr. P. Poldre that:

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

i. Dr. Peter Tadros
ii. Mr. John Langs
iii. Mr. Harry Erlichman

CARRIED

PRESENTATION

Dr. Robert Bell, Deputy Minister of Health and Long Term Care, presented an update on the status of key governmental reviews, including areas where the College and government have been working together in the public interest, and also addressed governance models in relation to health regulatory colleges.

FOR DECISION

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

03-C-02-2016

It is moved by Mr. E. Therien and seconded by Dr. C. Leet 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 "A" to the minutes of this meeting), as a policy of the College.

CARRIED

Prescribing Naloxone for Opioid Overdose Emergency Kits

04-C-02-2016

It is moved by Dr. E. Stanton and seconded by Dr. J. Rosenblum that:

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

CARRIED

05-C-02-2016

It is moved by Dr. Carol Leet and seconded by Dr. S. Bodley that:

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

CARRIED

By-Law #107 (Membership Fee)

06-C-02-2016

It is moved by Mr. S. Beri and seconded by Mr. P. Pielsticker 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;

CARRIED

MEMBER TOPICS

There were no member topics brought forward.

PRESENTATIONS

Regulatory Models

Ms. Vicki White, Co-Director of the Legal Office, reviewed governing, discipline and oversight structures in other jurisdictions to inform the future direction of Council.

Regulatory Models and an Overview of the Law Society of Upper Canada

Mr. Robert G. Lapper, Chief Executive Officer, provided an overview of regulatory models and the Law Society of Upper Canada.

COUNCIL AWARD WINNER

Dr. Dennis Pitt presented the Council Award to Dr. Stephen Feder, Children's Hospital of Eastern Ontario (CHEO), Ottawa, Ontario.

FOR DECISION

Governance Committee Report

Dr. C. Leet provided Council members with an update on the activity of the Governance Committee.

07-C-02-2016

It is moved by Dr. E. Stanton and seconded by Dr. M. Gabel 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.

CARRIED

REGISTRAR'S REPORT

1. Strategic Initiatives Including Dashboard Update
2. Divisional Reports
3. Stakeholder Relations

PHYSICIAN ASSISTED DEATH

The Registrar provided an overview of the current status of various Physician-Assisted Death initiatives at the provincial and federal level.

TOPICS FOR INFORMATION

1. Policy Report
2. Governance Committee Report
3. Support for Public Members
4. Government Relations Report
5. Discipline Committee – Report of Completed Cases, February

MOTION TO GO IN CAMERA

08-C-02-2016

It is moved by Mr. S. Beri and seconded by Dr. P. Tadros:

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

CARRIED

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 1:00 p.m.

_____
Dr. Joel Kirsh, President

_____
Franca Mancini, Recording Secretary

College of Physicians and Surgeons of Ontario

POLICY STATEMENT #2-16

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

APPROVED BY COUNCIL: November 2001

REVIEWED AND UPDATED: November 2006; February 2016

TO BE REVIEWED BY: February 2021

PUBLICATION DATE: Issue 1, 2016

KEY WORDS: Self; Family Members; Others Close to Them; Minor condition; Non-patients; Relationships; Emotional and clinical objectivity; Professional judgment; Standard of care; Spouses or Sexual/Romantic Partners; Prescribing and administering drugs; Controlled and monitored drugs and substances.

RELATED TOPICS: Practice Guide; Confidentiality of Personal Health Information; Maintaining Appropriate Boundaries and Preventing Sexual Abuse; Marijuana for Medical Purposes; Physicians and Health Emergencies; Prescribing Drugs.

LEGISLATIVE REFERENCES:

Controlled Drugs and Substances Act, S.C. 1996, c. 19.
- *Benzodiazepines and Other Targeted Substances Regulations,* SOR/2000-217.
- *Marihuana for Medical Purposes Regulations,* SOR/2013-119.
- *Narcotic Control Regulations,* C.R.C., c. 1041.

Health Care Consent Act, 1996, S.O. 1996, c. 2, Schedule A.

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991,* S.O. 1991 c. 18.

Medicine Act, 1991, S.O. 1991 c. 30.
- *Registration,* O Reg 865/93.

Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22.

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Schedule A.

REFERENCE MATERIALS: See Page 7

OTHER REFERENCES: Frequently Asked Questions

COLLEGE CONTACT: Physician Advisory Services

8

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

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 may provide such treatment. The policy sets out the College's expectations for physicians in meeting their professional obligations to practise 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 r*easonably 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]

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.
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 Section 4 of the *Medicine Act, 1991*, S.O. 1991, c. 30. (hereinafter *Medicine Act*).
5. The definition of "treatment" in this policy has been adapted, and modified, from the definition of "treatment" as set out in the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Schedule A, at Section 2(1) (hereinafter *HCCA*). Physicians should note that the exceptions to "treatment" under the *HCCA* do not apply to this policy.

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.

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

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.
7. Please see the following articles:
- American Academy of Pediatrics Committee on Bioethics. (2009). Policy statement -- Pediatrician-family-patient-relationships: managing the boundaries. *Pediatrics*, 124(6), 1685-1688.
- Chambers, R. & Belcher, J. (1992). Self-reported health care over the past 10 years: a survey of general practitioners. *British Journal of General Practice*, 42(357), 153-156.
- Chen, F.M., Feudtner, C., Rhodes, L.A., Green, L.A. (2001). Role conflicts of physicians and their family members: rules but no rulebook. *Western Journal of Medicine*, 175(4), 236-239.
- Gold, K.J., Goldman, E.B., Kamil, L.H. et. al. (2014). No appointment necessary? Ethical challenges in treating friends and family. *New England Journal of Medicine*, 371(13), 1254-1258.
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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).

10

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

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.

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]

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). http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf.
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.
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. 24-30, (Feb 2014).
11. Sections 2(1)(c) and 2(5) of *Registration*, O Reg. 865/93, enacted under the *Medicine Act*.
12. For more information, please the College's policy entitled *Physicians and Health Emergencies*.

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.

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 *Regulated Health Professions Act, 1991* 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.

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.
15. Physicians must abide by their legal obligations under the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A, 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 *Health Professions Procedural Code,* Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18. 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.

12

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

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 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.

18. Narcotics are defined in Section 2 of the *Narcotic Control Regulations*, C.R.C., c. 1041, enacted under the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*): the term "narcotics" includes opioids.
19. Controlled drugs and substances are defined in Section 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. *CDSA*.
22. See Section 53(2) of the *Narcotic Control Regulations,* C.R.C., c. 1041, and Section 58 of the *Benzodiazepines and Other Targeted Substances Regulations*, SOR/2000-217, enacted 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 Section 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*, SOR/2013-119, enacted under the *CDSA*, establish the legal framework that enables patients to obtain authorization to possess dried marijuana for medical purposes. Please see the College's *Marijuana for Medical Purposes* policy.

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PHYSICIAN TREATMENT OF SELF, FAMILY MEMBERS, OR OTHERS CLOSE TO THEM

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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT 3-16

Prescribing Drugs

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KEY WORDS: Prescribing, Electronic Prescribing (ePrescribing), Drug, Drug Sample, Narcotic, Opioid, Controlled Substance, Monitored Drug, Electronic Medical Record (EMR), Physician-Patient Relationship, Clinical Assessment, Consent, Medical Record, Audit, Refill, Circle of Care, Unapproved Drugs, Preventing Medication Errors, Prescription Drug Abuse, Treatment Agreement

RELATED TOPICS: The Practice Guide: Medical Professionalism and College Policies, Medical Records, Confidentiality of Personal Health Information, Consent to Medical Treatment, MD Relations with Drug Companies, Dispensing Drugs, Delegation of Controlled Acts, Treating Self and Family Members, Mandatory and Permissive Reporting, Disclosure of Harm, Ending the Physician-Patient Relationship

LEGISLATIVE REFERENCES:

Controlled Drugs and Substances Act, S.C. 1996, c. 19.

Narcotic Control Regulations, C.R.C. c. 1041.

Benzodiazepines and Other Targeted Substances Regulations, S.O.R./2000-217.

Food and Drugs Act, R.S.C, 1985, c. F-27.

Medicine Act, 1991, S.O. 1991, c. 30.

General, O. Reg., 114/94.

Regulated Health Professions Act, 1991, S.O. 1991, c. 18.

Drug and Pharmacies Regulation Act, R.S.O.1990, c. H.4.

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Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c. P.23.

Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22.

General, O. Reg., 381/11.

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Schedule A.

REFERENCE MATERIALS: See Back Page

COLLEGE CONTACT: Public and Physician Advisory Service

Prescribing Drugs

INTRODUCTION

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

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

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

PRINCIPLES

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

1. Acting in patients' best interests;
2. Demonstrating professional competence, which includes maintaining the medical knowledge and clinical skills necessary to prescribe appropriately. This involves keeping abreast of current developments in:
   a. applicable legislation;
   b. CPSO expectations and guidelines regarding prescribing;
   c. prescribing practices, including technology related to medication management, electronic prescribing and associated information systems;
   d. relevant practice guidelines and tools; and
   e. implementing these expectations and best practices, as appropriate.
3. Maintaining patients' confidentiality and privacy when collecting, using or disclosing (e.g., transmitting) prescription information;
4. Collaborating effectively with patients, physicians and other health-care providers;
5. Communicating with patients and other health-care providers with civility and professionalism; and
6. Not pursuing personal advantage, whether financial or otherwise, at the expense of the patient, when prescribing drugs, so as not to compromise their duty to their patients.[5]

PURPOSE AND SCOPE

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

DEFINITIONS

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

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

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

Electronic Prescribing (ePrescribing): Electronic prescribing encompasses the electronic generation, authoriza-

1. *Food and Drugs Act*, R.S.C, 1985, c. F-27.
2. *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*).
3. *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22 (hereinafter *NSAA*).
4. *Drug and Pharmacies Regulation Act*, R.S.O.1990, c. H.4 (hereinafter *DPRA*).
5. For more information on conflicts of interest, please see Part IV of the *General*, O. Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act, General Regulation*) and the CPSO's MD Relations with Drug Companies policy.

5a. Specific additional expectations for prescribing dried marijuana for medical purposes are contained in the College's Marijuana for Medical Purposes policy.

6. Section 1(1) of the *DPRA*.
7. Section 27 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.
8. Physicians may both prescribe and dispense the drug. For more information on dispensing, please see the CPSO's Dispensing Drugs policy.

tion and transmission of dispensing directions for a drug or mixture of drugs.

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

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

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

POLICY

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

1. General Expectations

Before Prescribing

Physician-Patient Relationship

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

Assessment

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

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

b) An appropriate physical examination and/or any other examinations or investigations.

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

a) they have reasonable grounds to believe that the person conducting the assessment has the appropriate knowledge, skill and judgment to do so. In most circumstances, this will require that the physician know the person conducting the assessment and be aware of his or her qualifications and training. In some limited circumstances, such as large health institutional settings (e.g., hospital or long-term care home), the physician may be able to rely upon his or her knowledge of the institution's practices to satisfy him or herself that the person conducting the assessment has the appropriate knowledge, skill and judgment to do so; and

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

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

9. Section 2(1) of the *CDSA*.

10. Section 2 of the *Narcotic Control Regulations*, C.R.C. c. 1041, enacted under the *CDSA* (hereinafter *CDSA, Narcotic Control Regulations*).

11. A physician-patient relationship may not be established when physicians provide episodic care for minor conditions to a family member, or incidental medical care to their spouse. For more information on treating family members, please see the CPSO's Treating Self and Family Members policy.

12. Physicians may obtain information from records or databases unless the physician is aware that the patient has expressly withheld or withdrawn consent for the use or disclosure of this information. If a patient has expressly restricted disclosure of their information, it is advisable to note this in the patient's medical record.

Prescribing Drugs

Exceptions

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

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

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

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

d) Prescribing naloxone for inclusion in an opioid overdose emergency kit.[12a]

Diagnosis

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

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

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

Informed Consent

As with the usual requirements for informed consent when considering any treatment,[15] physicians are required to advise the patient about the material risks[16] and benefits of the drug being prescribed, including the drug's effects and interactions, material side effects, contraindications, precautions, and any other information pertinent to the use of the drug.

When Prescribing

Content of Prescriptions

Physicians must include the following information on a prescription:

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

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

It is recommended that physicians consider, on a case-by-case basis,[21] whether it is appropriate to include the following information on the prescription:

- Address and/or date of birth of patient

12a 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.

13. Other information relevant to the patient's condition or medication usage e.g., information from family, other health-care providers and other sources.

14. For more information on refills, please see the 'Refills' section of this policy.

15. For more information on consent, please refer to the CPSO's Consent to Medical Treatment policy.

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

17. Although this is only required in legislation for monitored drugs as defined in the *NSAA*, the College requires physicians to include their CPSO number on all prescriptions for all drugs.

18. See Section 2 of the *NSAA* for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website at: http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx.

19. See the list of approved forms of identification at: http://www.health.gov.on.ca/en/public/programs/drugs/ons/publicnotice/identification_list.aspx.

20. See Sections 3 and 6 of the *General*, O. Reg., 381/11, enacted under the *NSAA*.

21. Physicians must not have blanket policies to write "no substitutions", "do not adapt", "do not extend" or "do not refill" notations on all prescriptions. For more information about blanket 'no refill' policies, see the 'Refills' section of this policy.

- Indication for use, if prescribed p.r.n.
- "No substitutions", if applicable and clinically appropriate[22,23]
- "Do not adapt", "do not extend" or "do not refill", when prudent or advisable[24]
- The patient's weight and/or age (e.g., where the patient is a child and this information would affect dosage)

Clarity of Prescriptions

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

a) Verbal Prescriptions

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

b) Handwritten or Electronic Prescriptions

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

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

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

Authorization

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

a) Verbal

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

b) Signature

A prescription can be authorized by a physician's signature. The signature must be authentic and unaltered.[32] Electronic signatures may be acceptable if they meet the College of Pharmacists (OCP) *Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files*. For example, the electronic signature must be a unique, clearly identifiable, life-size image.[33] Before physicians begin signing prescriptions electronically, it is recommended that they communicate with the pharmacist

22. Section 4(3) of the *Drug Interchangeability and Dispensing Fee Act*, R.S.O. 1990, c. P.23 requires that this notation be handwritten on the prescription.
23. If there are no clinical reasons not to use a generic drug, physicians are encouraged to consider prescribing the generic in order to save costs to the public health-care system.
24. However, physicians are advised that there may be occasions where pharmacists use their professional judgment to adapt, extend or refill prescriptions to ensure continuity of patient care.
25. For guidelines on verbal prescribing, please see the 'Preventing Medication Errors' section of this policy.
26. Physicians may wish to review the following documents for more information: the Institute for Safe Medication Practices (ISMP) Canada *Safety Bulletin: Eliminate Use of Dangerous Abbreviations, Symbols and Dose Designations* at: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2006-04Abbr.pdf; the ISMP Canada list at: http://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf; and the CPSO's *Dialogue* article "Eliminate Use of Dangerous Abbreviations, Symbols, and Dose Designations."
27. For example, predni**SONE** or prednis**OLONE**, and **HYDRO**codone or oxy**CODONE**. For more information, please see the 'Preventing Medication Errors' section of this policy, and the following documents: the ISMP *FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters* (available at: https://www.ismp.org/tools/tallmanletters.pdf); and the ISMP Canada *Safety Bulletin: Application of TALLman Lettering for Drugs Used in Oncology.*
28. For a list of easily confused drug names, see the following ISMP document, available at: http://www.ismp.org/tools/confuseddrugnames.pdf.
29. Duplicate copies of the prescription must not be created. If physicians wish to provide a copy of the prescription to their patients for information purposes, they may provide them with the prescription information in a format that does not resemble a prescription (e.g. paper receipt).
30. The Ontario College of Pharmacists (OCP) created a summary of federal and provincial laws governing verbal prescription requirements, which can be found here: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Summary+of+Laws/$file/Summary+of+Laws.pdf.
31. However, "verbal prescription narcotics", as defined in Section 1(1) of the *General*, O. Reg., 58/11, enacted under the *DPRA* may be dispensed. The rules regarding when verbal prescriptions can be dispensed are complex, and physicians are encouraged to contact the pharmacist if they are uncertain about whether a particular verbal prescription is permitted.
32. Section 40(4) a) of the *DPRA*.
33. For more information, see the OCP Guidelines at: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Fax+or+Digitized+Guidelines.

Prescribing Drugs

regarding the process they are using to sign the prescriptions, to ensure the pharmacists' requirements are being met.

c) Electronic

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

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

After Prescribing

Transmitting a Prescription

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

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

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

Documentation

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

- The date the drug is prescribed;
- The type of prescription (verbal, handwritten, electronic);
- The name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for use of the drug;
- The fact that the drug's material risks, including material side effects, contraindications or precautions were discussed with the patient;[45]
- Refill information; and

34. No other members of staff can authorize a prescription unless there is a direct order or medical directive in place. If so, there must be a mechanism within the system to identify precisely who authorized the prescription and under what authority. For more information on delegation, please see the CPSO's Delegation of Controlled Acts policy.
35. Mechanisms could include such things as strong passwords, tokens, biological markers, or any combination of these.
36. Secure means there are reasonable safeguards in place to prevent prescriptions from being generated by people inside or outside of the system who are not authorized to prescribe. Obligations with respect to the security of personal health information are set out in Sections 12 and13 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A (hereinafter *PHIPA*).
37. The capability for true ePrescribing outside of a closed environment (e.g., hospital) is currently being developed. As such, there are currently no guidelines regarding security and which electronic prescription authorization mechanisms, other than an electronic signature, are acceptable. As discussed above, electronic signatures must be unique, clearly identifiable, life-size images, and it is advisable to discuss arrangements for their use with the pharmacist in advance.
38. Refer to the following OCP documents: *Policy on Faxed Prescriptions*; and *Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files.*
39. Unless an EMR-generated, faxed prescription with an attached electronic signature meets the OCP *Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files*, physicians must continue to print and sign all EMR-generated prescriptions before either transmitting them to pharmacies, or handing them to patients to carry into a pharmacy.
40. If a prescription written by a prescriber is faxed to the pharmacy by a patient or a patient's agent, the original prescription must be provided to the pharmacist before dispensing is completed and the medication is released.
41. Obligations with respect to the security of personal health information are set out in Sections 12 and13 of *PHIPA*. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's *Guidelines on Facsimile Transmission Security.*
42. If physicians are ePrescribing, they must give patients a choice as to whether they would like the prescription transmitted to the pharmacy electronically, or whether they would like a paper prescription. This is to ensure that patients are able to fill their prescription at a pharmacy of their choosing, until such time that all pharmacies can accept electronic prescriptions and paper prescriptions are phased out.
43. For more information on strengthening protocols between physicians and pharmacists, please see the *Dialogue* article "Recommended Protocols can Strengthen Physician/Pharmacist Working Relations".
44. Sections 18-21 of the *Medicine Act, General Regulation*. For full details of the requirements concerning medical records, see the CPSO's Medical Records policy.
45. The College recommends that physicians consider documenting which risks were discussed with the patient, as this information may be helpful for future reference.

- Other relevant information (e.g., drug cannot be substituted; prescription cannot be adapted, extended or refilled, as applicable).

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

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

a) Audit

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

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

Monitoring

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

Sharing Information

To ensure good patient care is provided, communication between physicians and health-care providers is recommended. If the patient has a primary care provider, it is important for that provider to have all relevant information about his or her patient. This includes information about drugs prescribed for the patient. Unless a patient has expressly withheld or withdrawn consent, health information can be shared within the 'Circle of Care'[48] in accordance with the *Personal Health Information Protection Act, 2004 (PHIPA)*.

2. Specific Issues in Prescribing

Refills[49]

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

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

46. For full details of the requirements concerning medical records, see the CPSO's Medical Records policy.

47. Audit requirements are set out in the CPSO's Medical Records policy and in Section 20 of the *Medicine Act, General Regulation.*

48. 'Circle of Care' is a term commonly used to describe the ability of certain health information custodians (e.g., physicians and other regulated health professionals) to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care to that individual, in circumstances defined in *PHIPA*. For more information, see the Information and Privacy Commissioner of Ontario's *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* document. Sharing information in the context of prescribing narcotics and controlled substances is discussed in more detail in the 'Narcotics and Controlled Substances' section of this policy.

49. Also known as 'prescribing with repeats' or 'renewing prescriptions'.

50. Certain drugs cannot be refilled. A summary of the relevant federal and provincial laws governing refills, among other things, can be found at: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Summary+of+Laws/$file/Summary+of+Laws.pdf.

Prescribing Drugs

adverse events.

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

'No Refill' Policies

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

Drug Samples

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

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

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

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

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

Redistributing Unused Drugs

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

Narcotics and Controlled Substances

Narcotics and controlled substances are important tools in the safe, effective and compassionate treatment of acute or chronic pain, mental illness, and addiction. Physicians with the requisite knowledge and experience are advised to pre-

51. If physicians are delegating this responsibility to staff, they must do so in accordance with the CPSO's Delegation of Controlled Acts policy.
52. The College recommends that physicians consider documenting which material risks were discussed with the patient, as this information may be helpful for future reference.
53. It is recommended that expired or damaged drugs be returned to a pharmacy for proper disposal.
54. It is recommended that the drugs be returned to a pharmacy for proper disposal.

scribe narcotics and controlled substances for these reasons, when clinically appropriate.

One of the risks when prescribing narcotics and controlled substances is the potential for prescription drug abuse. The non-medical use or abuse of prescription drugs is a serious and growing public health problem. Virtually any prescription drug can be consumed for reasons other than its medical purpose; however, it is usually drugs with psychoactive properties (e.g., opioids) that are the focus of abuse.[55]

Physicians may be able to reduce or impede the diversion,[56] misuse and/or abuse of narcotics and controlled substances by: carefully considering whether these drugs are the most appropriate choice for the patient; recognizing patients who may be double-doctoring,[57] diverting, misusing or abusing prescription drugs; sharing information with others, as appropriate; instituting measures to prevent prescription pad theft or tampering; taking measures to prevent the theft of drugs from their offices; and educating patients.

The purpose of this section of the policy, along with the related guidelines, is to clarify for physicians their obligations when prescribing narcotics and controlled substances and their role in preventing and addressing prescription drug abuse. This policy does not attempt to curb the prescribing of narcotics and controlled substances for legitimate reasons (i.e., acute or chronic pain, mental illness or addiction), but does reinforce the requirement that physicians prescribe these drugs in an appropriate manner.

Considerations

In addition to complying with the general requirements set out for prescribing any drug and any applicable legislation, physicians must carefully consider whether the narcotic or controlled substance is the most appropriate choice for the patient, even if the patient has been prescribed these drugs in the past.[58] Special consideration is necessary given that narcotics and controlled substances are highly susceptible to diversion, misuse and/or abuse because of their psychoactive properties. These drugs are extremely harmful to patients and to society when they are diverted, misused and/or abused, so physicians must first consider whether an alternate treatment or drug is clinically appropriate. If there are no appropriate or reasonably available alternatives, physicians are advised to record this fact in the patient's medical record. The benefits of prescribing narcotics and controlled substances must be weighed against their potential risks when used long-term.

Office Policies and Practices: Setting and Managing Patient Expectations

a) General Policies and Practices

It is recommended that physicians who prescribe narcotics and controlled substances consider implementing office policies and practices regarding the prescribing of these drugs, for example, a policy on the use of treatment agreements.[59] Communicating these office policies and practices to patients can help manage patient expectations and help monitor whether the treatment is being used as prescribed.

b) 'No Narcotics' Prescribing Policy

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

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

As such, the College recommends that physicians do not adopt a blanket policy refusing to prescribe narcotics and controlled substances, unless physicians have restrictions

55. Canadian Centre on Substance Abuse, *Prescription Drug Abuse FAQs* (CCSA, 2007).

56. Drug diversion, broadly defined, is when the legal supply chain of prescription drugs is broken, and drugs are transferred from a licit to an illicit channel of distribution or use.

57. Obtaining multiple prescriptions from different physicians.

58. The College recommends that physicians refer to relevant guidelines and tools for prescribing narcotics and controlled substances. For example, physicians are advised to refer to the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* when prescribing opioids for chronic non-cancer pain. Available at: http://nationalpaincentre.mcmaster.ca/opioid/. Tools for appropriate patient screening may be particularly helpful in this regard. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

59. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

60. Some patients may seek prescriptions for narcotic and controlled substances for reasons that are not legitimate. It may be very difficult for physicians to determine this, so it is recommended that they use their professional judgment to determine whether prescribing narcotics or controlled substances is prudent. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

Prescribing Drugs

preventing them from prescribing narcotics and controlled substances. Prescribing narcotics and controlled substances are part of good clinical care and refusing to prescribe these drugs altogether may lead to inadequate management of some clinical problems and may leave patients seeking treatment from other physicians, putting pressure on others to manage these cases, or otherwise leaving patients without appropriate treatment.

Monitoring Patients: Misuse, Abuse and Double-Doctoring

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

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

Sharing Information

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

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

a) Circle of Care

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

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

b) Permitted Disclosure

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

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

i) Disclosure for authorized investigations or inspections

- This provision enables information to be disclosed in the context of an investigation or inspection, for the purposes of facilitating that investigation.
- The investigation or inspection must be authorized by a warrant, or by an Act of Ontario or an Act of Canada.
- The disclosure must be made to the person who is authorized to do the investigation or inspection.[65]

The Canadian Medical Protective Association (CMPA) has provided information regarding double-doctoring and responding to inquiries from law enforcement officials in

61. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

62. Section 4(2) of the *CDSA*.

63. Section 20(2) of *PHIPA*. Physicians who wish further detail on the Circle of Care are advised to consult the Information and Privacy Commissioner of Ontario's *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* document.

64. For information on mandatory and permissive reporting obligations, please see the CPSO's Mandatory and Permissive Reporting policy.

65. Section 43(1)(g) of *PHIPA*.

66. The CMPA advises that it is appropriate for physicians to respond to inquiries from police to verify whether a prescription in the possession of the police is authentic as having been written or authorized by the physician. Aside from this information, physicians are advised to refrain from answering questions that require them to disclose specific information concerning a patient's health. For more information, please see the CMPA's *Responding to Prescription Fraud* document.

its article *Responding to Prescription Fraud*.[66]

ii) Disclosures related to risks

- This provision allows for information to be disclosed in order to prevent or reduce a risk of harm to others.
- To rely on this provision, health-care providers must believe on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.[67]

Mandatory Reporting Obligation

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

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

Physicians must not prescribe drugs that have not been approved for use in Canada, that is, drugs for which Health Canada has not issued a Notice of Compliance (NOC).[69] However, there are two circumstances when access to an unapproved drug can be obtained for patient use. The first is when drugs have been authorized by Health Canada for research purposes as part of a clinical trial. The other is when drugs have been authorized under Health Canada's Special Access Programme.[70]

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

GUIDELINES

Preventing Medication Errors

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

Physicians can help reduce the occurrence of some medication errors by considering the following guidelines.

Verbal Prescriptions[71]

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

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

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

67. Section 40(1) of *PHIPA*. This provision is not specific to opioids; the threshold is 'risk of serious bodily harm'. It doesn't specify to whom the disclosure is to be made.

68. Section 55(g) of the *CDSA, Narcotic Control Regulations*; Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, S.O.R./2000-217, enacted under the *CDSA*. These obligations are also set out in the CPSO's Mandatory and Permissive Reporting policy.

69. Federal legislation stipulates that no one can sell or advertise a new drug unless the Minister has issued an NOC to the manufacturer. The NOC indicates that the drug meets the required standards for use in humans or animals and is approved for sale in Canada. A manufacturer receives an NOC when it has met Health Canada's regulatory requirements for the safety, efficacy and quality of a product. For more information, see Health Canada's *Notice of Compliance* webpage.

70. The Special Access Programme (SAP) provides access to non-marketed drugs for practitioners treating patients with serious or life-threatening conditions when conventional therapies have failed, are unsuitable, or unavailable. The SAP authorizes a manufacturer to sell a drug that cannot otherwise be sold or distributed in Canada. For more information, see Health Canada's *Special Access Programme – Drugs* document.

71. Alberta College of Pharmacists, College and Association of Registered Nurses of Alberta & College of Physicians and Surgeons of Alberta, *Ensuring Safe & Efficient Communication of Medication Prescriptions in Community and Ambulatory Settings* (ACP, CARNA & CPSA, 2007).

Prescribing Drugs

asking someone who has an understanding of the drug and indication to communicate the prescription information, unless the prescription is a refill.

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

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

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

Look-alike/Sound-alike Drug Names

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

- writing prescriptions clearly by printing the name of the product in block letters or using TALLman lettering,[74] by not using abbreviations, or by using electronic prescriptions;
- including more information about the drug (e.g., include both brand name and generic name, and the reason for prescribing the medication);
- ensuring that the strength, dosage and directions for use are clearly indicated on the prescription; and
- communicating to the patient (or a family member) the reason the medication has been prescribed and verifying that the patient can read the prescription.

High-alert Medications

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

Vulnerable Populations/High-alert Environments

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

Double-Checking

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

Patient Involvement

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

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

If a prescription is generated, authorized and transmitted

72. See the *ISMP's List of Confused Drug Names*, available at: http://www.ismp.org/tools/confuseddrugnames.pdf.
73. Health Canada, *Look-alike Sound-alike Health Product Names* (HC, 2009).
74. For more information, see the following documents: the ISMP *FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters* (available at: https://www.ismp.org/tools/tallmanletters.pdf); and the ISMP Canada *Safety Bulletin: Application of TALLman Lettering for Drugs Used in Oncology.*
75. See the *ISMP's List of High-Alert Medications* for more information, available at: http://www.ismp.org/Tools/highalertmedications.pdf.
76. Alberta College of Pharmacists, College and Association of Registered Nurses of Alberta & College of Physicians and Surgeons of Alberta, *Ensuring Safe & Efficient Communication of Medication Prescriptions in Community and Ambulatory Settings* (ACP, CARNA & CPSA, 2007) at p.3.

electronically, the physician may wish to generate a record/receipt of the prescription for the patient. This would accomplish several things:

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

Reporting Adverse Drug Reactions or Medication Incidents

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

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

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

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

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

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

Narcotics and Controlled Substances

Responding to Requests for Narcotics and Controlled Substances

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

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

77. Adverse drug reactions are unwanted effects that happen when drugs are used under normal conditions. Adverse drug reactions are also called side effects. Adverse drug reactions are not medication incidents. Unlike a medication incident, an adverse drug reaction generally doesn't involve a mistake and typically can't be prevented.
78. Health Canada's *Adverse Reaction Information* webpage describes a serious adverse drug reaction as one that requires in-patient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening or results in death. Adverse reactions that require significant medical intervention to prevent one of these listed outcomes are also considered to be serious.
79. A medication incident is a mistake with medication, or a problem that could cause a mistake with medication. 'Medication error' is another name for one kind of medication incident. Medication incidents include obvious things like receiving the wrong medication or dose, but might also include problems like a confusing label that might lead to someone receiving the wrong medication.
80. Please see the next section on 'Identifying Aberrant Drug-Related Behaviour' for more information.

Prescribing Drugs

Identifying Aberrant Drug-Related Behaviour[81]

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

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

The chart on this page lists aberrant drug-related behaviours potentially indicative of opioid misuse.

Indicator	Examples
Altering the route of delivery	❑ Injecting, biting or crushing oral formulations ❑ Biting, chewing, swallowing or injecting topical preparations (e.g., sustained-release analgesic patches)
Accessing opioids from other sources	❑ Taking the drug from friends or relatives ❑ Purchasing the drug from the "street" ❑ Double-doctoring
Unsanctioned use	❑ Multiple unauthorized dose escalations ❑ Binge rather than scheduled use
Drug seeking	❑ Recurrent prescription losses ❑ Aggressive complaining about the need for higher doses ❑ Harassing staff for faxed scripts or fit-in appointments ❑ Nothing else "works"
Repeated withdrawal symptoms	❑ Marked dysphoria, myalgias, GI symptoms, craving
Accompanying conditions	❑ Currently addicted to alcohol, cocaine, cannabis or other drugs ❑ Underlying mood or anxiety disorders not responsive to treatment
Social features	❑ Deteriorating or poor social function ❑ Concern expressed by family members
Views on the opioid medication	❑ Sometimes acknowledges being addicted ❑ Strong resistance to tapering or switching opioids ❑ May admit to mood-leveling effect ❑ May acknowledge distressing withdrawal symptoms

Office Practices and Policies: Setting and Managing Patient Expectations

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

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

Treatment Agreements

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

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

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

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

81. National Opioid Use Guideline Group, *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* (NOUGG, 2010).

82. See the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* for a sample treatment agreement, available at: http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b05.html.

83. For information on ending the physician-patient relationship, please see the CPSO's Ending the Physician-Patient Relationship policy.

Monitoring Patients

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

Preventing Prescription Fraud[86]

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

- If using a paper prescription pad:
  - Use carbon copies or numbered prescription pads;
  - Write the prescription in words and numbers;
  - Draw lines through unused portions of the prescription; and
  - Keep blank prescription pads secure.
- If using desk-top prescription printing:
  - Use EMR-enabled security features such as watermarks.
  - Write a clear signature and do not use a scribbled initial.
- Promote the patient's use of a single dispensing pharmacy of their choice. Include the name of the pharmacy the patient would like to take the prescription to be dispensed, on the prescription.
- Fax (or electronically transmit when available) prescriptions directly to the pharmacy.
- If using fax or electronic transmission of the prescription (when permitted) ensure confidentiality,[87] confirm destination, and retain copies.

Security of Drugs

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

Advice for Patients[88]

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

- Read the label and take the drug exactly as directed. Take the right dose at the right time.
- Follow the other directions that may come with the drugs, such as not driving, and avoiding the use of alcohol.
- Store narcotics and controlled substances in a safe place, out of the reach of children and teenagers, and keep track of the amount of drugs.
- Never share prescription drugs with anyone else, as this is illegal and may cause serious harm to the other person.
- Return any unused drugs to the pharmacy for safe disposal, in order to prevent diversion for illegal use and to protect the environment. Drugs must not be disposed of in the home (e.g., in the sink, toilet or trash).

In addition, physicians may want to advise patients about what to do if they miss a dose, and remind them that crushing or cutting open a time-release pill destroys the slow release of the drug and can lead to an overdose with serious health effects.

84. See the College of Physicians and Surgeons of Newfoundland and Labrador's sample narcotic flow sheet, available at: http://www.cpsnl.ca/userfiles/file/Narcotic%20Flow%20Sheet.pdf.
85. It is recommended that physicians look for evidence of non-compliance, escalation of dose, early renewals, misrepresentation, or fraud.
86. National Opioid Use Guideline Group, *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* (NOUGG, 2010).
87. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's *Guidelines on Facsimile Transmission Security.*
88. Health Canada, *It's Your Health: Opioid Pain Medications* (HC, 2009).

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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT 3-16

Prescribing Drugs

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KEY WORDS: Prescribing, Electronic Prescribing (ePrescribing), Drug, Drug Sample, Narcotic, Opioid, Controlled Substance, Monitored Drug, Electronic Medical Record (EMR), Physician-Patient Relationship, Clinical Assessment, Consent, Medical Record, Audit, Refill, Circle of Care, Unapproved Drugs, Preventing Medication Errors, Prescription Drug Abuse, Treatment Agreement

RELATED TOPICS: The Practice Guide: Medical Professionalism and College Policies, Medical Records, Confidentiality of Personal Health Information, Consent to Medical Treatment, MD Relations with Drug Companies, Dispensing Drugs, Delegation of Controlled Acts, Treating Self and Family Members, Mandatory and Permissive Reporting, Disclosure of Harm, Ending the Physician-Patient Relationship

LEGISLATIVE REFERENCES:

Controlled Drugs and Substances Act, S.C. 1996, c. 19.

Narcotic Control Regulations, C.R.C. c. 1041.

Benzodiazepines and Other Targeted Substances Regulations, S.O.R./2000-217.

Food and Drugs Act, R.S.C, 1985, c. F-27.

Medicine Act, 1991, S.O. 1991, c. 30.

General, O. Reg., 114/94.

Regulated Health Professions Act, 1991, S.O. 1991, c. 18.

Drug and Pharmacies Regulation Act, R.S.O.1990, c. H.4.

General, O. Reg., 58/11.

Drug Interchangeability and Dispensing Fee Act, R.S.O. 1990, c. P.23.

Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22.

General, O. Reg., 381/11.

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Schedule A.

REFERENCE MATERIALS: See Back Page

COLLEGE CONTACT: Public and Physician Advisory Service

Prescribing Drugs

INTRODUCTION

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

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

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

PRINCIPLES

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

1. Acting in patients' best interests;
2. Demonstrating professional competence, which includes maintaining the medical knowledge and clinical skills necessary to prescribe appropriately. This involves keeping abreast of current developments in:
   a. applicable legislation;
   b. CPSO expectations and guidelines regarding prescribing;
   c. prescribing practices, including technology related to medication management, electronic prescribing and associated information systems;
   d. relevant practice guidelines and tools; and
   e. implementing these expectations and best practices, as appropriate.
3. Maintaining patients' confidentiality and privacy when collecting, using or disclosing (e.g., transmitting) prescription information;
4. Collaborating effectively with patients, physicians and other health-care providers;
5. Communicating with patients and other health-care providers with civility and professionalism; and
6. Not pursuing personal advantage, whether financial or otherwise, at the expense of the patient, when prescribing drugs, so as not to compromise their duty to their patients.[5]

PURPOSE AND SCOPE

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

DEFINITIONS

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

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

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

Electronic Prescribing (ePrescribing): Electronic prescribing encompasses the electronic generation, authoriza-

1. *Food and Drugs Act*, R.S.C, 1985, c. F-27.
2. *Controlled Drugs and Substances Act*, S.C. 1996, c. 19 (hereinafter *CDSA*).
3. *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22 (hereinafter *NSAA*).
4. *Drug and Pharmacies Regulation Act*, R.S.O.1990, c. H.4 (hereinafter *DPRA*).
5. For more information on conflicts of interest, please see Part IV of the *General*, O. Reg., 114/94, enacted under the *Medicine Act, 1991*, S.O. 1991, c. 30 (hereinafter *Medicine Act, General Regulation*) and the CPSO's MD Relations with Drug Companies policy.

5a. Specific additional expectations for prescribing dried marijuana for medical purposes are contained in the College's Marijuana for Medical Purposes policy.

6. Section 1(1) of the *DPRA*.
7. Section 27 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.
8. Physicians may both prescribe and dispense the drug. For more information on dispensing, please see the CPSO's Dispensing Drugs policy.

tion and transmission of dispensing directions for a drug or mixture of drugs.

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

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

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

POLICY

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

1. General Expectations

Before Prescribing

Physician-Patient Relationship

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

Assessment

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

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

b) An appropriate physical examination and/or any other examinations or investigations.

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

a) they have reasonable grounds to believe that the person conducting the assessment has the appropriate knowledge, skill and judgment to do so. In most circumstances, this will require that the physician know the person conducting the assessment and be aware of his or her qualifications and training. In some limited circumstances, such as large health institutional settings (e.g., hospital or long-term care home), the physician may be able to rely upon his or her knowledge of the institution's practices to satisfy him or herself that the person conducting the assessment has the appropriate knowledge, skill and judgment to do so; and

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

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

9. Section 2(1) of the *CDSA*.

10. Section 2 of the *Narcotic Control Regulations*, C.R.C. c. 1041, enacted under the *CDSA* (hereinafter *CDSA, Narcotic Control Regulations*).

11. A physician-patient relationship may not be established when physicians provide episodic care for minor conditions to a family member, or incidental medical care to their spouse. For more information on treating family members, please see the CPSO's Treating Self and Family Members policy.

12. Physicians may obtain information from records or databases unless the physician is aware that the patient has expressly withheld or withdrawn consent for the use or disclosure of this information. If a patient has expressly restricted disclosure of their information, it is advisable to note this in the patient's medical record.

Prescribing Drugs

Exceptions

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

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

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

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

d) Prescribing naloxone for inclusion in an opioid overdose emergency kit.[12a]

Diagnosis

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

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

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

Informed Consent

As with the usual requirements for informed consent when considering any treatment,[15] physicians are required to advise the patient about the material risks[16] and benefits of the drug being prescribed, including the drug's effects and interactions, material side effects, contraindications, precautions, and any other information pertinent to the use of the drug.

When Prescribing

Content of Prescriptions

Physicians must include the following information on a prescription:

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

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

It is recommended that physicians consider, on a case-by-case basis,[21] whether it is appropriate to include the following information on the prescription:

- Address and/or date of birth of patient

12a 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.

13. Other information relevant to the patient's condition or medication usage e.g., information from family, other health-care providers and other sources.

14. For more information on refills, please see the 'Refills' section of this policy.

15. For more information on consent, please refer to the CPSO's Consent to Medical Treatment policy.

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

17. Although this is only required in legislation for monitored drugs as defined in the *NSAA*, the College requires physicians to include their CPSO number on all prescriptions for all drugs.

18. See Section 2 of the *NSAA* for the definition of "monitored drug." For a complete list of monitored drugs, see the Ministry of Health and Long-Term Care's website at: http://health.gov.on.ca/en/pro/programs/drugs/monitored_productlist.aspx.

19. See the list of approved forms of identification at: http://www.health.gov.on.ca/en/public/programs/drugs/ons/publicnotice/identification_list.aspx.

20. See Sections 3 and 6 of the *General*, O. Reg., 381/11, enacted under the *NSAA*.

21. Physicians must not have blanket policies to write "no substitutions", "do not adapt", "do not extend" or "do not refill" notations on all prescriptions. For more information about blanket 'no refill' policies, see the 'Refills' section of this policy.

- Indication for use, if prescribed p.r.n.
- "No substitutions", if applicable and clinically appropriate[22,23]
- "Do not adapt", "do not extend" or "do not refill", when prudent or advisable[24]
- The patient's weight and/or age (e.g., where the patient is a child and this information would affect dosage)

Clarity of Prescriptions

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

a) Verbal Prescriptions

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

b) Handwritten or Electronic Prescriptions

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

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

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

Authorization

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

a) Verbal

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

b) Signature

A prescription can be authorized by a physician's signature. The signature must be authentic and unaltered.[32] Electronic signatures may be acceptable if they meet the College of Pharmacists (OCP) *Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files*. For example, the electronic signature must be a unique, clearly identifiable, life-size image.[33] Before physicians begin signing prescriptions electronically, it is recommended that they communicate with the pharmacist

22. Section 4(3) of the *Drug Interchangeability and Dispensing Fee Act*, R.S.O. 1990, c. P.23 requires that this notation be handwritten on the prescription.
23. If there are no clinical reasons not to use a generic drug, physicians are encouraged to consider prescribing the generic in order to save costs to the public health-care system.
24. However, physicians are advised that there may be occasions where pharmacists use their professional judgment to adapt, extend or refill prescriptions to ensure continuity of patient care.
25. For guidelines on verbal prescribing, please see the 'Preventing Medication Errors' section of this policy.
26. Physicians may wish to review the following documents for more information: the Institute for Safe Medication Practices (ISMP) Canada *Safety Bulletin: Eliminate Use of Dangerous Abbreviations, Symbols and Dose Designations* at: http://www.ismp-canada.org/download/safetyBulletins/ISMPCSB2006-04Abbr.pdf; the ISMP Canada list at: http://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf; and the CPSO's *Dialogue* article "Eliminate Use of Dangerous Abbreviations, Symbols, and Dose Designations."
27. For example, predni**SONE** or prednis**OLONE**, and **HYDRO**codone or oxy**CODONE**. For more information, please see the 'Preventing Medication Errors' section of this policy, and the following documents: the ISMP *FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters* (available at: https://www.ismp.org/tools/tallmanletters.pdf); and the ISMP Canada *Safety Bulletin: Application of TALLman Lettering for Drugs Used in Oncology.*
28. For a list of easily confused drug names, see the following ISMP document, available at: http://www.ismp.org/tools/confuseddrugnames.pdf.
29. Duplicate copies of the prescription must not be created. If physicians wish to provide a copy of the prescription to their patients for information purposes, they may provide them with the prescription information in a format that does not resemble a prescription (e.g. paper receipt).
30. The Ontario College of Pharmacists (OCP) created a summary of federal and provincial laws governing verbal prescription requirements, which can be found here: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Summary+of+Laws/$file/Summary+of+Laws.pdf.
31. However, "verbal prescription narcotics", as defined in Section 1(1) of the *General*, O. Reg., 58/11, enacted under the *DPRA* may be dispensed. The rules regarding when verbal prescriptions can be dispensed are complex, and physicians are encouraged to contact the pharmacist if they are uncertain about whether a particular verbal prescription is permitted.
32. Section 40(4) a) of the *DPRA*.
33. For more information, see the OCP Guidelines at: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Fax+or+Digitized+Guidelines.

Prescribing Drugs

regarding the process they are using to sign the prescriptions, to ensure the pharmacists' requirements are being met.

c) Electronic

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

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

After Prescribing

Transmitting a Prescription

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

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

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

Documentation

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

- The date the drug is prescribed;
- The type of prescription (verbal, handwritten, electronic);
- The name of the drug, drug strength and quantity or duration of therapy;
- Full instructions for use of the drug;
- The fact that the drug's material risks, including material side effects, contraindications or precautions were discussed with the patient;[45]
- Refill information; and

34. No other members of staff can authorize a prescription unless there is a direct order or medical directive in place. If so, there must be a mechanism within the system to identify precisely who authorized the prescription and under what authority. For more information on delegation, please see the CPSO's Delegation of Controlled Acts policy.
35. Mechanisms could include such things as strong passwords, tokens, biological markers, or any combination of these.
36. Secure means there are reasonable safeguards in place to prevent prescriptions from being generated by people inside or outside of the system who are not authorized to prescribe. Obligations with respect to the security of personal health information are set out in Sections 12 and13 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Schedule A (hereinafter *PHIPA*).
37. The capability for true ePrescribing outside of a closed environment (e.g., hospital) is currently being developed. As such, there are currently no guidelines regarding security and which electronic prescription authorization mechanisms, other than an electronic signature, are acceptable. As discussed above, electronic signatures must be unique, clearly identifiable, life-size images, and it is advisable to discuss arrangements for their use with the pharmacist in advance.
38. Refer to the following OCP documents: *Policy on Faxed Prescriptions*; and *Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files.*
39. Unless an EMR-generated, faxed prescription with an attached electronic signature meets the OCP *Guidelines for Prescriptions Transmitted to Pharmacists by Fax or in Digitized Image Files*, physicians must continue to print and sign all EMR-generated prescriptions before either transmitting them to pharmacies, or handing them to patients to carry into a pharmacy.
40. If a prescription written by a prescriber is faxed to the pharmacy by a patient or a patient's agent, the original prescription must be provided to the pharmacist before dispensing is completed and the medication is released.
41. Obligations with respect to the security of personal health information are set out in Sections 12 and13 of *PHIPA*. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's *Guidelines on Facsimile Transmission Security.*
42. If physicians are ePrescribing, they must give patients a choice as to whether they would like the prescription transmitted to the pharmacy electronically, or whether they would like a paper prescription. This is to ensure that patients are able to fill their prescription at a pharmacy of their choosing, until such time that all pharmacies can accept electronic prescriptions and paper prescriptions are phased out.
43. For more information on strengthening protocols between physicians and pharmacists, please see the *Dialogue* article "Recommended Protocols can Strengthen Physician/Pharmacist Working Relations".
44. Sections 18-21 of the *Medicine Act, General Regulation*. For full details of the requirements concerning medical records, see the CPSO's Medical Records policy.
45. The College recommends that physicians consider documenting which risks were discussed with the patient, as this information may be helpful for future reference.

- Other relevant information (e.g., drug cannot be substituted; prescription cannot be adapted, extended or refilled, as applicable).

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

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

a) Audit

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

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

Monitoring

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

Sharing Information

To ensure good patient care is provided, communication between physicians and health-care providers is recommended. If the patient has a primary care provider, it is important for that provider to have all relevant information about his or her patient. This includes information about drugs prescribed for the patient. Unless a patient has expressly withheld or withdrawn consent, health information can be shared within the 'Circle of Care'[48] in accordance with the *Personal Health Information Protection Act, 2004 (PHIPA)*.

2. Specific Issues in Prescribing

Refills[49]

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

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

46. For full details of the requirements concerning medical records, see the CPSO's Medical Records policy.

47. Audit requirements are set out in the CPSO's Medical Records policy and in Section 20 of the *Medicine Act, General Regulation.*

48. 'Circle of Care' is a term commonly used to describe the ability of certain health information custodians (e.g., physicians and other regulated health professionals) to assume an individual's implied consent to collect, use or disclose personal health information for the purpose of providing health care to that individual, in circumstances defined in *PHIPA*. For more information, see the Information and Privacy Commissioner of Ontario's *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* document. Sharing information in the context of prescribing narcotics and controlled substances is discussed in more detail in the 'Narcotics and Controlled Substances' section of this policy.

49. Also known as 'prescribing with repeats' or 'renewing prescriptions'.

50. Certain drugs cannot be refilled. A summary of the relevant federal and provincial laws governing refills, among other things, can be found at: http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Summary+of+Laws/$file/Summary+of+Laws.pdf.

Prescribing Drugs

adverse events.

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

'No Refill' Policies

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

Drug Samples

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

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

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

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

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

Redistributing Unused Drugs

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

Narcotics and Controlled Substances

Narcotics and controlled substances are important tools in the safe, effective and compassionate treatment of acute or chronic pain, mental illness, and addiction. Physicians with the requisite knowledge and experience are advised to pre-

51. If physicians are delegating this responsibility to staff, they must do so in accordance with the CPSO's Delegation of Controlled Acts policy.
52. The College recommends that physicians consider documenting which material risks were discussed with the patient, as this information may be helpful for future reference.
53. It is recommended that expired or damaged drugs be returned to a pharmacy for proper disposal.
54. It is recommended that the drugs be returned to a pharmacy for proper disposal.

scribe narcotics and controlled substances for these reasons, when clinically appropriate.

One of the risks when prescribing narcotics and controlled substances is the potential for prescription drug abuse. The non-medical use or abuse of prescription drugs is a serious and growing public health problem. Virtually any prescription drug can be consumed for reasons other than its medical purpose; however, it is usually drugs with psychoactive properties (e.g., opioids) that are the focus of abuse.[55]

Physicians may be able to reduce or impede the diversion,[56] misuse and/or abuse of narcotics and controlled substances by: carefully considering whether these drugs are the most appropriate choice for the patient; recognizing patients who may be double-doctoring,[57] diverting, misusing or abusing prescription drugs; sharing information with others, as appropriate; instituting measures to prevent prescription pad theft or tampering; taking measures to prevent the theft of drugs from their offices; and educating patients.

The purpose of this section of the policy, along with the related guidelines, is to clarify for physicians their obligations when prescribing narcotics and controlled substances and their role in preventing and addressing prescription drug abuse. This policy does not attempt to curb the prescribing of narcotics and controlled substances for legitimate reasons (i.e., acute or chronic pain, mental illness or addiction), but does reinforce the requirement that physicians prescribe these drugs in an appropriate manner.

Considerations

In addition to complying with the general requirements set out for prescribing any drug and any applicable legislation, physicians must carefully consider whether the narcotic or controlled substance is the most appropriate choice for the patient, even if the patient has been prescribed these drugs in the past.[58] Special consideration is necessary given that narcotics and controlled substances are highly susceptible to diversion, misuse and/or abuse because of their psychoactive properties. These drugs are extremely harmful to patients and to society when they are diverted, misused and/or abused, so physicians must first consider whether an alternate treatment or drug is clinically appropriate. If there are no appropriate or reasonably available alternatives, physicians are advised to record this fact in the patient's medical record. The benefits of prescribing narcotics and controlled substances must be weighed against their potential risks when used long-term.

Office Policies and Practices: Setting and Managing Patient Expectations

a) General Policies and Practices

It is recommended that physicians who prescribe narcotics and controlled substances consider implementing office policies and practices regarding the prescribing of these drugs, for example, a policy on the use of treatment agreements.[59] Communicating these office policies and practices to patients can help manage patient expectations and help monitor whether the treatment is being used as prescribed.

b) 'No Narcotics' Prescribing Policy

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

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

As such, the College recommends that physicians do not adopt a blanket policy refusing to prescribe narcotics and controlled substances, unless physicians have restrictions

55. Canadian Centre on Substance Abuse, *Prescription Drug Abuse FAQs* (CCSA, 2007).

56. Drug diversion, broadly defined, is when the legal supply chain of prescription drugs is broken, and drugs are transferred from a licit to an illicit channel of distribution or use.

57. Obtaining multiple prescriptions from different physicians.

58. The College recommends that physicians refer to relevant guidelines and tools for prescribing narcotics and controlled substances. For example, physicians are advised to refer to the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* when prescribing opioids for chronic non-cancer pain. Available at: http://nationalpaincentre.mcmaster.ca/opioid/. Tools for appropriate patient screening may be particularly helpful in this regard. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

59. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

60. Some patients may seek prescriptions for narcotic and controlled substances for reasons that are not legitimate. It may be very difficult for physicians to determine this, so it is recommended that they use their professional judgment to determine whether prescribing narcotics or controlled substances is prudent. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

Prescribing Drugs

preventing them from prescribing narcotics and controlled substances. Prescribing narcotics and controlled substances are part of good clinical care and refusing to prescribe these drugs altogether may lead to inadequate management of some clinical problems and may leave patients seeking treatment from other physicians, putting pressure on others to manage these cases, or otherwise leaving patients without appropriate treatment.

Monitoring Patients: Misuse, Abuse and Double-Doctoring

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

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

Sharing Information

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

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

a) Circle of Care

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

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

b) Permitted Disclosure

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

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

i) Disclosure for authorized investigations or inspections

- This provision enables information to be disclosed in the context of an investigation or inspection, for the purposes of facilitating that investigation.
- The investigation or inspection must be authorized by a warrant, or by an Act of Ontario or an Act of Canada.
- The disclosure must be made to the person who is authorized to do the investigation or inspection.[65]

The Canadian Medical Protective Association (CMPA) has provided information regarding double-doctoring and responding to inquiries from law enforcement officials in

61. Physicians are advised to refer to the guidelines on 'Narcotics and Controlled Substances' in this policy for more information.

62. Section 4(2) of the *CDSA*.

63. Section 20(2) of *PHIPA*. Physicians who wish further detail on the Circle of Care are advised to consult the Information and Privacy Commissioner of Ontario's *Circle of Care: Sharing Personal Health Information for Health-Care Purposes* document.

64. For information on mandatory and permissive reporting obligations, please see the CPSO's Mandatory and Permissive Reporting policy.

65. Section 43(1)(g) of *PHIPA*.

66. The CMPA advises that it is appropriate for physicians to respond to inquiries from police to verify whether a prescription in the possession of the police is authentic as having been written or authorized by the physician. Aside from this information, physicians are advised to refrain from answering questions that require them to disclose specific information concerning a patient's health. For more information, please see the CMPA's *Responding to Prescription Fraud* document.

its article *Responding to Prescription Fraud*.[66]

ii) Disclosures related to risks

- This provision allows for information to be disclosed in order to prevent or reduce a risk of harm to others.
- To rely on this provision, health-care providers must believe on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.[67]

Mandatory Reporting Obligation

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

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

Physicians must not prescribe drugs that have not been approved for use in Canada, that is, drugs for which Health Canada has not issued a Notice of Compliance (NOC).[69] However, there are two circumstances when access to an unapproved drug can be obtained for patient use. The first is when drugs have been authorized by Health Canada for research purposes as part of a clinical trial. The other is when drugs have been authorized under Health Canada's Special Access Programme.[70]

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

GUIDELINES

Preventing Medication Errors

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

Physicians can help reduce the occurrence of some medication errors by considering the following guidelines.

Verbal Prescriptions[71]

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

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

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

67. Section 40(1) of *PHIPA*. This provision is not specific to opioids; the threshold is 'risk of serious bodily harm'. It doesn't specify to whom the disclosure is to be made.

68. Section 55(g) of the *CDSA, Narcotic Control Regulations*; Sections 7(1) and 61(2) of the *Benzodiazepines and Other Targeted Substances Regulations*, S.O.R./2000-217, enacted under the *CDSA*. These obligations are also set out in the CPSO's Mandatory and Permissive Reporting policy.

69. Federal legislation stipulates that no one can sell or advertise a new drug unless the Minister has issued an NOC to the manufacturer. The NOC indicates that the drug meets the required standards for use in humans or animals and is approved for sale in Canada. A manufacturer receives an NOC when it has met Health Canada's regulatory requirements for the safety, efficacy and quality of a product. For more information, see Health Canada's *Notice of Compliance* webpage.

70. The Special Access Programme (SAP) provides access to non-marketed drugs for practitioners treating patients with serious or life-threatening conditions when conventional therapies have failed, are unsuitable, or unavailable. The SAP authorizes a manufacturer to sell a drug that cannot otherwise be sold or distributed in Canada. For more information, see Health Canada's *Special Access Programme – Drugs* document.

71. Alberta College of Pharmacists, College and Association of Registered Nurses of Alberta & College of Physicians and Surgeons of Alberta, *Ensuring Safe & Efficient Communication of Medication Prescriptions in Community and Ambulatory Settings* (ACP, CARNA & CPSA, 2007).

Prescribing Drugs

asking someone who has an understanding of the drug and indication to communicate the prescription information, unless the prescription is a refill.

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

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

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

Look-alike/Sound-alike Drug Names

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

- writing prescriptions clearly by printing the name of the product in block letters or using TALLman lettering,[74] by not using abbreviations, or by using electronic prescriptions;
- including more information about the drug (e.g., include both brand name and generic name, and the reason for prescribing the medication);
- ensuring that the strength, dosage and directions for use are clearly indicated on the prescription; and
- communicating to the patient (or a family member) the reason the medication has been prescribed and verifying that the patient can read the prescription.

High-alert Medications

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

Vulnerable Populations/High-alert Environments

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

Double-Checking

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

Patient Involvement

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

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

If a prescription is generated, authorized and transmitted

72. See the *ISMP's List of Confused Drug Names*, available at: http://www.ismp.org/tools/confuseddrugnames.pdf.

73. Health Canada, *Look-alike Sound-alike Health Product Names* (HC, 2009).

74. For more information, see the following documents: the ISMP *FDA and ISMP Lists of Look-Alike Drug Names with Recommended Tall Man Letters* (available at: https://www.ismp.org/tools/tallmanletters.pdf); and the ISMP Canada *Safety Bulletin: Application of TALLman Lettering for Drugs Used in Oncology.*

75. See the *ISMP's List of High-Alert Medications* for more information, available at: http://www.ismp.org/Tools/highalertmedications.pdf.

76. Alberta College of Pharmacists, College and Association of Registered Nurses of Alberta & College of Physicians and Surgeons of Alberta, *Ensuring Safe & Efficient Communication of Medication Prescriptions in Community and Ambulatory Settings* (ACP, CARNA & CPSA, 2007) at p.3.

electronically, the physician may wish to generate a record/receipt of the prescription for the patient. This would accomplish several things:

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

Reporting Adverse Drug Reactions or Medication Incidents

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

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

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

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

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

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

Narcotics and Controlled Substances

Responding to Requests for Narcotics and Controlled Substances

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

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

77. Adverse drug reactions are unwanted effects that happen when drugs are used under normal conditions. Adverse drug reactions are also called side effects. Adverse drug reactions are not medication incidents. Unlike a medication incident, an adverse drug reaction generally doesn't involve a mistake and typically can't be prevented.
78. Health Canada's *Adverse Reaction Information* webpage describes a serious adverse drug reaction as one that requires in-patient hospitalization or prolongation of existing hospitalization, causes congenital malformation, results in persistent or significant disability or incapacity, is life-threatening or results in death. Adverse reactions that require significant medical intervention to prevent one of these listed outcomes are also considered to be serious.
79. A medication incident is a mistake with medication, or a problem that could cause a mistake with medication. 'Medication error' is another name for one kind of medication incident. Medication incidents include obvious things like receiving the wrong medication or dose, but might also include problems like a confusing label that might lead to someone receiving the wrong medication.
80. Please see the next section on 'Identifying Aberrant Drug-Related Behaviour' for more information.

Prescribing Drugs

Identifying Aberrant Drug-Related Behaviour[81]

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

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

The chart on this page lists aberrant drug-related behaviours potentially indicative of opioid misuse.

Indicator	Examples
Altering the route of delivery	❑ Injecting, biting or crushing oral formulations ❑ Biting, chewing, swallowing or injecting topical preparations (e.g., sustained-release analgesic patches)
Accessing opioids from other sources	❑ Taking the drug from friends or relatives ❑ Purchasing the drug from the "street" ❑ Double-doctoring
Unsanctioned use	❑ Multiple unauthorized dose escalations ❑ Binge rather than scheduled use
Drug seeking	❑ Recurrent prescription losses ❑ Aggressive complaining about the need for higher doses ❑ Harassing staff for faxed scripts or fit-in appointments ❑ Nothing else "works"
Repeated withdrawal symptoms	❑ Marked dysphoria, myalgias, GI symptoms, craving
Accompanying conditions	❑ Currently addicted to alcohol, cocaine, cannabis or other drugs ❑ Underlying mood or anxiety disorders not responsive to treatment
Social features	❑ Deteriorating or poor social function ❑ Concern expressed by family members
Views on the opioid medication	❑ Sometimes acknowledges being addicted ❑ Strong resistance to tapering or switching opioids ❑ May admit to mood-leveling effect ❑ May acknowledge distressing withdrawal symptoms

Office Practices and Policies: Setting and Managing Patient Expectations

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

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

Treatment Agreements

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

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

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

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

81. National Opioid Use Guideline Group, *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* (NOUGG, 2010).

82. See the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* for a sample treatment agreement, available at: http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b05.html.

83. For information on ending the physician-patient relationship, please see the CPSO's Ending the Physician-Patient Relationship policy.

Monitoring Patients

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

Preventing Prescription Fraud[86]

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

- If using a paper prescription pad:
  - Use carbon copies or numbered prescription pads;
  - Write the prescription in words and numbers;
  - Draw lines through unused portions of the prescription; and
  - Keep blank prescription pads secure.
- If using desk-top prescription printing:
  - Use EMR-enabled security features such as watermarks.
  - Write a clear signature and do not use a scribbled initial.
- Promote the patient's use of a single dispensing pharmacy of their choice. Include the name of the pharmacy the patient would like to take the prescription to be dispensed, on the prescription.
- Fax (or electronically transmit when available) prescriptions directly to the pharmacy.
- If using fax or electronic transmission of the prescription (when permitted) ensure confidentiality,[87] confirm destination, and retain copies.

Security of Drugs

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

Advice for Patients[88]

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

- Read the label and take the drug exactly as directed. Take the right dose at the right time.
- Follow the other directions that may come with the drugs, such as not driving, and avoiding the use of alcohol.
- Store narcotics and controlled substances in a safe place, out of the reach of children and teenagers, and keep track of the amount of drugs.
- Never share prescription drugs with anyone else, as this is illegal and may cause serious harm to the other person.
- Return any unused drugs to the pharmacy for safe disposal, in order to prevent diversion for illegal use and to protect the environment. Drugs must not be disposed of in the home (e.g., in the sink, toilet or trash).

In addition, physicians may want to advise patients about what to do if they miss a dose, and remind them that crushing or cutting open a time-release pill destroys the slow release of the drug and can lead to an overdose with serious health effects.

84. See the College of Physicians and Surgeons of Newfoundland and Labrador's sample narcotic flow sheet, available at: http://www.cpsnl.ca/userfiles/file/Narcotic%20Flow%20Sheet.pdf.
85. It is recommended that physicians look for evidence of non-compliance, escalation of dose, early renewals, misrepresentation, or fraud.
86. National Opioid Use Guideline Group, *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* (NOUGG, 2010).
87. For more information on the security of faxed prescriptions, see the Information and Privacy Commissioner of Ontario's *Guidelines on Facsimile Transmission Security.*
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Appendix C

THE COLLEGE OF PHYSICIANS AND SURGEONS

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.

EXECUTIVE COMMITTEE'S REPORT TO COUNCIL
April 2015 – March 2016
In Accordance with Section 12 HPPC
The College of Physicians and Surgeons of Ontario

April 29, 2015 EXECUTIVE COMMITTEE MEETING

1. Governance Committee Report - Committee Appointment for New Public Member, Peter Pielsticker

The Executive Committee appointed new public member Mr. Peter Pielsticker to the Discipline and Quality Assurance Committees.

2. Bill 77, *Affirming Sexual Orientation and Gender Identity Act*

The Executive Committee was updated on a private member's bill that seeks to prohibit services broadly referred to as conversion or reparative therapy, whose intent is to seek to change or direct the sexual orientation or gender identity of a patient. Bill 77 would prevent public payment for conversion therapy offered by a regulated health provider and ban it for those under 18. It would do so by amending the *Health Insurance Act* and the *Regulated Health Professions Act*.

A letter from the Minister of Health to the CPSO and three other regulatory Colleges requested assurance that conversion therapy is not being practised by its members. The Executive Committee approved a draft letter responding to the Minister's correspondence.

June 19, 2015 EXECUTIVE COMMITTEE MEETING

1. Transitional Council of the College of Naturopaths of Ontario and the Ministry of Health: Consultation Documents

The CPSO submitted a formal response to the Transitional Council of the College of Naturopaths of Ontario and the Ministry of Health in May 2015 outlining its significant concerns regarding the proposed drugs/substances and tests they are proposing be included in their scope of practice, many of which we have set out on four prior occasions.

October 6, 2015 EXECUTIVE COMMITTEE MEETING

1. Fertility Services Oversight

The Executive Committee directed staff to continue to work with the Ministry of Health to develop a comprehensive quality oversight regime for infertility services. A change to the OHP regulation will be required in order to enable the College to regulate these services. Currently, the OHP program only covers some of the procedures associated with IVF.

The Executive Committee agreed that this is an area of medicine that could benefit from quality oversight.

November 3, 2015 EXECUTIVE COMMITTEE MEETING

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

Medical regulatory authorities from six provinces have joined together to design and manage a project that will identify, understand and use empirically defined factors of practice that support physician performance or that suggests a risk of poor performance.

The Executive Committee was provided with a progress report for this pan-Canadian project and discussed how it might integrate with the CPSO's objective for more physician assessments ('every doctor every ten years').

2. Marijuana for Medical Purposes Regulations (MMPR)

The federal *MMPR* enables Medical Regulatory Authorities to request information from licensed producers of marijuana in a number of specified circumstances.

The Executive Committee recommended that the College seek information about particular physicians pursuant to an investigation, but not develop a larger marijuana database using historical or quarterly reports at this time.

January 26, 2016 EXECUTIVE COMMITTEE MEETING

1. Rights and Responsibilities/What to Expect During Medical Encounters – Revised Draft for Final Approval

The Executive Committee reviewed the revisions made to the draft document, now titled 'What to Expect During Medical Encounters', to reflect the feedback Council provided at its December 2015 meeting and the recent feedback received from the Ontario Medical Association (OMA).

The Executive Committee approved the revised draft document 'What to Expect during Medical Encounters' for distribution to the public.

2. HPRAC Consultation on Registered Nurse Prescribing

In accordance with the Minister of Health and Long-Term Care's direction, the Health Professions Regulatory Advisory Council (HPRAC) is conducting a consultation on three models of Registered Nurse (RN) prescribing and will be providing recommendations to the Minister on the most suitable model for Ontario.

The three models are: independent prescribing, use of protocols (delegation) and supplementary prescribing (a hybrid of the first two models).

The CPSO has experience with a delegation model and is satisfied that it 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.

The Executive Committee directed that a response be sent to HPRAC which states that the CPSO is supportive of the second model: use of protocols. This model appears to reflect the status quo, where RNs are able to prescribe via delegation, under direct orders or medical directives.

3. The Responsibilities of Practice Monitor Chaperones

Currently, Practice Monitors for physicians subject to Gender Based Restrictions (GBRs) can perform both clinical/administrative duties as well as acting as chaperones. Breaches of restrictions, however, have occurred with monitors performing this dual role. The Executive Committee approved a proposal to limit the role of practice monitors to chaperoning only.

The new requirements will be implemented in 2016 for new cases only; changes will not affect current GBRs with a Practice Monitor. The change will be monitored and revisited when further information is available.

4. Registrar's Report

The Ministry of Health's Laboratory Services Expert Panel Report recommends changes to funding and lab services. The report also addresses other issues: accreditation, licensing, physician ordering accountability and the role of the Institute for Quality Management in Health Care (IQMH), which is run by the OMA, and assesses labs. The report recommends that the IQMH be either a stand-alone entity or "placed in corporate alignment with the CPSO".

There has been no specific request from the government yet but the issue will be monitored.

5. Governance Committee Report

The Executive Committee appointed Dr. Anita Rachlis, an infectious disease/internal medicine specialist, to the Inquiries, Complaints and Reports Committee. The Executive Committee accepted the resignations of Dr. Wayne Johnston and Dr. Bernard Goldman and rescinded their appointments to the ICRC.

March 29, 2016 EXECUTIVE COMMITTEE MEETING

1. College of Optometrists of Ontario (COO) Consultation

The College of Optometrists of Ontario (COO) is consulting on a number of proposed amendments to the legislative framework for the practice of optometry. The specific amendments proposed relate to prescribing and dispensing drugs, removing superficial foreign bodies from the cornea, and using diagnostic ultrasound for the performance of corneal pachymetry or A/B scan ocular ultrasonography.

The draft response states that the CPSO is generally supportive of most of the proposed amendments, but is concerned that some may exceed the scope of practice for optometrists, putting patients at risk. More specifically, the CPSO is supportive of the proposed amendments regarding prescribing and dispensing

provided that:

- prescribing is limited to specified categories of drugs;
- certain drugs be restricted, such as oral steroids and oral immunosuppressants;
- optometrists have any additional education and training in pharmacology that may be required in order to prescribe a broader range of drugs (e.g. specified categories of drugs instead of prescribing from a drug list) and to dispense drugs in a safe and effective manner; and
- prescribing and dispensing is done in a manner that is consistent with the CPSO's expectations for physicians.

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May 2016

COUNCIL BRIEFING NOTE

TOPIC: Physician Behaviour in the Professional Environment – Consultation Report and Revised Draft Policy

FOR DECISION – FINAL APPROVAL

ISSUE:

- The draft Physician Behaviour in the Professional Environment policy was circulated for external consultation between December 2015 and February 2016.

- Council is provided with a report on the consultation and the proposed revisions made to the draft policy in response to the feedback received.

- Council is asked whether the revised draft policy can be approved as a policy of the College.

BACKGROUND:

- The College's current Physician Behaviour in the Professional Environment policy has been reviewed in accordance with the policy review cycle. The policy was first approved by Council in 2007 and was developed as part of the College's broader Disruptive Physician Behaviour Initiative that started in 2003.

- The current policy sets out expectations for physician behaviour grounded in the principles of medical professionalism, namely that physicians act in a respectful, courteous, and civil manner towards their patients, colleagues and others involved in the provision of care and that they not engage in disruptive behaviours.

- During the initial stages of this review, extensive research was undertaken. 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.

- With the assistance of Dr. Peter Prendergast, Dr. Michael Szul, and Dr. Eugenia Piliotis (medical advisors), Carolyn Silver (legal counsel), and Dr. Bill McCready, Dr. Marc Gabel, and Dr. Peeter Poldre (Council members), the

research and consultation feedback was used to help inform the development of an updated draft policy.

- The draft policy was approved by Council for external consultation at their December 2015 meeting.

CURRENT STATUS:

- Council is provided with a report on the consultation, as well as the proposed revisions undertaken in response to the feedback received.

A. Report on Consultation

Consultation process

- Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire CPSO membership and key stakeholder organizations. In addition, a general notice was posted on the CPSO's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and *Patient Compass* (the College's public e-newsletter, formerly known as *Noteworthy*).

- Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to a consultation-specific discussion page.

- The consultation was held between December 9th, 2015 and February 12th, 2016.

Number of responses

- The CPSO received a total of 78 consultation feedback responses: 30 comments posted on the consultation-specific discussion page and 48 online surveys[1]

- Of the discussion page comments, 14 (47%) were from physicians, 6 (20%) from members of the public, 3 (10%) from organizations[2], and 7 (23%) were anonymous respondents.

[1] 55 respondents started the survey, but of these, 7 did not complete any of the substantive questions, leaving 48 surveys for analysis.

[2] Organizations who responded to the consultation via the discussion page were the following: Ontario Medical Association (OMA); Professional Association of Residents of Ontario (PARO); The Canadian Medical Protective Association (CMPA).

- Of the surveys, 32 (67%) of the surveys were submitted by physicians, 9 (19%) were submitted by members of the public, 6 (12%) by other health care professionals, and 1 (2%) by an anonymous respondent.

Feedback

- All written feedback received during the consultation, along with a report of the feedback obtained through the online survey, is posted on the CPSO website in keeping with regular consultation processes and posting guidelines.

General comments

- Broadly speaking, the feedback was mixed and the level of support for the policy in general, differed significantly between the discussion page and the online survey.

- Those who provided feedback on the consultation discussion page expressed strong opposition to the policy, with approximately 40% of respondents asserting that the policy was either not needed or would be harmful.

- In contrast, the majority of survey respondents expressed general support for the policy in both the quantitative and open-ended responses.

Support for the policy

- Of those respondents who supported the draft policy, many noted that the expectations of professional behaviour were reasonable and agreed that disruptive behaviour can negatively impact quality delivery of health care as well as patient safety and outcomes.
- One supportive member of the public commented that “good behaviour applies to every job, everywhere”.
- Of the 48 respondents to the online survey, 63% thought that the draft policy was helpful to physicians, other members of the health care team (66%), trainees (69%), and health system organizations (66%). Respondents were less certain about whether the draft policy is helpful to patients and the public (46%).

Objection to the Policy

- Of those respondents who objected to the draft policy, many felt that there was no need for the policy because of hospital codes of conduct, for example. Others questioned how complaints about disruptive behaviour would be

investigated, especially given what they saw as the subjective nature of assessing this behaviour.

- Some respondents felt that the policy should focus on disruptive patient behaviour arguing that "the College is living by an old paradigm of 'physicians have the power in the doctor-patient relationship'" and that "the College should balance this policy with making it easier for physicians to discharge abusive 'disruptive' patients".

- Concerns were raised by a number of respondents about whether disagreements and conflicting views on patient care would be mislabelled as disruptive behaviour.

Substantive comments

- Overall the vast majority of responses provided in this consultation were general in nature. Those that were substantive and/or included specific constructive suggestions are set out below.

Definition of disruptive behaviour

  - Some respondents felt that the definition included words that are vague and others felt that the definition was too general.

Patient disruptive behaviour

  - A significant number of respondents argued that the policy should set expectations of appropriate behaviour for patients and include advice for physicians on how to manage disruptive patients.

Examples of disruptive behaviour

  - The Canadian Medical Protective Association (CMPA) suggested that certain examples of disruptive behaviour such as "failure to work collaboratively or cooperatively with others" and "refusal to comply with accepted practice standards" was subjective and broad.

Causes of disruptive behaviour

  - The Professional Association of Residents of Ontario (PARO) was concerned that the draft policy did not contain an in-depth statement on the potential causes of disruptive behavior. PARO suggested that the policy "acknowledge that disruptive behaviour can often be a symptom of a sick system or sick or bunt out physician."

Physician Health Program and Confidentiality

- The CMPA was concerned that the revised draft removed information about the confidentiality parameters of physician's interaction with the Physician Health Program (PHP) and recommended that this be added back in.

Responsibilities to the Profession

- PARO noted their appreciation that the revised draft specifically mentions the importance of modeling professional behaviour for trainees.

B. Revisions in Response to Feedback

- All of the feedback has been carefully reviewed and used to develop a revised draft policy that can be found for Council's information at **Appendix 1**.

- All revisions have been undertaken with the assistance of Dr. Peter Prendergast, Dr. Michael Szul, and Dr. Eugenia Piliotis (medical advisors), Carolyn Silver (legal counsel), and Dr. Bill McCready, Dr. Marc Gabel, and Dr. Peeter Poldre (Council members).

<u>Key Revisions</u>

1) A number of minor wording and organizational changes were made to the draft policy in order to improve clarity.

2) As per the suggestion of PARO, the paragraph that notes the *Guidebook for Managing Disruptive Physician Behaviour* as the companion document to this policy now includes a reference to the Guidebook's assistance in identifying disruptive behaviour.

3) In response to the CMPA's feedback, reference to the confidentiality provisions of the PHP that were included in the existing policy have been added back into the draft policy. However, changes have been made to this statement in order to accurately reflect the circumstances in which the College could receive information from the PHP. The line now reads "Physicians should note that their interactions with the PHP, if any, are confidential unless a mandatory reporting obligation applies or the physician has signed an agreement with the PHP to release information to the College."

4) In response to the CMPA's feedback, "Refusal to comply with accepted practice standards" was removed from the list of examples of disruptive behaviour contained in Appendix A of the revised draft policy. As the CMPA noted, "physicians adhering to a different, but equally accepted, practice standards may lead to a physician inaccurately being accused of disruptive

behaviour." While concerns around a physician's adherence to accepted practice standards may be of concern, this could be addressed through other College mechanisms. The list of examples was also reorganized so that the most significant forms of disruptive behaviours are at the top of the list.

Changes that were not made in response to the feedback

- Respondents had requested that the policy include a statement about disruptive patient behaviour. However, as the medical regulator of Ontario, it is not in the College's jurisdiction to set expectations for patient behaviour.

- Respondents had suggested that more information about the causes of disruptive behaviour be included. While serious consideration was given to this request, it was ultimately decided that the existing statement listing the broad categories of potential causes (personal, professional, or situational) was adequate.

NEXT STEPS:

- Should Council approve the draft policy, as revised, it will be published in *Dialogue* and will replace the current Physician Behaviour in the Professional Environment policy on the CPSO website.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the Physician Behaviour in the Professional Environment revised draft policy?

2. Does Council approve the revised draft Physician Behaviour in the Professional Environment policy?

CONTACT: Miriam Barna, ext. 557

DATE: May 12, 2016

Attachments:

Appendix 1: *Physician Behaviour in the Professional Environment* – Revised draft policy with track changes

Appendix 1

Physician Behaviour in the Professional Environment

Policy Number:

Policy Category: Practice

Approved by Council: November 2007

Reviewed and Updated:

Publication Date:

College Contact: Physician Advisory Services

Introduction

Physicians are expected to act in a respectful, courteous, and civil manner towards their patients,[1] colleagues,[2] and others involved in the provision of health care. Doing so fosters an atmosphere of trust, shared accountability, and collaboration[3] and is an essential component to upholding the values and principles of medical professionalism. Conversely, behaviour that is unprofessional and/or disruptive undermines medical professionalism and the trust of the public. Literature shows that these behaviours can negatively impact both the delivery of quality health care and ~~delivery~~ patient safety and outcomes by eroding the effective communication and collaboration that underpin good medical practice.[4]

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[1] This includes the family and friends of patients.

[2] Colleagues are considered all those who work with the physician, whether members of a health regulatory college or not. This includes other physicians, nurses, trainees, non-clinical staff, volunteers, and all other individuals who contribute to health care delivery.

[3] Shapiro, J., Whittemore, A., Tsen, L.C. (2014). Instituting a culture of professionalism: the establishment of a center for professionalism and peer support. Joint Commission Journal on Quality and Patient Safety, 40(4), 168-177.

[4] The literature indicates a strong relationship between disruptive behaviour and poor patient safety and outcomes. The following is a representative selection of this literature.

- Leape, L.L., Shore, M.F., Dienstag, J.L. et. al. (2012). Perspective: a culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. Academic Medicine, 87(7), 845-852.
- Sanchez, L.T. (2014). Disruptive behaviors among physicians. Journal of the American Medical Association, 312(21), 2209-2210.
- Leape, L.L. & Fromson, J.A. (2006). Problem doctors: is there a system-level solution? Annals of Internal Medicine, 144(2), 107-115.

This policy sets out the College's expectations of physician behaviour in the professional environment and identifies a subset of unprofessional behaviour known as disruptive behaviour.

The Guidebook for Managing Disruptive Physician Behaviour[5] is the companion document to this policy as it provides institutions and organizations with advice and tools for creating environments that foster medical professionalism, identifying disruptive behaviour, and effectively addressing disruptive behaviour in a staged approach.

Terminology

Disruptive behaviour: Disruptive behaviour occurs when the use of inappropriate words, or actions and inactions, by a physician interferes with his or her ability to collaborate, or may interfere with, the delivery of quality health care ~~delivery~~ or the safety or perceived safety of others.

Disruptive behaviour may be demonstrated in a single unacceptable act but more commonly such behaviour will be identified through several events demonstrative of a pattern. The gravity of disruptive behaviour depends on the nature of the behaviour, the context in which it arises, and the consequences flowing from it. Examples of behaviours that may be disruptive are set out in Appendix A.

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:

1. Always acting in the best interests of their patients;
2. Communicating effectively and with respect, sensitivity, and compassion;
3. Collaborating effectively and respectfully with patients, colleagues, and others involved in the provision of health care;
4. Demonstrating professional competence, which includes meeting the standard of care and acting in accordance with all relevant and applicable legal and professional obligations and expectations, to provide the highest possible quality of care;
5. Participating in the self-regulation of the medical profession by acting in accordance with the expectations set out in this policy.

[5] The Guidebook for Managing Disruptive Physician Behaviour (April 2008) has been endorsed by the College of Physician and Surgeons of Ontario and the Ontario Hospital Association.

Purpose & Scope

This policy sets out the College's expectations of physician behaviour and professionalism.

This policy applies to physicians working in a professional capacity and in their interactions with patients, colleagues, and others involved in the provision of health care.

Policy

Physicians are expected to take responsibility for their behaviour and to meet the obligations and expectations set out in this policy, the Practice Guide, applicable legislation,[6] along with the expectations set out in institutional Codes of Conduct, policies or by-laws. Specifically, physicians are expected to uphold the standards of medical professionalism, conduct themselves in a professional manner, and not engage in disruptive behaviours.

This dual expectation that physicians uphold the standards of medical professionalism and not engage in disruptive behaviours forms the basis for this policy and both are set out in the sections below. Where a physician's behaviour does not meet this dual expectation, the physician is expected to change or cease his or her behaviour accordingly.

If the physician is unable to control the behaviour on his or her own, the physician is advised to seek appropriate assistance to do so. In addition to whatever resources may be available in the local setting (medical school, hospital, or other work environment), physicians and their colleagues are advised to contact the Ontario Medical Association's Physician Health Program (PHP)[7] to explore the resources available for obtaining assistance. Physicians should note that their interactions with the PHP, if any, are confidential unless a mandatory reporting obligation applies or the physician has signed an agreement with the PHP to release information to the College.

Medical Professionalism: Responsibilities

The social contract between physicians and society is the underpinning of medical professionalism. A physician's responsibilities[8] in this regard include, but are not limited to those set out in the subsections below~~:~~.

Responsibilities to the Patient

[6] For example, physicians must abide by their legal obligations under the *Occupational Health and Safety Act*, R.S.O. 1990, c.0.1 (hereinafter OHSA).
[7] More information on the Physician Health Program can be found at: http://php.oma.org/index.htm.
[8] For further information see: Canadian Medical Association, Medical Professionalism (Update 2005).

The physician's primary responsibility is to act in the best interests of the individual patient.[9] This includes acting respectfully towards patients, and their families, friends or visitors, and prospective patients, even under stressful situations.

Physicians have a responsibility, individually and collectively, to advocate for their patients[10] and, at times, this could lead to disagreements or conflict with colleagues or the administration of the institution in which they work. The College views advocacy as an important component of the physician's role and recognizes that disagreements do not necessarily constitute disruptive behaviour. However, physicians are reminded that the expectation for professional behaviour remains even in the context of advocacy or conflict.

Responsibilities to Other Health Care Professionals

To ensure the safe and effective delivery of health care and a healthy working environment,[11] physicians must work respectfully and collaboratively with other members of the health care team. This includes all who are involved in the provision of health care.

Responsibilities to the Profession

Physicians must uphold the standards of the medical profession by modelling appropriate behaviour for other members of the health care team, in particular trainees, and fostering a culture of respect within their practice setting or workplace.

Disruptive Behaviour

Physicians must not engage in disruptive behaviours because they undermine professionalism as well as a culture of safety. ~~and~~ These behaviours pose a threat to patients and outcomes by inhibiting the collegiality and collaboration essential to teamwork, impeding communication, undermining morale, and inhibiting compliance with and implementation of new practices.[12]

While there may be a myriad of reasons for disruptive behaviour, whether personal, professional, or situational, physicians are nevertheless expected to demonstrate professional behaviour at all times.

[9] Specifically, the Practice Guide notes that, "when providing care to a patient, a physician should always put that patient first." For more information see The Practice Guide: Medical Professionalism and College Policies.
[9] See page 12 of *The Practice Guide*.
[10] See page 12 of *The Practice Guide*.
[11] Physicians may have other obligations under the *OHSA* both in regards to their own behaviour in the workplace, as well as specific obligations if they are employers, as defined by the *OHSA*.
[12] Leape, L.L., Shore, M.F., Dienstag, J.L. et. al. (2012). Perspective: a culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. Academic Medicine, 87(7), 845-852.

Appendix A

Examples of Disruptive Behaviour

~~The following list provides examples of behaviour that may be disruptive~~ As noted in the Terminology section of the policy, behaviour is considered disruptive when it interferes with a physician's ability to collaborate, with the delivery of quality health care, or with the safety or perceived safety of others. ~~when it interferes with quality health care delivery, a physician's ability to function well with others, or another person's safety or perceived safety.~~

The following list provides examples of a range of behaviours that may be disruptive.

- Rude, profane, disrespectful, insulting, demeaning, threatening, bullying or abusive language, tone, innuendos, and behaviour;
- Arguments[13] or outbursts of anger including throwing or breaking things;
- Use, attempted use, or threat of violence or physical force with patients, colleagues, and others involved in the provision of health care;[14]
- Comments or actions that may be perceived as harassing or may contribute to a poisoned professional environment;
- Mocking, shaming, disparaging, or censuring patients, colleagues, and others involved in the provision of health care;
- ~~Failure to work collaboratively or cooperatively with others;~~
- ~~Refusal to comply with accepted practice standards;~~
- Repeated failure to promptly respond to calls or requests for information or assistance when on-call or expected to be available;
- Failure to work collaboratively or cooperatively with others.
- ~~Mocking, shaming, disparaging, or censuring patients, colleagues, and others involved in the provision of health care.~~

This list above is not exhaustive. Notably, unprofessional behaviours captured by other College policies, such as those that could constitute sexual abuse or misconduct as set out in Maintaining Appropriate Boundaries and Preventing Sexual Abuse or discrimination as outlined in the Professional Obligations and Human Rights are not provided above. Physicians are expected to be aware of and comply with these, and other relevant College policies.

[13] Respectful discussions, in which disagreement is expressed, are not arguments.
[14] The policy does not intend to capture circumstances where, for instance, force may be necessary to restrain a patient who poses a threat to themselves or those providing them with care.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: PROPOSED CHANGES TO OHPIP STANDARDS – ACCOUNTABILITY OF MEDICAL DIRECTOR, STAFF QUALIFICATIONS, INFECTION CONTROL AND QUALITY ASSURANCE

FOR DECISION

ISSUE:

- A Working Group (a subset of the Premises Inspection Committee) has been meeting over the last few months to discuss opportunities to increase the accountability of the Medical Director role in Out-of-Hospital Premises (OHPs). This is in response to a number of concerns raised across the College specific to the accountability associated with this role.

- The Working Group has proposed key changes to the Out-of-Hospital Premises Inspection Program (OHPIP) Standards that would enhance the responsibilities and accountability of the Medical Director.

- Additional sections of the OHPIP Standards that reference the role of the Medical Director were also updated and are included for feedback.

- Council is being provided with the draft OHPIP Standards, and is being asked whether the document can be released for external consultation.

BACKGROUND:

- The Working Group identified the following issues related to the Medical Director role which posed concerns related to accountability:

    1. *Absenteeism* – a Medical Director may not always be physically present at the OHP with which he or she is affiliated.

    2. *Restricted Certificate/No Independent Practice certificate* – a Medical Director may hold a restricted certificate which limits his or her scope of practice to an area of medicine that is not associated with the type/scope of procedures being performed at the OHP.

       In other cases, a Medical Director may hold a Restricted certificate of registration that is at odds with the Medical Director role, e.g. a physician who holds a Restricted certificate of registration that requires him or her to be supervised (pathway 4), and yet is a Medical Director.

3. *Authority for Appropriate Patient Selection/Admission* – The Medical Director may not have the medical specialty background to appropriately select/approve/exclude patients for procedures being performed.

4. *Infection Prevention and Control* – The Medical Director's responsibility for infection control and prevention practices of OHP clinic staff needs to be increased. In particular, he or she needs to verify that infection prevention and control procedures are being followed by OHP staff.

5. *Corporate Ownership* – often a corporation will appoint a Medical Director in name only, i.e. there is minimal follow-up/lack of accountability when a lapse occurs.

6. *Different Specialties working in OHP* –The Medical Director who is certified in one specialty (e.g. plastic surgeon) needs to ensure that he or she is meeting responsibilities in relation to another type of procedure being performed in the same OHP, e.g. interventional pain management.

- Recent events occurring in OHPs have increased the focus on the role of the Medical Director, including requests to enhance the requirements in the OHPIP Standards specific to the responsibilities and accountabilities for physicians in this role.

- The OHPIP Working Group was comprised of PIC members, OHP Program staff, Investigations and Resolutions staff, CPSO legal counsel, and project coordinator.

- In April 2016, the Premises Inspection Committee reviewed the draft OHPIP Standards, and provided the following feedback:

    - Members considered the issue of the "mismatch" between a Medical Director's qualifications/scope of practice and the services provided in the OHP(s) that he or she oversees, which can result in lack of understanding of the quality of care issues that might be encountered in the premises. It was acknowledged that some OHPs provide multiple services so it would be impractical to require the Medical Director to be qualified to practise in all of the OHP's service areas. Also, it was noted that under the proposed changes, Medical Directors can appoint other individuals in their OHPs to assist with monitoring and reporting on the quality of procedures.

    - The Committee also provided comments related to wording that could be modified for greater clarity in some areas of the document. These suggestions have been incorporated into the draft document.

CURRENT STATUS:

- The Working Group is proposing a number of changes to the OHPIP Standards that aim to address the various accountability concerns. The proposed changes are limited to Sections 2 (OHP Background), Section 5 (OHP Staff Qualifications), Section 7 (Infection Control), and Section 8 (Quality Assurance), and are summarized in 'Appendix A'.

- For comparison purposes, current versions of Sections 2, 5 7, and 8 of the OHPIP Standards are also provided ('Appendix B').

- In addition to re-numbering certain sections/subsections, removing redundancies, and re-locating some content, the following are the key changes (which correspond to the shaded text in 'Appendix A'):

  Section 2: OHP Background

  - The "Medical Director Responsibilities" subsection was modified to include the new concept of an "Acting Medical Director". In particular:

    - An Acting Medical Director (when appointed) would take on all the same responsibilities as the Medical Director - with the exception of Section 8 (Quality Assurance), which cannot be assigned by the Medical Director to another individual.

    - Timeframe for a Medical Director to respond to adverse events, and regular CPSO requests was added, along with the notion that *"*Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee*".*

  - A new subsection "Appointment of Acting Medical Director" was added to address the issue of absenteeism. Of particular note:

    - If the Medical Director is unable, or unavailable to perform his or her duties, then he or she must appoint an Acting Medical Director who is acceptable to the CPSO; this individual must sign an agreement which details the full scope of his or her responsibilities.

    - If the CPSO determines that a Medical Director (or Acting Medical Director) is not performing his or her duties, the CPSO may require the Medical Director to appoint an Acting Medical Director acceptable to the CPSO, or take other steps as deemed necessary.

    - The Medical Director must notify the CPSO of any changes to the Medical Director role within 48 hours of the change.

  - A new Annual Declaration of Responsibilities is to be signed by the Medical Director, and is aimed, in part, at corporate ownership situations where a single Medical Director is overseeing many premises, i.e. to remind Medical Directors of the full scope of their duties.

- With regard to OHP policies and procedures, the Medical Director is now not only responsible for reviewing and updating, but also ensuring implementation of said policies and procedures at the OHP.
    - Under procedures, there is now a requirement that all OHPs have detailed and clear patient selection/admission/exclusion criteria.

Section 5: OHP Staff Qualifications

- All staff who administer sedation, regional anesthesia, or general anesthesia; or who monitor or recover such patients must maintain a current ACLS certification – this requirement previously excluded anesthesiologists who are Royal College certified.
- New wording has been added that would preclude a physician with disciplinary or incapacity proceeding to become a Medical Director, as well as the onus on the physician to self-report should this happen in the course of serving in the Medical Director role.
- Nurse qualifications have been clarified to state that only RNs are required to have current ACLS if administering sedation to, monitoring or recovering patients.
- The CPSO is now named as a contact for OHP staff to obtain an approved list of education and training courses in the areas of sterilization and reprocessing.

Section 7: Infection Control

- Additional wording was added to emphasize Medical Directors' responsibility for ensuring implementation of and compliance with infection control requirements by all physicians and staff of the OHP. This includes periodic reviews of the CPSO and Public Health Ontario website documents by the Medical Director, staff, and physicians working in the OHP.

Section 8: Quality Assurance (QA)

- The Medical Director's responsibility for OHP compliance with all regulatory requirements (Acts, OHPIP Standards, Companion documents to Standards, and other provincial guidelines) as well as policies, guidelines, and OHP policies and procedures manual has been emphasized.
- Recognizing that a Medical Director may not necessarily be qualified to provide services or opine on quality of services in the OHPs that he or she oversees, the Medical Director may "appoint other individuals as

necessary to assist" with monitoring and reporting on the quality of anesthetic and surgical procedures.

- A new requirement that the Medical Director must attend and chair a minimum of two Quality Assurance (QA) Committee meetings per year at each OHP has been added, along with a minimum list of standard topics to be included on every QA agenda.
- Changes were made such that members who do not document Tier 2 events and submit them annually to the College may receive a Fail outcome by the Premises Inspections Committee.

CONSIDERATIONS:

- As part of its deliberations, the Working Group considered the following background materials:
    - The current section of the OHPIP Standards re: Medical Director Responsibilities
    - IHF Quality Advisor role (Appendix C) - The Independent Health Facilities Program (IHFP) requires the role of a Quality Advisor for each IHF. Note that one of the requirements for the quality advisor in the IHFA that differs from the role of the medical director in an OHP is specific to qualifications related to the procedures performed at the facility. OHPIP does not require that the medical director be qualified to perform the procedures in the OHP.
    - Medical Director role descriptions from other Canadian medical regulatory authorities, as well as other related information from Canada:
        - BC's current Medical Director role & BC's proposed Medical Director role
        - BC's Diagnostic Accreditation Program Manitoba's Medical Director role
        - Saskatchewan's Medical Director role

Next Steps

- If Council supports the updates made to the OHPIP Standards, the document will be released for external consultation.

May 2016

DECISION FOR COUNCIL:

Council is being provided with the draft OHPIP Standards, and is being asked whether the document can be released for external consultation.

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DATE: April 27, 2016

Appendices:
Appendix A: **DRAFT** OHPIP Standards dated April 15, 2016 – Changes to Sections 2, 5, 7, and 8
Appendix B: **Current** OHPIP Standards - Sections 2, 5, 7, and 8
Appendix C: Role of the IHF Quality Advisor

2 OHP Background

In April 2010, Regulation 114/94 provided a 60-day window for all CPSO members performing or assisting in procedures in Out-of-Hospital Premises (OHPs) to notify the College. By June 2012, all premises that existed prior to June 2010 had their inspection-assessment completed. New premises or relocating premises continue to be inspected within 180 days of notification.

Ontario Regulation 114/94[1], made under the **Medicine Act**, 1991 is amended by adding the following: **Part XI: Inspection of Premises and Equipment**.

Out-of-Hospital Premises (OHP) means any non-hospital site at which a physician engages or proposes to engage in:

(a) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed under the administration of,
  (i) general anesthesia,
  (ii) parenteral sedation, or
  (iii) regional anesthesia, except for a digital nerve block; and,

(b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to,
  (i) any tumescent procedure involving the administration of dilute, local anesthetic;
  (ii) surgical alteration or excision of any lesions or tissue performed for cosmetic purposes,
  (iii) injection or insertion of any permanent filler, autologous tissue, synthetic device, materials or substances for cosmetic purposes;
  (iv) a nerve block solely for the treatment or management of chronic pain; or
  (v) any act that, in the opinion of the College, is similar in nature to those set out in subclauses (i) to (iii) and that is performed for a cosmetic purpose;

but does not include,

(c) surgical alteration or excision of lesions or tissue for a clinical purpose, including for the purpose of examination, treatment or diagnosis of disease, or

(d) minor dermatological procedures including without being limited to, the removal of skin tags, benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangioma and neurofibromata.

[1] Please refer to Appendix 1 for a complete reference to the Regulation.

2.1 CPSO Responsibilities

CPSO is responsible to consider all issues related to the provision of anesthesia/sedation and procedural services within OHPs. The Out-of-Hospital Premises Inspection Program is overseen by the Premises Inspection Committee.

CPSO responsibilities include but are not limited to:

1) developing and maintaining "OHP Standards"
2) conducting inspection-assessments of the premises and medical procedures to ensure that services for patients are provided according to the standard of the profession
3) determining the outcome of inspection-assessments
4) maintaining a current public record of Inspection Outcomes (on the CPSO website).

2.1.1 Maintaining the "OHP Standards"

CPSO:

1) reviews the "OHP Standards" within a five year cycle, or as required, at the discretion of the Premises Inspection Committee
2) prepares revisions of the Standards and associated inspection-assessment tools
3) coordinates approval of revisions through an established external review process
4) makes revisions available to all relevant parties
5) issues notices for payment of OHP fees.

2.1.2 Conducting the Inspection-Assessment

1. **Timeframe:** The timeframe for conducting the inspection-assessment differs for new and existing OHPs.

For:	**Inspection-assessment conducted:**
CPSO members *planning* to use a premises for the purpose of performing procedures as defined by O. Reg. 114/94	within 180 days of CPSO receiving the CPSO member's notice

2. **Process**: The inspection-assessment may involve but is not limited to:
   1) completion of the on-line notification process
   2) completion of a pre-visit visit questionnaire
   3) a site visit by a team of healthcare professionals including one or more physicians (with expertise in the appropriate area of medical practice) appointed by CPSO that includes:
      - a review of records and other documentation
      - observation of procedures performed at the OHP
      - review of the OHP's compliance with accepted standards
      - review of any other material deemed relevant to the inspection-assessment
   4) enquiries as may be relevant.

3. **Reports:** OHP assessors provide OHP inspection-assessment reports to CPSO; the CPSO provides a copy of the inspection-assessment report to all members performing procedures in the OHP.

2.1.3 Determining the Outcome of the Inspection-Assessment

1. The **Premises Inspection Committee** is responsible, as outlined in the Ontario Regulation 114/94, for determining the inspection-assessment outcome; see Table 01.

Table 01: Inspection-Assessment Outcomes

Note: Deficiency is anything that can negatively impact the safe and effective provision of medical services for patients.

Outcome	Comments
Pass	"OHP Standards" are met for the specific procedures identified by the OHP at the time of the inspection-assessment; no deficiencies are identified. Note: If a "passed" OHP wishes to add procedures, CPSO must be notified of the intent and conduct an inspection before the new procedures may be performed.
Pass with Conditions	Deficiencies are identified. 1) The OHP may be restricted to specific procedures. 2) The OHP may make submissions in writing to CPSO within 14 days of receiving the report. 3) A follow-up inspection-assessment may be conducted at CPSO's discretion within 60 days of receiving the OHP written submission. 4) A "Pass" will be assigned when deficiencies have been corrected to CPSO's satisfaction.
Fail	Significant deficiencies are identified. 1) The CPSO member(s) cease(s) performance of all procedures. 2) The OHP may make submissions in writing to CPSO within 14 days of receiving the report. 3) A follow-up inspection-assessment may be conducted at CPSO's discretion within 60 days of receiving the OHP written submission. 4) A "Pass" or "Conditional Pass" will be assigned when deficiencies have been corrected to CPSO's satisfaction.

2. "Pass" and "Pass with Conditions" outcomes are considered current to a maximum of five years from the date of outcome, but inspections can occur more often if, in CPSO's opinion, it is necessary or advisable to do so.

2.2 Medical Director Responsibilities

In addition to all of the duties described in this section, the Medical Director is also responsible for Infection Control (Chapter 7), and Quality Assurance (Chapter 8).

Note: With the exception of Section 8 (Quality Assurance), whenever the term "Medical Director" is used in the Standards, the term "Acting Medical Director" applies in the event that the OHP is being operated by a physician other than the Medical Director (Refer to section 2.2.3).

2.2.1 Notification to Operate a New OHP

Notification by a Medical Director planning to operate a new OHP shall be made to the CPSO. Notification is accessed through the Member's Portal log-in on the CPSO website at https://www.cpso.on.ca/Login.aspx

All physicians planning to work in an OHP must complete the online Staff Affiliation form by logging in to their membership account on the College Website. Upon completion of the form, an email will be sent to confirm the notification was sent. College staff will review and email the physician when the notification is approved. A copy of this approval email should be shared with the Medical Director prior to performing procedures in an OHP.

2.2.2 Inspection-Assessment Process

The **Medical Director** must inform patient(s) prior to the scheduled inspection-assessment that an observation of the procedure may be a component of the inspection-assessment process.

The **Medical Director** is the main contact for any information related to the premises. Any reports pertaining to the inspection-assessment of an OHP are directed to the Medical Director for review and response. The **Medical Director** must respond to CPSO requests for documentation in the form and timeframe required, as follows:

- Within 24 hours for adverse events (as indicated in College By-law No. 77)
- Within 14 days for regular CPSO requests

Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee.

The **Medical Director** must ensure that patient records are established and maintained, are accurate, legible, complete, follow a consistent format, meet legislative requirements and adhere to the CPSO *Medical Records* policy; a patient record shall include, but is not limited to:

a) Consent form(s) for the procedure and anesthetic signed by the patient or substitute decision maker/legal guardian and witnessed
b) Pre-procedure assessment
c) "Surgical Safety Checklist" – a modified surgical safety checklist is required for endoscopy premises.
d) "Anesthetic/sedation Record"
e) Notes about procedural care
f) Notes about post-procedure care
g) Adverse event reports as required by CPSO.

The **Medical Director** must ensure that complete records are onsite on the date of the inspection-assessment. In carrying out an inspection of a premises under the regulation, the College may require any or all of the following: Examination and copying of books, accounts, reports, records or similar documents that are, in the opinion of the College, relevant to the performance of a procedure in the practice of the member.

2.2.3 Appointment of Acting Medical Director

In the event the Medical Director is unable or unavailable to perform all of his or her duties due to illness, leave, or other circumstance, then the OHP Medical Director must appoint an Acting Medical Director who is acceptable to the CPSO. An agreement must be signed by the Acting OHP Medical Director that articulates all responsibilities, with emphasis on the need to respond to CPSO requests for documentation in the form and timeframe required, as follows:

- Within 24 hours for adverse events (as indicated in College By-law No. 77)
- Within 14 days for standard CPSO requests

In general, the CPSO encourages Medical Directors to make prior arrangements that identify Acting Medical Director(s) at each of their premises to ensure systematic coverage during absences.

Failure to provide the information may result in an outcome of Fail by the Premises Inspection Committee, which means that the premises can no longer provide the services under the OHPIP regulation.

All staff working at the OHP must be notified in the event an Acting Medical Director is appointed.

In addition, any change to the Medical Director must be reported to the CPSO (see 2.2.4 “Notification of Changes to OHP”) within 48 hours of the change.

All of the above applies with such modifications as are necessary in the event that the Acting Medical Director is unable or unavailable to perform his or her duties due to illness, leave, or other circumstance.

The Medical Director/Acting Medical Director is professionally accountable for fulfilling all of their obligations and duties to the OHP and the CPSO. In the event that the CPSO determines that the Medical Director or Acting Medical Director is not performing his or her duties in accordance with the legislation, regulations, and policies, the CPSO can require the OHP Medical Director to appoint an Acting Medical Director acceptable to the CPSO and/or take such other steps as deemed necessary.

2.2.4 Notification OHP changes to the CPSO

The **Medical Director** must notify the CPSO forthwith in writing of any OHP changes with regard to the following:

a) Ownership of the medical practice
b) OHP Medical Director (within 48 hours of change)
c) Name and/or address of the OHP
d) Structural changes to patient care areas
e) Types of procedures or practices

f) Physicians performing procedures or administering anesthesia (additions/deletions)
g) Numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment)
h) there is a new arrangement to rent space to other physicians for the performance of any surgical or anesthetic technique covered by the OHP policy and procedures.
i) If overnight stays are permitted
j) Decision to cease operation of the OHP.

2.2.5 Annual Declaration of Responsibilities

The **Medical Director** must review, and sign an annual declaration of his/her responsibilities, which will include agreement to:

- perform his or her duties with due diligence and in good faith;
- ensure that the OHP meets its responsibilities;
- attend and chair QA Committee meetings at the OHP at a minimum of twice per year;
- ensure staff qualifications are current;
- ensure policies and procedures are reviewed and updated when necessary, and in accordance with relevant standards and guidelines including, but not limited to, the CPSO OHPIP Standards, updates to the Provincial Infectious Diseases Advisory Committee's (PIDAC) Infection Prevention and Control for Clinical Office Practice, Malignant Hyperthermia Association of the United States (MHAUS), etc.

2.2.6 OHP Policies and Procedures

The Medical Director is responsible for the regular review, update, and implementation of OHP policies and procedures, which must address the following areas:

2.2.6.1 Administrative:

a) responsibility for developing and maintaining the policy and procedure manual
b) organizational chart
c) scope and limitations of OHP services provided
d) overnight stays, if applicable.
e) ensuring that records are kept for each RHP working in the OHP are current and include qualifications, relevant experience, and relevant hospital privileges as appropriate to the RHP.
f) ensuring all physicians performing OHP procedures at the premises have provided online notification to satisfy the regulation requirements (see section 2.2.1), and documentation verifying approval (emails from College staff) is on file.

2.2.6.2 General Response to Emergencies:

Each OHP shall have a policy on management of relevant emergency situations, including, but not limited to:

a) need to summon additional staff assistance urgently within the OHP
b) fire
c) power failure
d) other emergency evacuation
e) need to summon help by 911, and coordination of OHP staff with those responders.

2.2.6.3 Urgent Transfer of Patients:

The OHP must have an established procedure to facilitate the urgent transfer of patients to the most appropriate acute-care hospital for the management of an urgent- adverse patient event; it should include the following:

a) The patient must be transferred by appropriate transportation service; in most situations this would mandate transfer by ambulance
b) ~~A regulated health professional staff member should accompany the patient during the transfer~~
c) The most-responsible physician (MRP) ensures that essential medical information is sent with the patient (e.g., pre-op history, ECG strips, OR record, anesthesia record, consultation note); however, this information must not delay transfer
d) The MRP, if not accompanying the patient, must contact the receiving physician/premises immediately, by phone or in person. No other means of communication will be deemed sufficient
e) If the MRP refers the patient to *1)* a specialist or *2)* other physician, the MRP must contact the specialist/other physician, by phone or in person, to ensure continuity of care.
f) The MRP must complete an adverse event report (see Section 8.1.2).

2.2.6.4 Job Descriptions:

a) OHP staff job descriptions that define scope and limitations of functions and responsibilities for patient care
b) responsibility for supervising staff.

2.2.6.5 Procedures:

a) Adverse events: monitoring, reporting, and reviewing
b) Adverse events: response to an adverse event
c) Combustible and Volatile Materials
d) Delegating controlled acts
e) ~~Emergency evacuation~~
f) Equipment: routine maintenance and calibration
g) Infection control, including staff responsibilities in relation to the *Occupational Health and Safety Act*
h) Medications handling and inventory
i) Medical Directives
j) Patient booking system
k) Detailed and clear patient selection/admission/exclusion criteria for services provided at the OHP
l) Patient consent (written or verbal) based on the scope of the OHP practice
m) Patient Preparation for OHP procedures
n) Response to Latex Allergies

o) Safety precautions regarding electrical, mechanical, fire, and internal disaster.
p) Urgent transfer of patients (see Section 6.5)
q) Waste and garbage disposal

2.2.6.6 Forms used

2.2.6.7 Inventories/Lists of equipment to be maintained

2.2.6.8 External (non-OHP) policies: as determined to be necessary by each OHP.

2. The **Medical Director** shall ensure that all staff:
a) read the P&P manual upon being hired, and confirm action with signature and date
b) review the P&P manual annually, and confirm action with signature and date
c) read their individual job descriptions of duties and responsibilities, and sign and date, indicating they have been read and understood.

3. The Medical Director is responsible for ensuring that OHP staff who are members of regulated health professions have adequate insurance in place, e.g., Directors & Officers, Errors & Omissions, and general liability. Physicians need to have professional liability protection in accordance with CPSO bylaws.

5 OHP Staff Qualifications

1. It is expected that physicians will manage medical and surgical conditions within the scope of their specialty training, certification and experience.
2. All staff ~~other than anesthesiologists who are Royal College certified~~: 1) who administer sedation, regional anesthesia, or general anesthesia; or 2) who monitor or recover such patients; must maintain a current ACLS certification.
   Note: Basic (BLS), advanced (ACLS) or paediatric (PALS) life-saving training, as referenced in these standards, includes certification in both theory and hands-on components[3].
3. If services are provided to infants and children, staff must be trained to handle paediatric emergencies and maintain a current PALS certification.
4. Physicians who do not meet OHP Physician Qualification standards must successfully complete a Change in Scope of Practice application process, which may include the necessity to demonstrate education, training, and/or competency in the area of practice. This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.
5. Qualifications of all regulated health professionals (RHPs) must meet requirements of their respective regulatory college, and they must practice within their scope of practice.

Note: Change in Scope of Practice. For any Change in Scope of Practice requests from physicians that involve procedures or anesthetic in Out-of-Hospital Premises, the College's Quality Assurance Committee will provide oversight to the decision regarding the suitability of the request. The College may (based on the nature of the request) establish training and supervision requirements that must be completed before a final assessment is conducted to formally approve the physician in his/her new scope of practice.

5.1 OHP Medical Director Qualifications

The Medical Director must hold a valid CPSO certificate of registration and must ***not*** be the subject of any disciplinary or incapacity proceeding.

If, during the course of serving as a Medical Director, the Medical Director becomes the subject of a disciplinary or incapacity proceeding, the Medical Director must inform the Out-of-Hospital Premises program staff at the CPSO, and appoint a substitute Medical Director. The Medical Director may only resume the role upon CPSO approval.

The OHP must have a Medical Director appointed at all times. Failure to have an appointed Medical Director will result in an outcome of Fail.

5.2 Physician Performing Procedures Qualifications

All physicians who perform procedures using local anesthesia in OHPs, as set out in O. Reg. 114/94, shall hold:

1) Valid CPSO certificate of registration
   and

2) **One** of the following:
   a) RCPSC or CFPC certification that confirms training and specialty designation pertinent to the procedures performed.
   b) CPSO recognition as a specialist that would include, by training and experience, the procedures performed (as confirmed by the CPSO "Specialist Recognition Criteria in Ontario" policy).
   c) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Physician Administering Anesthesia Qualifications

5.3 Physicians Administering General Anesthesia

Physicians administering general anesthesia shall hold:

1) Valid CPSO certificate of registration
   and
2) RCPSC designation as a specialist in anesthesia **OR one** of the following:
   a) Completion of a 12-month rotation in a program accredited by the College of Family Physicians of Canada (CFPC) under the category of "Family Medicine Anesthesia".
   b) CPSO recognition as a specialist in anesthesia as confirmed by CPSO "Specialist Recognition Criteria in Ontario" policy.
   c) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

5.4 Physicians Administering Regional Anesthesia

Physicians administering regional anesthesia shall hold:

1) Valid CPSO certificate of registration
   and
2) **One** of the following:
   a) RCPSC designation as a specialist in anesthesia.
   b) Completion of a 12-month rotation in a program accredited by the College of Family Physicians of Canada (CFPC) under the category of "Family Medicine Anesthesia".

c) CPSO recognition as a specialist in anesthesia, or other specialty pertinent to the regional anesthesia performed, as confirmed by CPSO "Specialist Recognition Criteria in Ontario" policy.

d) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

5.5 Physicians Administering Sedation

1. Physicians qualified for administering general anesthesia are considered qualified to administer deep sedation.

2. Physicians administering deep sedation must hold 1) qualifications to administer general anesthesia (Section 5.3.1) or 2) approval according to CPSO policy, *Changing Scope of Practice*.

3. Physicians ***not*** qualified for administering general anesthesia or deep sedation, but administering minimal-to-moderate sedation, shall hold:

   a) Valid CPSO certificate of registration
   b) Education and experience to manage the potential medical complications of sedation/anesthesia, including ability to 1) identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia, 2) assist in the management of complications, and 3) understand the pharmacology of the drugs used, and
   c) Current ACLS certification, and PALS certification if providing care for patients fourteen (14) years and younger.

5.6 Nurse Qualifications

1. Registered nurses (RNs) and registered practical nurses (RPNs) working within their scope of practice in OHPs must hold:
   a) current registration with the College of Nurses of Ontario
   b) additional training and appropriate experience as required for procedures performed
   c) current BLS certification
   d) must have current ACLS if administering sedation to, monitoring or recovering patients (RNs only).

2. Registered Nurses (RNs) working with a pediatric population (14 years and younger), who are involved in monitoring, administering sedation or recovering patients must maintain a current PALS certification.

5.7 Other Staff Qualifications

Staff from other regulated health professions must be adequately trained and registered with their regulatory body.

Staff responsible for the sterilization and reprocessing of medical equipment must be adequately educated and trained. Please contact the College for an approved list of courses specific to reprocessing and sterilization in an OHP.

7 Infection Control

The CPSO, in partnership with Public Health Ontario (PHO), have developed accepted standards of practice for OHPs and physician offices for infection control. The document can be found at the following link: www.publichealthontario.ca/ClinicalPractice

The Medical Director is responsible for compliance with the requirements set out in the Provincial Infectious Diseases Advisory Committee (PIDAC) document. He or she is also responsible for ensuring periodic reviews of the CPSO and PHO website documents by the Medical Director, staff and physicians working in the OHP. All OHP staff, including the Medical Director must stay current with standards for infection prevention and control. The Medical Director is responsible for ensuring implementation and compliance by all physicians and staff of the OHP with the PHO requirements.

OHPs shall adhere to the following:

1) Accepted standard(s) of infection control practices that are pertinent to the specific procedures performed at the OHP.

2) The *Routine Practice* approach to infection control. According to the concept of Routine Practices, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

3) Actions that minimize risk of infection in the operating room:
   a) adherence to proper use of disinfectants
   b) proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors)
   c) proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms)
   d) prompt management of water intrusion into OHP structural elements.

4) Accepted standards of handling regulated waste.
   "Regulated Waste" means:
   a) liquid or semi-liquid or other potential infectious material
   b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed
   c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling
   d) contaminated sharps
   e) pathological and microbiological wastes containing blood or other potentially infectious materials.

8 Quality Assurance (QA)

The Medical Director is responsible for OHP compliance with external regulatory requirements including all Acts relevant to the practise of Medicine[1], including the CPSO OHP Standards, Companion documents to the Standards, and other guidelines, such as, the Provincial Infectious Diseases Advisory Committee's (PIDAC) *Infection Prevention and Control for Clinical Office Practice*, Malignant Hyperthermia Association of the United States (MHAUS), etc. The Medical Director is also individually responsible for OHP compliance with all internal CPSO policies, guidelines and directives within their Policy and Procedure Manual.

The Medical Director is responsible for appointing other individuals as necessary to **assist** with OHP staff compliance with policies and procedures set out by the Medical Director, especially as it relates to monitoring and reporting on the quality of anesthetic and surgical procedures.

OHP Quality Assurance Committee

Each OHP must have a Quality Assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance so that the care provided will satisfy requirements as appropriate to the volume and scope of service provided.

The Medical Director must attend and chair, at a minimum, two QA Committee meetings at each OHP site, per year. Meetings must include representation from all staff providing patient care for every type of anesthetic or surgical procedure. All meetings must be documented. The documentation of the QA Committee meetings must be available upon request by the Premises Inspection Committee and be available for OHP assessors to review.

At minimum, every QA Committee meeting must address the following topics:
1) Reports on Quality of Care for each service (8.1)
2) Infection Control– duties as set out in Section 7
3) Adverse Events
4) Staffing credentials

8.1 Monitoring Quality of Care

The purpose of monitoring activity is to identify problems and frequency, assess severity, and develop remedial action as required to prevent or mitigate harm from adverse events.

Monitoring OHP Activity

The OHP must have a documented process in place to regularly monitor the quality of care provided to patients. These activities include, but are not limited to, the following:

1) Review of non-medical staff performance
2) Review of individual physician care to assess
   a) patient and procedure selection are appropriate
   b) patient outcomes are appropriate
   c) adverse events (see 8.2)

[1] RHPA, Medicine Act, etc.

The suggested protocol is, annually, random selection of 5-10 patient records to review:

i) record completion and documentation of informed consent
ii) percentage and type of procedures
iii) appropriate patient selection
iv) appropriate patient procedure
v) where required, reporting results in a timely fashion
vi) evaluation of complications (see 8.2)
vii) assessment of transfer to hospital, where required
viii) follow up of abnormal pathology and laboratory results

3) Review a selection of individual patient records to assess completeness and accuracy of entries by all staff
4) Review of activity related to cleaning, sterilization, maintenance, and storage of equipment
5) Documentation of the numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment).

8.2 Monitoring and Reporting Adverse Events

1. All OHP staff must monitor adverse events. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure.

2. Every member who performs a procedure in an OHP shall report the following events to the College within 24 hours of learning of the event. These events are termed 'Tier 1 Events' to denote the potential serious nature of the event and the need to prevent a recurrence.

   Tier 1 events are:
   a) Death within the premises;
   b) Death within ten (10) days of a procedure performed at the premises;
   c) Any procedure performed on the wrong patient, site or side; or,
   d) Transfer of a patient from the premises directly to a hospital for care.

3. Members performing procedures in an OHP are required to document other quality assurance incidents (Tier 2) which are deemed less critical for immediate action. The premises' QA Committee and the Medical Director must submit Tier 2 events to the College after review (on an annual basis). Failure to do so may result in an outcome of Fail by the Premises Inspection Committee.

   Tier 2 events include, but are **not limited to**:
   a) unscheduled treatment of a patient in a hospital within ten(10) days of a procedure performed at a premises
   b) complications such as infection, bleeding or injury to other body structures
   c) cardiac or respiratory problems during the patient's stay at the OHP
   d) allergic reactions
   e) medication-related adverse events

4. All OHP staff should report adverse events as follows:
   4.1 The member must report Tier 1 adverse events (see above) to the Medical Director and to the College in writing within 24 hours of learning of the event using the form provided on the College website. To access the form, the reporting physician must log in to his/her CPSO member portal on the CPSO website at https://www.cpso.on.ca/Login.aspx

4.2 Death occurring within the OHP must also be reported to the coroner.

4.3 The member should report in writing any Tier 2 adverse event (see above) to the Medical Director within 24 hours of the event.
The written report should include the following:
a) name, age, and sex of the person(s) involved in the incident; includes staff and patients
b) name of witness(es) to the event (if applicable)
c) time, date, and location of event
d) description of the incident and treatment rendered
e) date and type of procedure (if applicable)
f) analysis of reasons for the incident
g) outcome.

Note: OHPs should identify and adhere to quality indicators specific to procedures performed in their premises.

8.3 Review of Adverse Events and other QA Monitoring Activities

The Medical Director must:

1) Review all adverse events reports and QA monitoring findings occurring over a 12-month period
2) Document the review and any relevant corrective actions and quality improvement initiatives taken
3) Provide feedback to all staff regarding identified adverse events.

2 OHP Background

In April 2010, Regulation 114/94 provided a 60-day window for all CPSO members performing or assisting in procedures in Out-of-Hospital Premises (OHPs) to notify the College. By June 2012, all premises that existed prior to June 2010 had their inspection-assessment completed. New premises or relocating premises continue to be inspected within 180 days of notification.

Ontario Regulation 114/94[1], made under the **Medicine Act**, 1991 is amended by adding the following: **Part XI: Inspection of Premises and Equipment**.

Out-of-Hospital Premises (OHP) means any non-hospital site at which a physician engages or proposes to engage in:

(a) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed under the administration of,
  (i) general anesthesia,
  (ii) parenteral sedation, or
  (iii) regional anesthesia, except for a digital nerve block; and,

(b) any act that, when performed in accordance with the accepted standard of practice on a patient, is performed with the administration of a local anaesthetic agent, including, but without being limited to,
  (i) any tumescent procedure involving the administration of dilute, local anesthetic;
  (ii) surgical alteration or excision of any lesions or tissue performed for cosmetic purposes,
  (iii) injection or insertion of any permanent filler, autologous tissue, synthetic device, materials or substances for cosmetic purposes;
  (iv) a nerve block solely for the treatment or management of chronic pain; or
  (v) any act that, in the opinion of the College, is similar in nature to those set out in subclauses (i) to (iii) and that is performed for a cosmetic purpose;

but does not include,

(c) surgical alteration or excision of lesions or tissue for a clinical purpose, including for the purpose of examination, treatment or diagnosis of disease, or

(d) minor dermatological procedures including without being limited to, the removal of skin tags, benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangioma and neurofibromata.

[1] Please refer to Appendix 1 for a complete reference to the Regulation.

2.1 CPSO Responsibilities

CPSO is responsible to consider all issues related to the provision of anesthesia/sedation and procedural services within OHPs. The Out-of-Hospital Premises Inspection Program is overseen by the Premises Inspection Committee.

CPSO responsibilities include but are not limited to:

1) developing and maintaining "OHP Standards"
2) conducting inspection-assessments of the premises and medical procedures to ensure that services for patients are provided according to the standard of the profession
3) determining the outcome of inspection-assessments
4) maintaining a current public record of Inspection Outcomes (on the CPSO website).

2.2 Maintaining the "OHP Standards"

CPSO:

1) reviews the "OHP Standards" within a five year cycle, or as required, at the discretion of the Premises Inspection Committee
2) prepares revisions of the Standards and associated inspection-assessment tools
3) coordinates approval of revisions through an established external review process
4) makes revisions available to all relevant parties
5) issues notices for payment of OHP fees.

2.3 Conducting the Inspection-Assessment

1. **Timeframe:** The timeframe for conducting the inspection-assessment differs for new and existing OHPs.

For:	Inspection-assessment conducted:
CPSO members *planning* to use a premises for the purpose of performing procedures as defined by O. Reg. 114/94	within 180 days of CPSO receiving the CPSO member's notice

2. **Process**: The inspection-assessment may involve but is not limited to:
   1) completion of the on-line notification process
   2) completion of a pre-visit visit questionnaire
   3) a site visit by a team of healthcare professionals including one or more physicians (with expertise in the appropriate area of medical practice) appointed by CPSO that includes:
      - a review of records and other documentation
      - observation of procedures performed at the OHP
      - review of the OHP's compliance with accepted standards
      - review of any other material deemed relevant to the inspection-assessment
   4) enquiries as may be relevant.

3. **Reports:** OHP assessors provide OHP inspection-assessment reports to CPSO; the CPSO provides a copy of the inspection-assessment report to all members performing procedures in the OHP.

2.4 Determining the Outcome of the Inspection-Assessment

1. The **Premises Inspection Committee** is responsible, as outlined in the Ontario Regulation 114/94, for determining the inspection-assessment outcome; see Table 01.

Table 01: Inspection-Assessment Outcomes

Note: Deficiency is anything that can negatively impact the safe and effective provision of medical services for patients.

Outcome	Comments
Pass	"OHP Standards" are met for the specific procedures identified by the OHP at the time of the inspection-assessment; no deficiencies are identified. Note: If a "passed" OHP wishes to add procedures, CPSO must be notified of the intent and conduct an inspection before the new procedures may be performed.
Pass with Conditions	Deficiencies are identified. 1) The OHP may be restricted to specific procedures. 2) The OHP may make submissions in writing to CPSO within 14 days of receiving the report. 3) A follow-up inspection-assessment may be conducted at CPSO's discretion within 60 days of receiving the OHP written submission. 4) A "Pass" will be assigned when deficiencies have been corrected to CPSO's satisfaction.
Fail	Significant deficiencies are identified. 1) The CPSO member(s) cease(s) performance of all procedures. 2) The OHP may make submissions in writing to CPSO within 14 days of receiving the report. 3) A follow-up inspection-assessment may be conducted at CPSO's discretion within 60 days of receiving the OHP written submission. 4) A "Pass" or "Conditional Pass" will be assigned when deficiencies have been corrected to CPSO's satisfaction.

2. "Pass" and "Pass with Conditions" outcomes are considered current to a maximum of five years from the date of outcome, but inspections can occur more often if, in CPSO's opinion, it is necessary or advisable to do so.

2.5 Medical Director Responsibilities

The Medical Director is the main contact for any information related to the premises. Any reports pertaining to the inspection-assessment of an OHP are directed to the Medical Director for review and response.

1. The OHP **must appoint a Medical Director** (a physician holding a certificate of registration from CPSO), who, in performing his/her duties with due diligence and in good faith, ensures that the OHP meets its responsibilities, as outlined below. Each OHP must have a Medical Director at all times.

2. The **Medical Director** must ensure that:
   a) Qualifications of all regulated health professionals (RHPs) meet requirements of their respective regulatory bodies, and that they practice within their scope of practice.
   b) Records on each RHP working in the OHP are current and include qualifications, relevant experience, and, relevant hospital privileges as appropriate to the RHP.
   c) All physicians performing OHP procedures at the premises have notified online to satisfy the regulation requirements (see section 2.6). Ensure the collection of copies of the approval emails sent by College staff to the physician notifying to work at the premises.

3. The **Medical Director** must notify CPSO in writing of any OHP changes with regard to the following:
   a) Ownership of the medical practice or OHP Medical Director
   b) Name and/or address of the OHP
   c) Structural changes to patient care areas
   d) Types of procedures or practices
   e) Physicians performing procedures or administering anesthesia (additions/deletions)
   f) Numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment)
   g) If overnight stays are permitted
   h) Decision to cease operation of the OHP.

4. In carrying out an inspection of a premises under the regulation, the College may require any or all of the following: Examination and copying of books, accounts, reports, records or similar documents that are, in the opinion of the College, relevant to the performance of a procedure in the practice of the member.

   The **Medical Director** must ensure that patient records are established and maintained, are accurate, legible, complete, follow a consistent format, meet legislative requirements and adhere to the CPSO *Medical Records* policy; a patient record shall include, but is not limited to:
   a) Consent form(s) for the procedure and anesthetic signed by the patient or substitute decision maker/legal guardian and witnessed
   b) Pre-procedure assessment
   c) "Surgical Safety Checklist" – a modified surgical safety checklist is required for endoscopy premises.
   d) "Anesthetic/sedation Record"
   e) Notes about procedural care
   f) Notes about post-procedure care

g) Adverse event reports as required by CPSO.

The **Medical Director** must ensure that complete records are onsite on the date of the inspection-assessment.

6. The **Medical Director** must provide a Policy and Procedure (P&P) Manual that contains documentation for the following areas.

6.1 Administrative:

a) responsibility for developing and maintaining the policy and procedure manual
b) organizational chart
c) scope and limitations of OHP services provided
d) overnight stays, if applicable.

6.2 General Response to Emergencies:

Each OHP shall have a policy on management of relevant emergency situations, including, but not limited to:

a) need to summon additional staff assistance urgently within the OHP
b) fire
c) power failure
d) other emergency evacuation
e) need to summon help by 911, and coordination of OHP staff with those responders.

6.3 Urgent Transfer of Patients:

The OHP must have an established procedure to facilitate the urgent transfer of patients to the most appropriate acute-care hospital for the management of an urgent- adverse patient outcome; it should include the following:

a) The patient must be transferred by appropriate transportation service; in most situations this would mandate transfer by ambulance
b) A regulated health professional staff member should accompany the patient during the transfer
c) The most-responsible physician (MRP) ensures that essential medical information is sent with the patient (e.g., pre-op history, ECG strips, OR record, anesthesia record, consultation note); however, this information must not delay transfer
d) The MRP, if not accompanying the patient, must contact the receiving physician/premises immediately, by phone or in person. No other means of communication will be deemed sufficient
e) If the MRP refers the patient to *1)* a specialist or *2)* other physician, the MRP must contact the specialist/other physician, by phone or in person, to ensure continuity of care.
f) The MRP must complete an adverse event report (see Section 8.1.2).

6.4 Job Descriptions:

a) OHP staff job descriptions that define scope and limitations of functions and responsibilities for patient care
b) responsibility for supervising staff.

6.5 Procedures:
- a) Adverse events: monitoring, reporting, and reviewing
- b) Adverse events: response to an adverse event
- c) Combustible and Volatile Materials
- d) Delegating controlled acts
- e) Emergency evacuation
- f) Equipment: routine maintenance and calibration
- g) Infection control
- h) Medications handling and inventory
- i) Medical Directives
- j) Patient booking system
- k) Patient consent (written or verbal) based on the scope of the OHP practice
- l) Patient Preparation for OHP procedures
- m) Response to Latex Allergies
- n) Safety precautions regarding electrical, mechanical, fire, and internal disaster.
- o) Urgent transfer of patients (see Section 6.5)
- p) Waste and garbage disposal

6.6 Forms used

6.7 Inventories/Lists of equipment to be maintained

6.8 External (non-OHP) policies: as determined to be necessary by each OHP.

7. The **Medical Director** shall ensure that all staff:
   a) read the P&P manual on hire, and confirm action with signature and date
   b) review the P&P manual annually, and confirm action with signature and date
   c) read their individual job descriptions of duties and responsibilities, and sign and date, indicating they have been read and understood.

8. The **Medical Director** must respond to CPSO requests for documentation in the form and timeframe required.

9. It is strongly recommended that members of regulated health professions providing services in an OHP ensure there is adequate insurance in place, e.g., Directors & Officers, Errors & Omissions, and general liability. Physicians need to have professional liability protection in accordance with CPSO bylaws.

10. The **Medical Director** must inform CPSO if he/she is renting space to other physicians for the performance of OHP procedures and/or the administration of sedation/anesthesia/nerve blocks.

11. The **Medical Director** should inform patient(s) prior to the scheduled inspection-assessment that an observation of the procedure is a component of the inspection-assessment.

2.6 Notification to Operate a New OHP

Notification by a Medical Director planning to operate a new OHP shall be made to the CPSO. Notification is accessed through the Member's Portal log-in on the CPSO website at https://www.cpso.on.ca/Login.aspx

All physicians planning to work in an OHP must complete the online Staff Affiliation form by logging in to their membership account on the College Website. Upon completion of the form, an email will be sent to confirm the notification was sent. College staff will review and email the physician when the notification is approved. A copy of this approval email should be shared with the Medical Director prior to performing procedures in an OHP.

3 Administration of OHPs

3.1 OHP Levels

The OHP level has two determinants: anesthesia and procedure — the level is decided by the higher ranking of the two, e.g., if the patient is receiving a minor nerve block (level 1) for limited invasive procedure (level 2), the OHP is considered level 2.

Table 02: OHP Levels

OHP Level	Anesthesia	Procedure
OHP Level 1	• Local infiltration • Minor nerve block (e.g. digital) • Tumescent anesthesia < 500cc of infiltrate solution	Minimally Invasive: • No surgical wound is created **and** • Procedure does not interfere with target organ function or general physiological function.
OHP Level 2	• IV Sedation • Regional anesthesia (e.g., major nerve blocks, spinal, epidural, or caudal) • Tumescent anesthesia > 500cc of infiltrate solution	Limited Invasiveness: • Surgical wound is created, but not for the purpose of penetration of a body cavity or viscus (e.g., rhinoplasty, facelift) **and** • Procedure has minimal impact on target organ or general physiological response **and/or** • Liposuction 1 to 1000cc of aspirate **and/or** • A small subcutaneous implant is inserted (e.g. lip, chin)
OHP Level 3	• General anesthesia	Significantly Invasive: • Surgical wound allows access to a body cavity or viscus (e.g., laparoscopic banding surgery, arthroscopy), **OR** • A significant amount of liposuction aspirate is removed (1000 - 5000 cc.) **OR** • A large prosthesis is inserted (e.g., augmentation mammoplasty).

5 OHP Staff Qualifications

1. It is expected that physicians will manage medical and surgical conditions within the scope of their specialty training, certification and experience.
2. All staff other than anesthesiologists who are Royal College certified: 1) who administer sedation, regional anesthesia, or general anesthesia; or 2) who monitor or recover such patients; must maintain a current ACLS certification.
   Note: Basic (BLS), advanced (ACLS) or paediatric (PALS) life-saving training, as referenced in these standards, includes certification in both theory and hands-on components[3].
3. If services are provided to infants and children, staff must be trained to handle paediatric emergencies and maintain a current PALS certification.
4. Physicians who do not meet OHP Physician Qualification standards must successfully complete a Change in Scope of Practice application process, which may include the necessity to demonstrate education, training, and/or competency in the area of practice. This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Note: Change in Scope of Practice. For any Change in Scope of Practice requests from physicians that involve procedures or anesthetic in Out-of-Hospital Premises, the College's Quality Assurance Committee will provide oversight to the decision regarding the suitability of the request. The College may (based on the nature of the request) establish training and supervision requirements that must be completed before a final assessment is conducted to formally approve the physician in his/her new scope of practice.

5.1 OHP Medical Director Qualifications

The Medical Director must hold a valid CPSO certificate of registration.

5.2 Physician Performing Procedures Qualifications

All physicians who perform procedures using local anesthesia in OHPs, as set out in O. Reg. 114/94, shall hold:

1) Valid CPSO certificate of registration
   and
2) **One** of the following:
   a) RCPSC or CFPC certification that confirms training and specialty designation pertinent to the procedures performed.
   b) CPSO recognition as a specialist that would include, by training and experience, the procedures performed (as confirmed by the CPSO "Recognition of Non- Family Medicine Specialists" po licy) .

[3] To identify training courses, contact the Heart and Stroke Foundation of Ontario.

c) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on the CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

Physician Administering Anesthesia Qualifications

5.3 Physicians Administering General Anesthesia

Physicians administering general anesthesia shall hold:

1) Valid CPSO certificate of registration
   and
2) RCPSC designation as a specialist in anesthesia **OR one** of the following:
   a) Completion of a 12-month rotation in a program accredited by the College of Family Physicians of Canada (CFPC) under the category of "Family Medicine Anesthesia".
   b) CPSO recognition as a specialist in anesthesia as confirmed by CPSO "Specialist Recognition Criteria in Ontario" policy.
   c) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

5.4 Physicians Administering Regional Anesthesia

Physicians administering regional anesthesia shall hold:

1) Valid CPSO certificate of registration
   and
2) **One** of the following:
   a) RCPSC designation as a specialist in anesthesia.
   b) Completion of a 12-month rotation in a program accredited by the College of Family Physicians of Canada (CFPC) under the category of "Family Medicine Anesthesia".
   c) CPSO recognition as a specialist in anesthesia, or other specialty pertinent to the regional anesthesia performed, as confirmed by CPSO "Specialist Recognition Criteria in Ontario" policy.
   d) Satisfactory completion of all CPSO requirements for a physician requesting a change in their scope of practice (based on CPSO policy, *Changing Scope of Practice*). This may include physicians who are currently engaged in a CPSO approved change in scope of practice process.

5.5 Physicians Administering Sedation

1. Physicians qualified for administering general anesthesia are considered qualified to administer deep sedation.

2. Physicians administering deep sedation must hold 1) qualifications to administer general anesthesia (Section 5.3.1) or 2) approval according to CPSO policy, *Changing Scope of Practice*.

3. Physicians ***not*** qualified for administering general anesthesia or deep sedation, but administering minimal-to-moderate sedation, shall hold:

   a) Valid CPSO certificate of registration
   b) Education and experience to manage the potential medical complications of sedation/anesthesia, including ability to 1) identify and manage the airway and cardiovascular changes which occur in a patient who enters a state of general anesthesia, 2) assist in the management of complications, and 3) understand the pharmacology of the drugs used, and
   c) Current ACLS certification, and PALS certification if providing care for patients fourteen (14) years and younger.

5.6 Nurse Qualifications

1. Registered nurses (RNs) and registered practical nurses (RPNs) working within their scope of practice in OHPs must hold:
   a) current registration with the College of Nurses of Ontario
   b) additional training and appropriate experience as required for procedures performed
   c) current BLS certification
   d) must have current ACLS if administering sedation to, monitoring or recovering patients.

2. Registered Nurses (RNs) working with a pediatric population (14 years and younger), who are involved in monitoring, administering sedation or recovering patients must maintain a current PALS certification.

5.7 Other Staff Qualifications

Staff from other regulated health professions must be adequately trained and registered with their regulatory body.

Staff responsible for sterilization and reprocessing must be adequately trained and certified.

7 Infection Control

The CPSO, in partnership with Public Health Ontario (PHO), have developed accepted standards of practice for OHPs and physician offices for infection control. The document can be found at the following link: www.publichealthontario.ca/ClinicalPractice

Medical Directors should consult the specific section of the PHO website for the following information, which form part of the OHP standards expectations. Medical Directors are responsible to ensure periodic reviews of the CPSO and PHO website documents to stay current with standards for infection prevention and control, and ensure compliance with these recommendations.

OHPs shall adhere to the following:

1) Accepted standard(s) of infection control practices that are pertinent to the specific procedures performed at the OHP.

2) The *Routine Practice* approach to infection control. According to the concept of Routine Practices, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

3) Actions that minimize risk of infection in the operating room:
   a) adherence to proper use of disinfectants
   b) proper maintenance of medical equipment that uses water (e.g., automated endoscope reprocessors)
   c) proper ventilation standards for specialized care environments (i.e., airborne infection isolation, protective environment, and operating rooms)
   d) prompt management of water intrusion into OHP structural elements.

4) Accepted standards of handling regulated waste.
   "Regulated Waste" means:
   a) liquid or semi-liquid or other potential infectious material
   b) contaminated items that would release blood or other potential infectious materials in a liquid or semi-liquid state are compressed
   c) items that contain dried blood or other potential infectious materials and are capable of releasing these materials during handling
   d) contaminated sharps
   e) pathological and microbiological wastes containing blood or other potentially infectious materials.

8 Quality Assurance (QA)

Each OHP will have a quality assurance (QA) committee for the purpose of creating processes to establish standards, monitor activity, and improve performance so that the care provided will satisfy requirements as appropriate to the volume and scope of service provided.

The QA Committee will have representation from all staff providing patient care, and hold regular meetings that are documented. The documentation of the QA Committee meetings will be reviewed by the Medical Director, submitted annually to the Premises Inspection Committee and will be available for OHP assessors to review.

8.1 Monitoring Quality of Care

The purpose of monitoring activity is to identify problems and frequency, assess severity, and develop remedial action as required to prevent or mitigate harm from adverse events.

Monitoring OHP Activity

The OHP must have a documented process in place to regularly monitor the quality of care provided to patients. These activities include, but are not limited to, the following:

1) Review of non-medical staff performance
2) Review of individual physician care to assess
   a) patient and procedure selection are appropriate
   b) patient outcomes are appropriate
   c) adverse events (see 8.2)

   The suggested protocol is, annually, random selection of 5-10 patient records to review:

   i) record completion and documentation of informed consent
   ii) percentage and type of procedures
   iii) appropriate patient selection
   iv) appropriate patient procedure
   v) where required, reporting results in a timely fashion
   vi) evaluation of complications (see 8.2)
   vii) assessment of transfer to hospital, where required
   viii) follow up of abnormal pathology and laboratory results
3) Review a selection of individual patient records to assess completeness and accuracy of entries by all staff
4) Review of activity related to cleaning, sterilization, maintenance, and storage of equipment
5) Documentation of the numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment).

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1. All OHP staff must monitor adverse events. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure.

2. Every member who performs a procedure in an OHP shall report the following events to the College within 24 hours of learning of the event. These events are termed 'Tier 1 Events' to denote the potential serious nature of the event and the need to prevent a recurrence.

   Tier 1 events are:
   a) Death within the premises;
   b) Death within ten (10) days of a procedure performed at the premises;
   c) Any procedure performed on the wrong patient, site or side; or,
   d) Transfer of a patient from the premises directly to a hospital for care.

3. Members performing procedures in an OHP are required to document other quality assurance incidents (Tier 2) which are deemed less critical for immediate action. The premises' QA Committee and the Medical Director will submit Tier 2 events to the College after review (on an annual basis).

   Tier 2 events include, but are **not limited to**:
   a) unscheduled treatment of a patient in a hospital within ten(10) days of a procedure performed at a premises
   b) complications such as infection, bleeding or injury to other body structures
   c) cardiac or respiratory problems during the patient's stay at the OHP
   d) allergic reactions
   e) medication-related adverse events

4. All OHP staff should report adverse events as follows:
   4.1 The member must report Tier 1 adverse events (see above) to the Medical Director and to the College in writing within 24 hours of learning of the event using the form provided on the College website. To access the form, the reporting physician must log in to his/her CPSO member portal on the CPSO website at https://www.cpso.on.ca/Login.aspx

   4.2 Death occurring within the OHP should also be reported to the coroner.
   4.3 The member should report in writing any Tier 2 adverse event (see above) to the Medical Director within 24 hours of the event.
   The written report should include the following:
   a) name, age, and sex of the person(s) involved in the incident; includes staff and patients
   b) name of witness(es) to the event (if applicable)
   c) time, date, and location of event
   d) description of the incident and treatment rendered
   e) date and type of procedure (if applicable)
   f) analysis of reasons for the incident
   g) outcome.

Note: OHPs should identify and adhere to quality indicators specific to procedures performed in their premises.

8.3 Review of Adverse Events and other QA Monitoring Activities

The Medical Director should:

1) Review all adverse events reports and QA monitoring findings occurring over a 12-month period
2) Document the review and any relevant corrective actions and quality improvement initiatives taken
3) Provide feedback to all staff regarding identified adverse events.

Role of the Quality Advisor

As outlined in the IHF Regulations "Every licensee shall appoint a Quality Advisor to advise the licensee with respect to the quality and standards of services provided in the independent health facility".

Every Quality Advisor shall:

- Be FRCP or FRCS qualified (or equivalent) with similar privileges for endoscopy in a hospital or whose training enables him/her to advise the licensee on matters pertaining to standards or quality of care.
- Be appointed by the licensee to advise on issues of quality and standards of endoscopic care in the IHF
- Seek advice from other health professionals where necessary to ensure that all aspects of the services provided through the IHF are provided in accordance with generally accepted professional standards.
- Chair the Quality Advisory Committee at least semi-annually if the IHF has more than six full-time staff equivalents including the Quality Advisor, otherwise at least annually, and to document the substance of the discussion, the actions agreed upon and the completion date for any actions agreed upon.

The Quality Advisor shall advise the facility licensee and document this advice concerning the following:

- Qualifications, selection and ongoing education of the professional and technical staff working in the independent health facility.
- Whether adequate and appropriate staffing, equipment and procedures are available to ensure patient and staff safety in the independent health facility.
- Testing being performed on a periodic basis to ensure the accuracy and reliability of the independent health facility's equipment
- Proper design of consultation requests, performance protocols, documentation and reports used at the independent health facility.
- Development and maintenance of a quality assurance program for the facility.

Every licensee shall have a written agreement with the Quality Advisor requiring and authorizing the Quality Advisor to fulfill the requirements as set out above.

Note: Whenever the Quality Advisor has reasonable grounds to believe the conduct of the endoscopy services might jeopardize the safety of patients or the proper performance of services and where, in the judgment of the Quality Advisor, he or she is constrained from correcting the perceived deficiencies by actions taken or not taken by the licensee, then the Quality Advisor reports those concerns in writing to the Director, Independent Health Facilities as required by the Regulations under the Independent Health Facilities Act.

It is understood that the sections above do not in any manner remove from the licensee or impose upon the Quality Advisor the obligation or responsibility for operating the facility; it being understood that the Quality Advisor's sole responsibility is to provide advice to the licensee on the matters specified.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: ***Compensation of Public Members***

FOR DECISION

ISSUE:

- Ensuring that the College's public Council members are compensated fairly and equitably has been a longstanding College concern as well as a regular topic of discussion with government.

- Although there have been recent improvements in the application of the per diem and the administration of claims, the government has indicated that it is not willing to increase the per diem of public members.

- In addition to the question of fair compensation, there is also the issue of a significant difference in the public and physician Council members' per diem.

- The College is not permitted to pay or top up the public member per diem under existing legislation.

- Council is asked to consider:

    1) Whether the College should proceed with a formal request for legislative change that would permit the College to fund or top up the public member per diem and;

    2) Begin to consider the implications of this potential legislative change, from a budget perspective, that could start as early as the 2017 budget year.

BACKGROUND:

<u>Contribution of Public Members</u>

- Both public and physician members of Council provide a public service by regulating the practice of medicine to protect and serve the public.

- All Council members (public and physician) have consistent expectations and responsibilities. Public Council members work alongside physician Council members, making a vital contribution and dedicating a substantial amount of time, effort and expertise as members of the College Council and its

committees. Public members bring the public perspective as board and committee members to facilitate the regulation of Ontario's medical profession.

- The College requires a high level of participation from its public members who are expected to contribute approximately 80 days of service to the College each year. The most active public members contribute up to 150 days.

- Due to the nature of the College's work and public protection mandate, government seeks to attract public members with a wide breadth of expertise from around the province. Our public members have a broad range of educational credentials; develop a high level of medical literacy and an appreciation of jurisprudence. College work is complex, time consuming and requires the utmost discretion.

College advocacy and progress to date

- The College has had three main concerns with the support provided by government to public members of Council: inadequacy of per diem coverage; administration of claims; and per diem rates.

- The College has raised our concerns about these issues for many years through numerous meetings, conversations and correspondence with current and past Ministers of Health, as well as government staff and Health Board Secretariat staff (see Appendix 1 for recent correspondence on this issue).

- Recently, progress has been made in the first two areas.

- The remuneration framework for Ontario's Public Appointees was recently updated and the changes should lead to a broader application of the per diem rate. Most notably, the following changes have been made:
    - Per diem calculation will now be based on a 7.25 hour day, previously it was 7.5 hours.
    - Removal of quarter-day increment calculations. One-half of the established per diem will be paid for work less than three hours and anything above that will receive the full amount.
    - When a meeting finishes early, members will now be remunerated equal to the scheduled duration. Previously, attendance was payable equal to the actual meeting time.
    - When necessary, preparation for Discipline Committee Hearings will now be payable up to one per diem.

- We understand that the timeline of processing claims has been steadily improving.

- Although progress has been made in the first two areas, it is clear that the government is not willing to increase the per diem rate.

- However, we understand that the government may be willing to consider legislative changes to the RHPA and the Health Professions Procedural Code that would allow Colleges to top up public member payment.

- In the May 2015 letter from the Minister of Health to then President, Dr. Marc Gabel, the Minister stated that the Ministry "will review your concerns and consider any appropriate amendments."

Per diem rate

- Public members are compensated at the rate of $150 per day for College work. The per diem rate has not increased in approximately two decades and is not commensurate with the time, responsibility or workload of public members.

- Additionally, there is a significant difference in the public and physician Council members' per diem in spite of the fact that public members have equal responsibility and are expected to meet the same expectations as physician members of Council and College committees.

- It is also important to note that Physician members of Council are paid by the College directly rather than with public funds. As a result, unlike with public member compensation, the College has control of physician per diem.

- One exception to the above noted practices is that public members of the Patient Relations Committee (PRC) are paid the same as the physician members of PRC as both are not members of Council.

Legal considerations

- Section 8 of the Health Professions Procedural Code ("Code") states: "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."

- Further, section 94(1)(h) of the Code provides that Council may make by-laws "providing for the remuneration of the members of the Council and committees **other than persons appointed by the Lieutenant Governor in Council** and for the payment of the expenses of the Council and committees in the conduct of the business". (emphasis added)

- It is clear that compensation of the public members of Council by the College is not permitted under our current legislative regime. A request for legislative

change would have to be put forward and accepted by government in order for the College to contribute to public member compensation.

- Government may soon be "opening up" the Regulated Health Professions Act and this would provide an opportunity to pass the necessary amendments to the Code.

Other considerations

- Although in the regulatory setting most public board members receive their compensation or per diem from government, some regulatory bodies do provide compensation or, top up the per diem. Further, the compensation paid to public members varies widely across organizations with public appointees (see Appendix 2 for more information).

- The Law Society of Upper Canada also has public appointees ("lay benchers") on their governing board. In 2011 the Law Society decided to supplement the amount paid by the government or remunerate work that was not eligible for the government's per diem.

- Other medical regulatory colleges in Canada also provide compensation to their public members. The College of Physicians and Surgeons of British Columbia (CPSBC) compensates their five public members at the same rate as the ten professional members. We understand that Saskatchewan and Alberta also contribute to their public member per diem.

- Given the precedents set by other regulatory bodies and the fact that the government will not be making changes to the per diem rates for public members, the College may wish to consider if there is anything we can do to enhance public member compensation using College funds.

- Finally, the issue regarding the independence of public members may be raised if the College seeks to compensate public members for their College work.

POTENTIAL APPROACHES:

- Should government make the necessary amendments, a range of approaches as to how the College might begin to support public members warrants consideration. If the legislation is amended and the College is granted the ability to either top up or provide government with resources to support public members, the College needs to plan for this and allocate some resources starting as early as the 2017 fiscal year.

- The financial costs associated with supporting public members could be covered in a number of ways including but not limited to: increasing the membership fee; reducing the physician member per diem; or requiring an annual number of days of pro bono work. These are important details that will need to be explored further.

- Initial analysis shows that increasing support to public members could cost the College $180,000 a year up to $965,000. However, these are only initial estimates and more detailed figures would have to be developed.

NEXT STEPS:

- Depending on the direction of Council, proceed with a formal request for legislative change.

DECISIONS FOR COUNCIL:

1. Does Council support the development of a formal request for legislative change that would permit the College to fund or top up the public member per diem?

CONTACT: Louise Verity, ext. 466
Miriam Barna, ext. 557

DATE: May 12, 2016

Appendix 1: Recent correspondence between the College and Minister of Health

Appendix 2: Comparison Chart of Public Member's Per Diem

Ministry of Health
and Long-Term Care

Corporate Services Division

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Fax: 416 314-5915

Ministère de la Santé
et des Soins de longue durée

Division des services ministériels

Édifice Hepburn, 11e étage
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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.

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

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

Carol Leet MD, FRCPC
President

Attachments:

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

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

Ministry of Health
and Long-Term Care

Office of the Minister

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Ministère de la Santé
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Bureau du ministre

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Ontario

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HLTC2966MC-2014-7419

MAY 0 5 2015

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

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

80 College Street,
Toronto, Ontario.
Canada
M5G 2E2
Toll free: (800) 268-7096

From the Office of the President
Telephone: (416) 967-2600 x406
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.

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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

Organization	Mandate of Organization	Public Board Member's Responsibilities	Who Appoints the Public Members?	Number of Meetings & Amount of Prep time	No. of Public Members on the Board	Size of the Board	Remuneration for Public Members	Who pays the Public Members?
Cancer Care Ontario	The government's advisor on the cancer and renal systems, as well as access to care for key health services. Oversees $1.5 billion in funding for hospitals and other providers of services.	Overall governance of the CCO; may be asked to sit on board committees.	Minister's Order in Council (OiC)	At least 4 a year in Toronto	At least seven	14, including a Chair part-time Chair and Vice-Chair	Expenses only	MoHLTC
Consent and Capacity Board	To provide fair, timely, and effective hearings that balance legal and medical considerations while protecting individual rights and ensuring the safety of the community.	Sit on hearings, make judgements, participate in deliberations by making findings of fact from the evidence, then applying the law to those facts.	Minister's OiC	When requested; within 4 days of request, requiring approx. 3 hours of work	131	140, including a full-time Chair and 8 part-time Vice-Chairs	$398 per diem ($664 for lawyers and doctors)	MoHLTC
Council of Professional Engineers of Ontario	Licensing and disciplining engineers and engineering companies in the public's interest	Perform council and committee duties	Premier's OiC	At least four times a year	No fewer than 5 and no more than 7	15-20 elected PEng; 5-7 appointed PEng; 3-5 public members appointed	Nil for public members; $113 per diem for PEngs	Ministry of Attorney General
EHealth Ontario	To protect the privacy of individuals whose personal health records are collected, transmitted, stored etc. by the agency	Must sit on one committee in addition to regular duties	Minister's OiC	At the call of the chair, and at least four times a year	8 part-time members	No more than 12 members, including a Chair and CEO who is a Government employee	$380 per diem	MoHLTC
HealthForce Ontario Marketing and Recruitment Agency	Maintains the province's health human resources and if necessary, recruits health professionals	Sit on committee at least six hours a month during business hours	Minister's OiC	Monthly board meetings in Toronto Feb – Dec with a break in July & Aug	No more than 9	Currently there are 8 part-time members and 1 part-time chair	$200 per diem	MoHLTC
Health Professions Regulatory Advisory Council	Advises the Minister which health professions should be regulated and which should be unregulated	Perform council duties	Minister's OiC	Council meets monthly for two days	5 – 7	7 members including one Chair and one Vice-Chair	$150 per diem for members, $175 for Vice Chair, $600 for Chair	MoHLTC
Health Professions Appeal and Review Board	An adjudicative body which provides oversight to the regulated health professions and veterinarians of Ontario	Participate in appeals, reviews and hearings	Minister's OiC	As required	At least 12	40 members; 1 Chair, 2 Vice Chairs	$398 per diem	MoHLTC
Law Society of Upper Canada	Responsible for the Law Society's members education, licensing, supervision and conduct	Sit on Council; attend hearings & committees; participate in appeals	Premier's OiC	Monthly meetings except in July, August and December	Max of 8	45 elected benchers; 8 lay benchers; plus others	$177 per meeting; topped up to $340 a day by the Society	Combination of Society & Min of Attorney General

Organization	Mandate of Organization	Public Board Member's Responsibilities	Who Appoints the Public Members?	Number of Meetings & Amount of Prep time	No. of Public Members on the Board	Size of the Board	Remuneration for Public Members	Who pays the Public Members?
LHIN	Plan, fund and integrate health services for their local communities	Performs council duties	Minister's OiC	Two days per month and additional time for committees	Max of 9 per LHIN	No more than nine members	$200 per diem	MoHLTC
Ontario Agency for Health Protection and Promotion	Responsible for a wide range of initiatives to protect the public interest (e.g. provides support, enhance public policy, etc.)	Three committees report to the BofD; assume board members sit on committees	Minister's OiC	Regularly throughout the year; at least four times (met 5 times in 2015)		No more than thirteen members	$200 per diem	A Crown Corporation
Ontario Health Quality Council	Monitors and reports to the public on publically funded health services	Analyze all aspects of Ontario's health sector and makes recommendations	Minister's OiC	Meets regularly throughout the year, at least four times	12 part-time, including a Chair and Vice	No fewer than 9 and no more than 12 members	$200 per diem	MoHLTC
Pay Equity Commission of Ontario (Hearings)	A quasi-judicial tribunal responsible for disputes under the Pay Equity Act	Hear and make decisions regarding pay equity	Minister's OiC	Panels of three meet in Toronto when there are hearings	5	11, including a Presiding Officer and several deputy Presiding Officers	$398 per diem	Ministry of Labour
Physician Payment Review Board	Tries to solve payment matters that cannot be resolved between the General Manager of the Ont. Health Insurance Plan and a doctor	Sit on hearing panels and participate in decisions	Minister's OiC	As required	No fewer than 6 and not more than 10	26 (including one Chair and up to 3 Vice-Chairs)	$398 - per diem ($664 for MDs)	MoHLTC
Physician Services Payment Committee	Makes recommendations to the Minister on the schedules of physicians benefits and other payments	Currently there are no members	Minister's letter	Once a month. Working groups may meet an additional 1 or 2 times per month	21	21 (currently all vacant)	N/A	MoHLTC
Police Services Board	Governs the police forces of each municipality in Ontario		Premier's OiC	Meets at least four times a year	7	7 (including a Chair)	$8,791 annually[1]	Each municipality

[1] Has not changed since 1993.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: TRANSPARENCY INITIATIVE

A. Status Update
B. Proposed By-Law Amendment: Posting QAC SCERPs – For Approval
C. Ministry Transparency Working Group

FOR DECISION

ISSUE

The proposed by-law that would make QAC SCERPs public has been circulated for comment as required. This briefing note asks Council to approve the proposed by-law and provides a general update on the transparency initiative.

A. STATUS UPDATE (for information)

Information posted to date

- Since the first caution was posted to the public register on September 11, 2015, the following information has been made available to the public (to May 9, 2016[1]):

Cautions 36	Caution/SCERP 7	SCERPs 17	Criminal Charges 23

Criminal Convictions 3	Bail Conditions 11	Discipline Findings Other Jurisdictions 5

[1] These numbers reflect total outcomes in these categories. Note that physicians may have more than one outcome in a category, so the numbers of unique physicians are slightly lower. For example, 36 cautions have been given to 33 physicians, there have been 7 Cautions/SCERPS about 6 physicians, and 23 criminal charges against 21 physicians.

B. BY-LAW AMENDMENT FOR APPROVAL: POSTING QAC SCERPS

CONSULTATION REPORT

- A consultation specific page was created, giving stakeholders various options for submitting feedback. The consultation was held between December 4, 2015 and February 12, 2016.

- 87% of respondents opposed the proposed by-law amendment. 80% of total respondents were physicians.

- All written feedback received during the consultation is posted on the CPSO website in keeping with regular consultation processes and posting guidelines.

Total responses	39
Physician	31
Public	2
Anonymous	2
Organization PARO College of Audiologists and Speech Pathologists of Ontario Ontario Trial Lawyers Association FAIR: Fair Association of Victims of Accident Insurance Reform	4

- Most of those opposed to the proposed by-law did so based on the principles of the quality assurance program - education, remediation and confidentiality. Many respondents felt that posting any QAC outcome would conflict with the goals of quality improvement and assurance.

- Those opposed were fundamentally opposed to the purpose of the by-law. There were no suggestions for modifying the proposed by-law.

- A summary of the key comments received is set out below.

Education and remediation should be the main priority of the QAC

- 'I believe the point of this program should be education, remediation and public safety – not physician humiliation!'
- 'Since the QAC acts only to suggest remedial action as a result of say peer review or other non-complaint issues, it should not be able to make public the remediation procedure.'
- '…It is supposed to have a positive impact on the practice.'

Publishing SCERPs will be interpreted as a punitive measure

- '…goes against the non-punitive nature of QA undertakings'

- ‘Thought this was supposed to be an educational experience. Are we now heading more towards punishment?’
- ‘…If members consider the process potentially punitive, compliance might become an issue adversely affecting quality. Second, if the QA committee is seriously concerned about the member’s practice, it has the ability to refer that member to the ICRC with allegations of professional misconduct as per Schedule 2 of the Regulated Health Professions Act, 1991, Section 51(1) (b.0.1). CASLPO is in full support of making public SCERPs issued by the ICR Committee.’ **– College of Audiologists and Speech Language Pathologists of Ontario**

Removing anonymity in the QAC process will negatively impact outcomes

- ‘…the truth may suffer and it will not promote honest assessment of the issues in question.’
- ‘This would be inconsistent with QA and QI. Airline industry is leading in this area and they have complete anonymity to ensure full and active cooperation. Any punitive implication will be completely counterproductive to QA and QI program.’

Publishing QAC SCERPS provides no benefit to the public

- ‘So many of ‘we’ the public neither know what a Regulatory College is, nor understand the public protection mandate. A SCERP – taken out of context – would do a disservice to both College and physician.’

Concerns about the impacts the by-law would have on physician reputation, employment opportunities and wellness

- ‘For physicians wrestling with mental health issues, a negative finding could result in the suicide of one of our colleagues. I do not want this on my conscience.’
- ‘This may unduly shame him/her, affect his/her ability to gain employment opportunities or even adversely affect their ability to garner patient trust.’

Concerns about Interviewer variability and fairness

- ‘Mistakes are made in reviews. This is not a program that was built to be transparent for the public.’
- ‘different assessors may come to very different conclusions regarding the same individual’

Posting SCERPs on the register would be a regressive step for the College

- ‘There is much talk about education and improving quality of care in a non-punitive manner however this seems to be a step in the opposite direction.’

The College appears to be creating opportunities to increase staff and work at the cost of the membership

- To make SCERPs public serves no educational purpose. It just creates more work for the college staffs, is it a means that the college want to hire more staff? Or to justify its huge number of staff?
- ‘Is it to create more work for your 265 staff members or to smear doctors who were randomly targeted by one of your staff members to justify her salary..’

A vocal minority in support of the by-law provided substantive comments relating to the College's duty to protect the public and ensure transparency.

- 'The opinion-for-hire College members have managed to avoid accountability to the public through the anonymity of the secret college cautions and SCERPs.' – FAIR
- 'OTLA supports the proposed amendments which would see all SCERPs be published on the Public Register, regardless of the CPSO committee from which they arise, as this would promote greater transparency and accountability.' – Ontario Trial Lawyers Association
- 'Non-disclosure of a SCERP, undertaking or any matter that pertains to a patient's or to a future patient's care and treatment (whether an administrative matter or not) will have significant impact on public safety and public confidence. The harm arising from the preceding outweighs any benefit of physician privacy.' – Ontario Trial Lawyers Association

CONSIDERATIONS

- Throughout the transparency initiative, most physician respondents have objected to making more information available to the public.
- Making information resulting from a QA process public is a significant change at a conceptual level. The QAC, Executive and Council all considered the need to balance protection of QAC information and the principles underpinning the QA program, and the need to treat matters of similar risk in a consistent manner with respect to transparency.
- QAC prefers to use voluntary undertakings to achieve educational outcomes in appropriate cases. SCERPS are used periodically.
- The rationale for the proposed by-law amendment remains the same: No matter where a matter originates, the determination of whether the outcome is made public should be based on an evaluation of risk and handled with a consistent framework between committees.
- The principles of QA, to facilitate physician improvement in a confidential environment, remain intact.
- For these reasons, no substantive changes are recommended to the proposed by-law. A minor clarification amendment is proposed for s25.2, and the effective date has been changed to June 1 as set out below.

DECISION FOR EXECUTIVE COMMITTEE:

Does the Executive Committee wish to recommend to Council that the proposed by-law be approved with minor housekeeping revisions?

> **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:
>
> **25.1** In respect of a decision of the QAC that includes a disposition of a SCERP, if the decision is made on or after ~~January~~ June 1, 2016, the elements of the SCERP.
>
> **25.2** In respect of the elements of ~~the~~ a SCERP, referred to in paragraph 25.1 above, a notation that all of the elements have been completed, when so done.
>
> **25.3** Where a decision referred to in paragraph 25.1 above is overturned on review, the summary shall be removed from the Register.

C. Ministry Transparency Strategy: Transparency Working Group

- The Ministry created a Transparency Working Group (TWG) in October 2015. It includes health regulatory colleges, patient representatives and representation from the healthcare sector.

- The TWG focusses its work in 4 areas:
  - Making more information publically available
  - Ensuring decision-making processes are more open and accountable
  - Having information that is easy to understand, and
  - Strategy coordination

- The Ministry is focussed on the development of 'common guidelines' for all Colleges relating to the public register, Council meetings and the complaints and discipline processes, in order to ensure consistency. It also wants Colleges to have consistent approaches to public engagement and consultation.

- It appears that the overall goal will be to ensure that all Colleges implement the AGRE recommendations and improve their public registers.

- The work of the TWG is currently scheduled to continue to the end of 2016 and will connect with both the RHPA review and the Health Regulatory Modernization work, once these activities commence.

DECISION FOR COUNCIL

Does Council approve the proposed by-law with minor housekeeping revisions?

> **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:
>
> **25.1** In respect of a decision of the QAC that includes a disposition of a SCERP, if the decision is made on or after ~~January~~ June 1, 2016, the elements of the SCERP.
>
> **25.2** In respect of the elements of ~~the~~ a SCERP, referred to in paragraph 25.1 above, a notation that all of the elements have been completed, when so done.
>
> **25.3** Where a decision referred to in paragraph 25.1 above is overturned on review, the summary shall be removed from the Register.

CONTACT: Maureen Boon (276), Lisa Brownstone (472), Michelle Tremblay (552)

DATE: May 12, 2016

COUNCIL BRIEFING NOTE

TOPIC: **By-law Amendments for Register Content**

FOR DECISION

ISSUE: This briefing note sets out several proposed amendments to the register provisions in the General By-law. The proposed amendments fall into two main categories:

(a) revisions intended to reflect current College practices, and

(b) corrections and minor improvements of a housekeeping nature.

A. AMENDMENTS TO REFLECT COLLEGE PRACTICES

The following amendments are proposed so that the applicable by-law provisions better reflect current College practices. These amendments do not propose new information to be posted; they reflect information that is already being included on the register.

Subsection 49 of By-law No. 1 (the General By-law) is amended as follows:

Content of Register Entries

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

Proposed Amendment	Explanatory Note
1. ~~The member's name and a~~A<u></u>ny changes in the member's name since his or her undergraduate medical training <u>that is used or to be used in his or her practice, and the date of such change, if known to the College</u>.	See also related change to s.51.1(1) below. Not all member name changes are posted on the register. The College posts name changes that affect the name used by the member in practice. In those cases, former names are posted, along with the date of the change. For example, if a member changes his/her name upon marriage but continues to practise using their pre-married name, this is not posted. The deletion of "the member's name" is a housekeeping change. Section 23(2)1 of the Health Professions Procedural Code (HPPC) already requires the member's name to be in the register. This removes the duplication.

Proposed Amendment	Explanatory Note
6. A description of the member's postgraduate training in Ontario.	The College only records post-graduate training in Ontario because only Ontario post-grad training is fully known and recorded in our database and verified.
7. If the member ~~has been~~ is certified by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada, i. that fact, ii. the date of the certification, and iii. the discipline or sub-discipline in which the member is certified~~, and~~ iv. ~~whether the member was certified by examination and, if not, by what process~~	The register does not include the information in clause iv (crossed out). Once registered, the distinction between "certified by exam" and "certified without exam" is of no consequence for specialist recognition or advertising purposes. Either way the physician is a certified specialist.
7.1 If the member is formally recognized as a specialist by the College, i. that fact, ii. the date of recognition, and iii. the discipline or sub-discipline in which the member is recognized.	This amendment is proposed because many specialist recognitions are currently on the register. Note that s. 23(2)4 of the HPPC requires specialist status, and the advertising regulation makes specific reference to the CPSO specialist recognition. The CPSO specialist recognition is removed from the register once a member is certified by RCPSC or CFPC, and also when a member's registration expires if it is tied to the licence.
12. The identity of each hospital ~~and health facility~~ in Ontario where the member has professional privileges, and where known to the College, all revocations, suspensions, ~~or~~ restrictions, resignations, relinquishments and rejections of appointment or reappointment applications reported to the College by hospitals under s. 85.5 of the Health Professions Procedural Code or s. 33 of the *Public Hospitals Act*, in each case commencing from the date ~~this by-law goes~~ the relevant	1. This amendment reflects the fact that the College does not post member privileges in health facilities, nor is this information collected in a systematic way for all non-hospital facilities. 2. The College receives notices under both HPPC and the *Public Hospitals Act*. It is not always clear from the notices whether they are being given pursuant to the HPPC or the *Public Hospitals Act*. The nature of the information under either is the same, and it makes sense to post information on the register whether it is

Proposed Amendment	Explanatory Note
portion of this by-law went into effect.	under an HPPC or *Public Hospitals Act* notice.
29. If the terms, conditions and limitations (other than those required by regulation) are imposed on a member's certificate of registration or if terms, conditions and limitations in effect on a member's certificate of registration are amended, i, the effective date of the terms, conditions and limitations imposed or of the amendments, and ii. a notation as to the committee or the member, as applicable, that imposed or amended the terms, conditions and limitations on the member's certificate of registration.	This is a new provision to reflect the College's practice of including the effective date of TCLs in the register. Section 23(2)5 of HPPC requires TCLs to be on the register but is silent with respect to posting the effective date and committee (or the member) who imposed the TCLs.
30. Where a member's certificate of registration is revoked or suspended, the committee that ordered the suspension or revocation of the member's certificate of registration, if applicable.	This is a new provision to reflect the College's practice of noting the committee that imposed a revocation or suspension on the register . Section 23(2)9 of HPPC requires revocations and suspensions to be noted on the register but is silent with respect to the effective date and committee. S. 49(1)8 of the by-law provides for the date of revocation or suspension to be posted.
31. Where a member's certificate of registration is expired, the reason for the expiry.	This is a new provision to reflect the College's practice of noting expired certificates of registration on the register, along with the basis for the expiry (i.e., resignation, failure to renew, etc.). Section 49(1)8 provides for posting the effective date of expiry.
32. Where a notation of a finding of professional negligence or malpractice in respect of the member is in the register,	This is a new provision to reflect the College's practice of including the date of a negligence/malpractice finding and the court name and location on the register (if

Proposed Amendment	Explanatory Note
i. the date of the finding, and ii. the name and location of the court that made the finding against the member, if known to the College.	known to the College). Section 23(2)8 of HPPC requires such findings to be noted on the register but is silent with respect to the date or court information.
33. The date on which the College issued a certificate of authorization in respect of the member, and the effective date of any revocation or suspension of the member's certificate of authorization.	This is a new provision to reflect the College's practice of including the dates of issuance, revocation and suspension of a certificate of authorization (for a health profession corporation) on the register. Note that section 23(2)2 of HPPC requires the name and contact information for each health profession corporation to be on the register, and s. 23(2)10 requires notation of revocation or suspension of a certificate of authorization.
34. The language(s) in which the member is competent to conduct practice, as reported by the member to the College.	This is a new provision to reflect the College's practice of listing languages in which the member is fluent on the register, based on the information provided by the member.

Subsection 50.1(1) of By-law No. 1 (the General By-law) is amended as follows:

Proposed Amendment	Explanatory Note
Public Information **50.1** (1) All information contained in the register, other than: (a) a member's preferred address for communications from the College, (b) a member's e-mail address, (c) a member's date of birth, (d) a member's place of birth, ~~and~~ (e) any information that, if made public, would violate a publication ban if known to the College, and (f) any information that the registrar	1. Section 23(11) of the HPPC eliminated the need for s. 50.1(1)(f) of the By-law. 2. The new clause (f) reinforces that information that the Registrar refuses to disclose or post for the reasons contemplated in s.23(6, 7, 8, 9 or 11) of the HPPC will not be public. 3. The change to clause (g) reflects the fact that terms, conditions and limitations (TCLs) that have been removed and no longer appear in the TCL section of the register still continue to appear in the member's registration

refuses or has refused to post on the College's website pursuant to subsection 23(6), (7), (8), (9) or (11) of the Health Professions Procedural Code, is designated as public except that~~if,~~ ~~(i) a finding of professional misconduct was made against a member,~~ ~~(ii) the penalty imposed was a reprimand or a fine, and~~ ~~(iii) at least six years have elapsed since the penalty order became final, the finding of misconduct and the penalty are no longer public information; and~~ (g) if, (i) terms, conditions or limitations were directed to be imposed upon a member's certificate of registration by a committee other than the discipline committee, and (ii) the terms, conditions or limitations have been removed, the ~~fact and~~ content of the terms, conditions or limitations are no longer public information.	history. Accordingly, the "fact" that a TCL had been imposed is technically public, but the contents of the TCL would no longer be posted.

Subsection 51(1) of By-law No. 1 (the General By-law) is amended as follows:

Proposed Amendment	Explanatory Note
Notification Required by Members **51.** (1) A member shall notify the College in writing or electronically as specified by the College of, (a) the member's preferred address (both mailing and e-mail) for communications from the College;	This amendment explicitly requires members to advise the College of a name change within a given time period (30 days under s. 51(2)). As noted re section 49(1)16, the College does not post all name changes. As it is professional misconduct to practise under a name that is different than the name in the register, we propose asking

Proposed Amendment	Explanatory Note
(b) the address and telephone number of the member's principal place of practice; (c) the identity of each hospital and health facility in Ontario where the member has professional privileges; ~~and~~ (d) any currently existing conditions of release (not including any information subject to a publication ban) following a charge for a criminal or provincial offence, or subsequent to a finding of guilt and pending appeal, and any variations to those conditions; and (e) any changes in the member's name since his or her undergraduate medical training that is used or will be used in the member's practice. (2) If there is a change in the information provided under subsection (1), the member shall notify the College in writing or electronically as specified by the College of the change within thirty days of the effective date of the change.	only for those changes in the member's name that the member will be practising under.

B. HOUSEKEEPING AMENDMENTS

The following are the proposed amendments to the By-law that are corrections and minor improvements of a housekeeping nature:

Subsection 49 of By-law No. 1 (the General By-law) is amended as follows:

Content of Register Entries

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

Proposed Amendment	Explanatory Note
8. The classes of certificate of registration held by the member and the date on which each certificate was issued and, if applicable, the ~~termination~~ revocation, suspension or expiration date, or date of removal of a suspension.	The word "termination" is replaced by "revocation" and "suspension" to reflect the terms used in the *Regulated Health Professions Act*. It also reflects College practice to note the date a suspension has been removed.
14. ~~If a finding of professional misconduct or incompetence has been made against the member in Ontario~~ If the result of a disciplinary proceeding in which a finding was made by the discipline committee in respect of the member is in the register, ~~that fact,~~ i. the date on which the discipline committee made~~of~~ the finding, and ~~and the place where it was made,~~ ii. the date on which the discipline committee ordered any penalty.~~a brief summary of the facts on which the finding was based,~~ ~~iii. the penalty, and~~ ~~subject to subsection 23(2.1) of the Health Professions Procedural Code, where the finding is under appeal, a notation to that effect.~~	Section 23(2)7 of HPPC requires the register to contain the result of the discipline proceeding if a finding was made, including a synopsis of the decision. Section 23(2)12 of HPPC also requires a notation of an appeal to be in the register until the appeal is disposed of. The redundancies have been removed.
16. If the result of an ~~a finding of~~ incapacity proceeding in which a finding was~~has been~~ made by the fitness to practise committee in respect of the member is in the register, i. ~~that fact~~the date on which the fitness to practise committee made the finding, ii. the effective date of any order of the fitness to practise committee,	Section 23(2)7 of HPPC requires the register to contain the result of the discipline proceeding if a finding was made, including a synopsis of the decision. The redundancies have been removed. The wording in clause (iv) is currently in subsection 49(2) of the by-law. It was originally added when s. 49(1)16 was the last paragraph in s. 49(1), so it flowed logically. Now that there are several

Proposed Amendment	Explanatory Note
~~a summary of the order made by the panel hearing the matter, and~~ iii. where the finding is under appeal, a notation to that effect, and iv. when an appeal of a finding of incapacity is finally disposed of, the notation added under subparagraph iii of this paragraph 16 shall be removed.	subsequent paragraphs in s. 49, it would be better to place this within para. 16 to which it relates.
23. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a Specified Continuing Education or Remediation Program ("SCERP")~~SCERP~~, if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file is dated on or after January 1, 2015, a summary of that decision, including the elements of the SCERP, and, where applicable, a notation that the decision has been appealed.	Adds a definition of SCERP.
24. In respect of the elements of ~~the~~ a SCERP referred to in paragraph 23 above, a notation that all of the elements have been completed, when so done.	
25. Where a decision referred to in paragraph 23 above is overturned on appeal or review, the summary shall be removed from the ~~R~~register.	
27. Where a member is currently registered or licens~~c~~ed to practice medicine in another jurisdiction, and such licen~~c~~s~~e~~e or registration has been made known to the College as	

Proposed Amendment	Explanatory Note
of or after September 1, 2015, the fact of that licensure or registration.	
~~49(2) When an appeal of a finding of incapacity is finally disposed of, the notation added under subparagraph iii of paragraph 16 of subsection (1) shall be removed~~	Subsection 49(2) of By-law No. 1 (the General By-law) is revoked. See note above re s. 49(1)16.
Subsection 50.2 of By-law No. 1 (the General by-law is amended by adding the following as a heading preceding the subsection: **Liability Protection**	This is to clarify that s.50.2 does not fall under the prior section headed **Public Information**.

NOTES:

1. Note also that once we add a provision under Section 49(1) to post certain information, there is an obligation to do so (subject to any knowledge caveat).

2. Note that these by-law amendments must be circulated to the profession for at least 60 days before approval by the Council.

DECISION FOR COUNCIL:

- Does Council wish to propose the by-law amendments outlined in this Briefing Note?

CONTACT: Marcia Cooper, ext. 546
Lisa Brownstone, ext. 472
James Stratford, ext. 210

DATE: May 10, 2016

May 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 May 30, 2016 meeting of Council, **Dr. Amanda Bell** of Port Colborne, Ontario will receive her Council Award

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DECISION FOR COUNCIL:

No decisions required

CONTACT: Tracey Sobers, ext. 402

DATE: May 2, 2016

Appendices: N/A

May 2016

COUNCIL BRIEFING NOTE

TOPIC: Continuity of Care Planning and Proposal

FOR DISCUSSION

ISSUE:

- In response to changes in the landscape and issues that have recently arisen regarding continuity of care, at its March 2014 meeting the Executive Committee asked staff to undertake preliminary work on the issue of continuity of care, including an analysis and recommendation regarding the development of a new policy.

- The timing of this work was affected by a number of urgent College priorities, including numerous external reviews. Preliminary work related to continuity of care began in early 2016 and has culminated in the development of a *Continuity of Care Planning and Proposal* (**Appendix 1**) which is presented to Council for review and feedback.

BACKGROUND:

- The College began development of a *Duty of Care* policy in 2000. Two years later, the Working Group overseeing this work was asked to address the issue of continuity of care more generally.

- As such, a draft *Continuity of Care* policy was developed and addressed multiple issues including, after-hours care, hospitalist care, walk-in clinics, home care, and on-call time.

- A consultation on the draft policy was held in 2003 and generated mostly negative feedback. While the principles of the policy were generally supported, most felt that the policy was overbroad and the expectations set out in the policy were unachievable in a reduced resource environment.

- In response, a scaled back and revised draft policy titled *Continuity of Care After Hours and During Other Absences* was developed. This policy was considered by Council in February 2004 and was not approved. At the time Council noted that:

    - Family physicians already do enough to facilitate access to after-hours care;

    - Resource shortages make it impossible to comply with the policy; and

- The policy may inadvertently increase the number of walk-in clinics as this would be the only way to ensure after-hours access is available, and that this may actually lead to a **decrease** in continuity of care.

- Recently, issues relating to continuity of care have arisen in several contexts.
  - The Health Quality Council of Alberta (HQCA) published a Continuity of Patient Care Study in December 2013.
    - The report was published in response to the unexpected death of a 30 year old patient named Greg Price, who experienced multiple breaks in continuity of care following a diagnosis of cancer.
    - Among the 13 recommendations included in the report, 5 were directed at the College of Physicians and Surgeons of Alberta (CPSA). Most notably, the study recommended that the CPSA actively monitor compliance with their After Hours Access to Care[1] Standard which requires physicians to ensure patients have access to continuous care and prohibits directing patients to the ER unless a formal agreement with the ER is in place.
  - Additionally, the College has recently been asked for access to physicians' non-public phone numbers because of continuing inability to reach primary care providers in a South Eastern Ontario city.
  - The College's Public and Physician Advisory Service often receives calls regarding patients' inability to contact physicians, both during and after-hours.
  - The College is also aware that: many physicians will answer their phone during limited weekday hours and very few allow patients to leave messages; while some practices provide comprehensive after-hours care, some provide none at all and continue to refer patients to the ER; and pharmacists often have difficulty reaching physicians to clarify prescriptions.

- The Executive Committee considered the issues detailed above at its March 2014 meeting and directed staff to undertake preliminary work on the issue of continuity of care in order to develop an analysis and recommendation regarding the potential development of a new policy.

[1] This standard was recently reissued by the CPSA Council in June 2015 and retitled *Continuity of Care*.

CURRENT STATUS:

- In accordance with the Executive Committee's direction, staff have developed a *Continuity of Care Planning and Proposal* (**Appendix 1**).

- Briefly, this proposal outlines the work that would be undertaken to facilitate the development of a new *Continuity of Care* policy, as well as a review of the College's existing *Test Results Management* policy, which addresses issues relating to continuity of care. In particular, the proposal sets out:

    - The need to identify continuity of care issues which can and should be addressed through College policy and the need for a mechanism to identify and capture 'systems' issues that cannot be addressed through policy, but where there is an opportunity for the College to provide recommendations and share our perspective.

    - Four overarching objectives that will drive the policy development process. This includes, ensuring that patient experience, patient safety, and the public interest play a fundamental role in shaping the policy expectations and ensuring that expectations regarding coordination of care, especially after-hours, are set out.

    - A number of anticipated issues that will be explored and/or addressed, including: walk-in clinics, after hours and vacation coverage, test results, the use of technology, managing medical records and information, appointment procedures, and physician health.

- It is proposed that the development and review process will culminate in the production of a number of deliverables, including: a new *Continuity of Care* policy, a revised *Test Results Management* policy, companion communication and/or supplemental resources, and a mechanism for communicating College recommendations regarding systems issues that cannot be addressed through policy.

- It is anticipated that there may be objections to a new policy on continuity of care, with many of the arguments and concerns heard in 2004 being repeated in the context of the current proposed work, particularly in light of the recent political climate between Ontario physicians and the Ministry of Health and Long-Term Care. With this in mind and to facilitate productive conversations, it is proposed that in addition to the typical elements of the College's policy review and development process, that additional outreach and consultation efforts be undertaken. This is likely to include: a preliminary consultation on continuity of care issues to help identify key problems and elicit potential solutions from stakeholders, public polling and focus groups, a physician and/or public forum modelled on the End-of-Life Care forum that preceded the College's public policy initiative on end of life issues, and outreach events with key public and/or patient stakeholder groups (e.g. CARP).

CONSIDERATIONS:

- As Council is aware, the Ministry of Health and Long-Term Care has signalled its interest in implementing broad primary care reform. Multiple reports expressing this commitment and outlining proposed actions have been released and staff are actively monitoring the situation for any decisions or developments that may impact the College's work relating to continuity of care.

- As part of these efforts, a high level summary of two key reports has been included in the "Policy Report" for Council's information. The Reports are, the Ministry's discussion paper *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* and the Ministry's Primary Health Care Expert Advisory Committee's report *Patient Care Groups: A new model of population based primary health care for Ontario*.

NEXT STEPS:

- Following the May 2016 Council meeting, preliminary consultations are planned in order to solicit feedback on the existing *Test Results Management* policy and to engage stakeholders in a discussion about continuity of care issues to help identify problems and potential solutions.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the *Continuity of Care Planning and Proposal*?

CONTACTS: Craig Roxborough, ext. 339

DATE: May 12, 2016

Attachments:

Appendix 1: Continuity of Care Planning and Proposal

Appendix 1

Continuity of Care Planning and Proposal

A. Project Scope

- Policy analysis, research, and consultation relating to the development of a new *Continuity of Care* policy will begin in 2016 under the direction of a Working Group.

- The current *Test Results Management* policy will also be reviewed, as this policy addresses issues relating to continuity of care. The same Working Group will oversee this review.

- To minimize confusion and focus the policy development process, a working definition of "continuity of care" will be proposed at the outset:
    - Continuity of care: the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient's medical needs and personal context. (HQCA, *Continuity of Patient Care Study*)

- Many continuity of care issues are 'systems' issues and outside the jurisdiction of the College or beyond the control of our members (e.g. practice models, fee structures, health human resources, development of province wide electronic health record, etc.). Particular care will be taken to identify those issues that can and should be addressed through policy and those that are beyond our control. Consideration will need to be given to how to handle or best address these broader 'systems' issues.

B. Objectives and Anticipated Issues

- There are four overarching objectives that will drive this policy development process:

    1) Ensure that patient experience, patient safety, and the public interest play a fundamental role in shaping the expectations and guidance provided.
    2) Set expectations regarding physicians' responsibility for coordination and follow-up with patients; in particular, to ensure patient care is coordinated outside of normal operating hours and during physician absences (i.e. after-hours and vacation coverage).
    3) Provide recommendations and set expectations regarding physicians' use of technology to facilitate continuity of care (e.g. providing direction regarding after-hours care, utilizing email/ONE Mail to streamline care, etc.).
    4) Set expectations for physicians regarding their availability to other health care professionals (e.g. inquiry regarding shared patient, follow-up care).

- In order to achieve these objectives, it is expected that a number of issues will need to be explored and/or addressed.

    1) **Walk-in Clinics**: episodic vs. primary care; orphan patients.
    2) **After-Hours/Vacation Coverage**: on-call groups; direction of patients to ER/clinics.
    3) **Test Results**: management; communication; follow-up.
    4) **Technology and Information**: EMR/EHR; information exchange and access among health care team; email/ONE Mail; ConnectingOntario; telemedicine.
    5) **Appointment Procedures**: transitions and scheduling; same/next day appointments.
    6) **Physician Health**: physician health cannot be compromised; work-life balance.

C. Deliverables

- It is proposed that this policy development and review process will lead to the production of a number of deliverables:
    1. A revised *Test Results Management* policy.
    2. A new *Continuity of Care* policy to address new and/or emerging areas of concern with reference to existing College policies or documents that address related issues (e.g. *Medical Records, Practice Management Considerations*, *eHealth* statement etc.).
    3. Companion communications and/or supplemental resources as needed (e.g. articles in *Dialogue* and *Patient Compass*, Frequently Asked Questions document, patient information sheet, etc.).
    4. A mechanism to identify and capture systems issues that cannot be addressed through policy, but where there is an opportunity for the College to provide recommendations or share our perspective (e.g. development of a white paper[1]).

D. Policy Development and Review Process

- A Working Group will be formed to oversee this process. Relevant areas of expertise requiring coverage include: primary care, specialist, hospitalist, technology/privacy, walk-in clinics, and the public perspective.

- The Working Group will be comprised of Council Members with relevant expertise or interest in continuity of care issues. Individuals external to the College with relevant expertise will either be invited to join as a member of the Working Group or give presentations on key issues.
    - This may include representatives from: Health Quality Ontario, Ontario College of Family Physicians, eHealth and/or Ministry of Health, the Ontario Medical Association.

- It is proposed that an extended outreach and consultation process will be undertaken to support this development and review process.
    1. Traditional elements of the policy review process will be adhered to regarding the review of the *Test Results Management* policy.

    2. To promote engagement, additional outreach and consultation processes are proposed.
        - This may include: a preliminary consultation to explore experiences, challenges, and potential solutions to continuity of care issues; public opinion polling and public focus groups to explore patient experiences; a physician and/or public forum to help identify issues and potential solutions.

E. Timelines

- Subject to the direction of the Working Group, Executive Committee or Council and any changes in the external landscape that impact this work, the goal is to seek final approval on the new *Continuity of Care* and revised *Test Results Management* policies in May 2018.

- While subject to change, key early milestones include:
    - Preliminary consultation following May 2016 Council.
    - Summer to Fall 2016: public polling, public focus groups, physician and/or public forum.
    - Draft policies for consideration at September 2017 Council.

[1] For example: Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis; Guidebook for Managing Disruptive Physician Behaviour.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: Physician-Assisted Death / Medical Assistance in Dying: Federal Activity and College Policy

FOR DECISION

ISSUE

- As Council is aware, by virtue of the Supreme Court of Canada's (SCC) decision in *Carter v. Canada,* physician-assisted death will become legal in Canada on June 6, 2016.

- Federal legislation has been introduced to create a consistent framework to govern physician-assisted death. It is not clear whether this legislation will be finalized by June 6, 2016.

- To ensure that the College can continue to provide accurate guidance to physicians and the public effective June 6, 2016, the Working Group has developed two revised policies. The draft *Medical Assistance in Dying* policy (attached as Appendix 'A'), incorporates amendments needed to ensure alignment with the proposed federal legislation. The draft *Physician-Assisted Death* policy (attached as Appendix 'B'), reflects the *Carter* decision. Both policies are consistent with the College's *Interim Guidance on Physician-Assisted Death* which Council approved in January 2016.

- Council is asked for its direction in relation to both policies, and with respect to next steps.

BACKGROUND

(A) The *Carter* Decision Revisited

- On February 6, 2015, the Supreme Court of Canada (SCC) released its decision in *Carter v. Canada* (*Carter*).

- In a unanimous decision, the SCC found that the *Criminal Code* provisions that prohibit physician-assisted death are constitutionally invalid, in circumstances where a competent adult:

    1) Clearly consents to the termination of life; and
    2) Has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

- The SCC suspended its decision for 12 months (until February 6, 2016) to allow the federal and/or provincial governments to design, should they so choose, a framework to govern the provision of physician-assisted death.

- In December 2015, the federal government applied to the SCC for an extension to allow the government additional time to develop a framework to govern the provision of physician-assisted death in Canada. In response to this request, the SCC granted a four-month extension. The *Carter* decision will now come into effect on June 6, 2016.

- The Court ruled that during the four-month extension period (from February 6, 2016 to June 6, 2016), an individual who is suffering intolerably from a grievous and irremediable medical condition, and wishes to seek assistance in dying, must obtain an exemption from the superior court in the individual's jurisdiction.

(B) Government Activity

- Both levels of government (federal and provincial/territorial) have been actively engaged in this issue.

- A Provincial-Territorial Expert Advisory Group led by the Government of Ontario was convened to provide advice on policies, practices and safeguards for provinces and territories to consider when the *Carter* decision comes into effect. The Expert Advisory Group's report was released in November 2015 and sets out a number of recommendations for implementing the *Carter* decision.

- Under former Prime Minister Harper, the federal government struck an External Panel to engage Canadians and key stakeholders on issues relevant to physician-assisted death, and to advise on legislative options. Under the Trudeau government, the federal government convened a Special Joint Parliamentary Committee to examine physician-assisted death and to provide recommendations for a legislative framework. Council may recall that the Special Joint Committee released its report titled, "*Medical Assistance in Dying: A Patient Centred Report*" on February 24, 2016.

- On April 14, 2016, the Parliament of Canada introduced proposed legislation titled '*An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)'* or Bill C-14. The proposed legislation is the federal government's response to the *Carter* decision.

- The current version of Bill C-14 may be accessed on the Parliament of Canada website.

- The Bill is currently making its way through the legislative process. As part of that process, both the House of Commons and the Senate Committees have reviewed the Bill and proposed amendments. The Bill has been amended in the House of

Commons and is expected to pass through the final Report stage in the House of Commons and be referred to the Senate in the coming days for their consideration.

- As Council may recall from the media coverage on this topic, there has been a great deal of debate on Bill C-14 and a diversity of opinions as to whether the Bill is consistent with the *Carter* decision.

- At this time, it is unclear whether Bill C-14 will pass through both the House of Commons and the Senate and become law by June 6, 2016, when physician-assisted death will become legal in Canada.

(C) College Activity

- The College has also been actively engaged in this topic. Council approved the College's *Interim Guidance on Physician-Assisted Death* at a Special Meeting of Council on January 26, 2016. The *Interim Guidance* was available to the public and the profession in advance of February 6, 2016, the commencement of the interim period. The College has also produced companion FAQ documents for the public and the profession.

- In relation to Bill C-14, the College has been following the Bill's progression carefully. Under the direction of the Working Group, which includes Dr. Kirsh, the College provided submissions to both the House of Commons Committee and the Senate Committee.

- The College, represented by Drs. Kirsh and Gerace, was also invited to appear before the Senate Committee on May 10, 2016.

CURRENT STATUS

- In this section of the brief, Council will be provided with an overview of Bill C-14, and the revised policies the Working Group has developed.

(A) Overview of Proposed Federal Legislation: Bill C-14

- Key elements of the Bill are detailed for Council's reference.

i. Terminology & Definitions under Bill C-14

- The proposed legislation adopts the term 'Medical Assistance in Dying' (MAID). This is stated to be in recognition of the collaborative nature of health care, and to reflect the involvement of different types of health care providers throughout the medical assistance in dying process. This term replaces 'physician-assisted death', which was used by the SCC in the *Carter* decision.

- The proposed legislation contemplates that MAID can be provided by a physician *or* a nurse practitioner. The inclusion of nurse practitioners, which was recommended by the Federal Government's 'Special Joint Committee on Physician-Assisted Death', is likely in anticipation of access issues that may arise in rural and remote regions of Canada, where physician providers may not be available.

- MAID encompasses situations where an individual self-administers a substance prescribed by a physician or an authorized nurse practitioner causing death, and the administration of a substance by a physician or authorized nurse practitioner that causes an individual's death. This is consistent with how physician-assisted death was set out in *Carter,* and in the College's *Interim Guidance on Physician-Assisted Death*.

ii. Eligibility Criteria Under Bill C-14

- Under Bill C-14, the eligibility criteria to access MAID is as follows:

    - the individual seeking MAID must be eligible for publicly funded healthcare in Canada;
    - the individual must be at least 18 years of age and capable of making decisions with respect to their health;
    - the individual must have a grievous and irremediable medical condition;
    - the individual must have made a voluntary request for MAID that, in particular, was not made as a result of external pressure; and
    - the individual must provide informed consent to receive MAID.

Definition of Adult

- Council will recall that although the *Carter* decision restricts physician-assisted death to 'competent adults', the SCC did not expressly define the term 'adult', nor specify a minimum age at which an individual would be considered an adult in this context.

- The proposed legislation fills this void by defining adult as an individual who is 'at least 18 years of age'. This confirms that 'mature minors' (i.e. young adolescents with decision-making capacity), would not be eligible for MAID.

Definition of a 'Grievous and Irremediable Medical Condition'

- The proposed legislation includes a statutory definition for a 'grievous and irremediable medical condition' that reads as follows:

    - A person has a grievous and irremediable medical condition if

        - they have a serious and incurable illness, disease or disability;

- they are in an advanced state of irreversible decline in capability;
- that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; *and*
- their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.

- The above definition of a 'grievous and irremediable medical condition' has been a primary topic of discussion among provincial governments, legal commentators, advocacy groups and the media since the release of Bill C-14.

- Several commentators have stated that the requirements that an individual have an 'incurable' illness, disease or disability, and that their natural death be 'reasonably foreseeable', has the effect of restricting MAID to those with terminal conditions.

iii. Safeguards Under Bill C-14

- The proposed legislation sets out a number of safeguards that must be complied with prior to physicians or nurse practitioners providing MAID.

- The safeguards in the proposed legislation include all of the following:

    - Two practitioners (physicians or nurse practitioners) must be of the opinion that the individual requesting MAID satisfies the eligibility criteria.

    - An individual's request for MAID must be made in writing. Should the person requesting MAID be unable to sign and date the request, another individual who is above the age of 18 may sign on the individual's behalf.

    - The request must be signed before two independent witnesses. An independent witness cannot, for instance, be a beneficiary under the will of the person making the request; the owner or operator of any health care facility at which the person making the request is being treated; or be providing health care to the person making the request.

    - The physician or nurse practitioner providing MAID and the physician or nurse practitioner giving the second opinion need to be independent of each other and of the patient. For instance, the physician or nurse practitioner who provides MAID must not be a mentor to the other practitioner or responsible for supervising their work.

- Following the MAID request, a mandatory 10-day reflection period is required between the day the written request is signed and the day MAID is provided. This period can be shortened if both practitioners involved in the request for MAID believe that the patient's death or loss of capacity to provide informed consent is imminent.

- The individual seeking MAID must be informed that they may, at any time and in any manner, withdraw their request for MAID. Further, the physician or nurse practitioner must, immediately before providing MAID (either administering the fatal dose of medication or writing the prescription for the fatal dose of medication), ensure that the individual gives their express consent.

iv. Protections from Criminal Liability

- The proposed legislation includes broad exemptions from criminal liability.

- These exemptions apply to physicians and nurse practitioners who provide MAID, pharmacists who dispense medication for MAID, those who support physicians and nurse practitioners in carrying out MAID, and any other person who aids a patient to self-administer the substance causing death.

v. Federal Regulations for the Purpose of Monitoring MAID

- The proposed legislation also stipulates that the Federal Minister of Health will make regulations on the collection of information pertaining to MAID for the purposes of monitoring its provision.

- Particularly, the regulation would stipulate to whom the physician or nurse practitioner providing MAID is to direct such information, and the form, manner and time period in which the information must be provided.

vi. Non-Legislative Elements

- The federal government has committed to conducting studies to consider the unique implications of requests for MAID from mature minors, advance requests for MAID, and situations where mental illness is the sole underlying condition driving a request for MAID.[1]

- The federal government has committed to working with the provinces and territories to support access to MAID, while recognizing the personal convictions of health care providers. It is unclear at this point what this work will entail, and whether it will also extend to conscientious objections by institutions.

[1] Under the proposed legislation, individuals with psychiatric conditions would not meet the eligibility criteria for medical assistance in dying if their death is not reasonably foreseeable or their mental illness renders them incompetent to make medical decisions.

- The federal government has committed to supporting improvements to a full range of end-of-life care options, which includes a multi-year health accord with improvements to home-care and palliative care.

- As noted above, the proposed legislation indicates that the federal government will develop regulations regarding data and reporting. Pending the development of regulations, the federal government has committed to working with the provinces and territories on a voluntary, interim protocol for the collection of data.

(B) Revised Policies

- In following the federal government activities with respect to Bill C-14, the Working Group's objective is to ensure that the College continues to provide effective and accurate guidance to the public and the profession on this topic.

- To that end, the Working Group has developed two revised policies (attached as Appendix 'A' and 'B'), in response to each of the following potential scenarios.

Scenario I: Bill C-14 becomes law

- The Working Group has developed the draft *Medical Assistance in Dying* policy (attached as Appendix 'A'). This draft policy is consistent substantively with the *Interim Guidance* document, with amendments made to ensure alignment with Bill C-14.

- It is proposed that the draft *Medical Assistance in Dying* policy would become the policy of the College, effective when the federal law comes into force.

- Highlights include:

    - Adoption of the term 'Medical Assistance in Dying' to ensure consistency with legislative language;

    - Clarifying that medical assistance in dying may be provided by either a medical practitioner (i.e. physician) or nurse practitioner;

    - Reframing eligibility criteria to mirror the language and structure of the proposed legislation. The definition of a 'grievous and irremediable medical condition', as set out in the proposed legislation, has been included.

    - Explicitly stating that advance requests for medical assistance in dying are not permitted;

    - Revising the 'Process Map' to reflect the safeguards set out in the proposed legislation; and

- The inclusion of links to resources available on the Ministry of Health and Long-Term Care website to assist physicians and those who support them to understand and comply with the legislation.

Scenario II: Bill C-14 is defeated or not approved by June 6, 2016

- In the event that Bill C-14 is defeated or is not in place by June 6, 2016, the *Carter* decision would take effect and would govern physician-assisted death.

- The Working Group has developed the draft *Physician-Assisted Death* policy to provide guidance in this scenario. This policy is substantively consistent with the College's *Interim Guidance*, with house-keeping amendments made to reflect the close of the interim period. Namely, the fact that after June 6, 2016, patients would no longer need to seek judicial authorization for physician-assisted death from a superior court.

- The draft *Physician-Assisted Death* policy is attached as Appendix 'B'. Key amendments include the following:

  - The document is renamed as the *Physician-Assisted Death* policy; and

  - Content that speaks to the role of the superior court in granting exemptions for physician-assisted death has been removed.

NEXT STEPS: Process Post-Council

- College staff and the Working Group will continue to follow the federal government proceedings closely.

- A number of next steps are proposed to ensure that the College can be responsive to the actions of the federal government and can continue to provide accurate and effective guidance to the public and the profession.

- Subject to Council's approval, the following are proposed as next steps:

  - <u>If Bill C-14 does not become law by June 6, 2016</u>, the *Physician-Assisted Death* policy will replace the *Interim Guidance* document on the College website, effective June 6, 2016.

  - <u>If Bill C-14 becomes law by June 6, 2016</u>, the *Medical Assistance in Dying* policy will replace the *Interim Guidance* document. It is proposed that should further amendments be needed to the *Medical Assistance in Dying* policy (i.e. to reflect any changes made to Bill C-14 between Council's meeting and June 6, 2016), these would be presented by the Working Group to the Executive Committee for final approval.

- If Bill C-14 is not finalized by June 6, 2016, but is finalized at a later date, the following is proposed:

    - The *Physician-Assisted Death* policy would take effect June 6 2016;
    - The *Medical Assistance in Dying* policy would take effect when the federal law is finalized. Any further amendments needed to ensure the policy aligns with the finalized federal law would be proposed by the Working Group to the Executive Committee for final approval.

DECISIONS FOR COUNCIL:

1. If Bill C-14 is defeated or is not approved by June 6, 2016, does Council approve the draft *Physician-Assisted Death* policy (Appendix 'B') as a policy of the College, effective June 6, 2016?

2. In the event that Bill C-14 undergoes further revisions as it proceeds through the legislative process, edits to the draft *Medical Assistance in Dying* policy may be required to comply with the legislation. Does Council support the Executive Committee approving any further revisions?

3. If Bill C-14 passes and becomes law, does Council approve the draft *Medical Assistance in Dying* policy (Appendix 'A') in principle, as a policy of the College as of the law's effective date, subject to any revisions that may be necessary to ensure compliance with the law?

DATE: May 26, 2016

Attachments:

Appendix A: Draft Policy – *Medical Assistance in Dying*
Appendix B: Draft Policy – *Physician-Assisted Death*

Medical Assistance in Dying

Introduction

Historically, it has been a crime in Canada to assist another person in ending his/her own life. This criminal prohibition has applied to circumstances where a physician provides or administers medication that intentionally brings about a patient's death, at the request of the patient.

In the case of *Carter v. Canada*,[1] the Supreme Court of Canada (SCC) considered whether the criminal prohibition on medical assistance in dying (referred to as 'physician-assisted death' by the SCC), violates the *Charter* rights of competent adults, who are suffering intolerably from grievous and irremediable medical conditions, and seek assistance in dying. The SCC unanimously determined that an absolute prohibition on medical assistance in dying does violate the *Charter* rights of these individuals, and is unconstitutional.

The SCC suspended its decision to allow the federal and/or provincial governments to design, should they so choose, a framework to govern the provision of medical assistance in dying. In response, the federal government enacted amendments to the *Criminal Code*[2]. This federal legislation gives competent adults with grievous and irremediable medical conditions the choice of medical assistance in dying**.**

Definitions

Medical Assistance in Dying: In accordance with federal legislation, medical assistance in dying includes circumstances where a medical practitioner or nurse practitioner, at an individual's request: (a) administers a substance that causes an individual's death; or (b) prescribes a substance for an individual to self-administer to cause their own death.

Medical Practitioner: A physician who is entitled to practise medicine in Ontario.

Nurse Practitioner: A registered nurse who, under the laws of Ontario, is entitled to practise as a nurse practitioner, and autonomously make diagnoses, order and interpret diagnostic tests, prescribe substances, and treat patients.[3]

[1] *Carter v. Canada (Attorney General)*, 2015 SCC 5 [*Carter*].
[2] R.S.C., 1985, c. C-46.
[3] For information on the professional accountabilities of nurses related to medical assistance in dying, please see the College of Nurses of Ontario document titled: [Placeholder for document name and LINK].

Purpose

This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in federal legislation, provincial legislation, and relevant College policies. The policy includes the eligibility criteria for medical assistance in dying and provides a process map for managing requests for medical assistance in dying.

Principles

The key values of medical professionalism, as articulated in the College's *Practice Guide*, are compassion, service, altruism, and trustworthiness. The fiduciary nature of the physician-patient relationship requires that physicians prioritize patient interests. In doing so, physicians must strive to create and foster an environment in which the rights, dignity, and autonomy of all patients are respected.

Physicians embody the key values of medical professionalism and uphold the reputation of the profession by, among other things:

- Respecting patient autonomy with respect to healthcare goals and treatment decisions;
- Acting in the best interests of their patients, and ensuring that all patients receive equitable access to care;
- Communicating sensitively and effectively with patients in a manner that supports patients' autonomy in decision-making, and ensures they are informed about their medical care; and
- Demonstrating professional competence, which includes meeting the standard of care, and acting in accordance with all relevant and applicable legal and professional obligations.

Policy

Physicians are expected to manage all requests for medical assistance in dying in accordance with the expectations set out in this policy.

Criteria for Medical Assistance in Dying

In accordance with federal legislation, for an individual to access medical assistance in dying, he/she must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;

3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. Provide informed consent to receive medical assistance in dying.

Physicians must use their professional judgement to assess an individual's suitability for medical assistance in dying against the above criteria. The content that follows elaborates upon each element of the criteria for medical assistance in dying.

1. Eligible for publicly funded health-care services in Canada

In accordance with federal legislation, medical assistance in dying must only be provided to patients who are eligible for publicly-funded health services in Canada.

The activities involved in both assessing whether a patient meets the criteria for medical assistance in dying, and providing medical assistance in dying, are insured services. These activities may include, for instance, counselling and prescribing. Accordingly, physicians must not charge patients directly for medical assistance in dying or associated activities. Physicians are advised to refer to the OHIP Schedule of Benefits for further information.

2. Capable adult of at least 18 years of age

(i) Age Requirement

The federal legislation specifies that medical assistance in dying is available only to individuals who are at least 18 years of age and capable of making decisions with respect to their health.

Physicians will note that the requirement that patients be at least 18 years of age and capable departs from Ontario's *Health Care Consent Act, 1996*,[4] which does not specify an 'age of consent'.

(ii) Capacity

Under Ontario's *Health Care Consent Act, 1996*, a patient has capacity to consent to treatment if they are able to understand the information that is relevant to making the decision, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[5] The patient must be able to understand and appreciate the history

[4] *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sched. A. (hereinafter *HCCA*).
[5] Section 4(1) of the *HCCA*.

and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

In the context of medical assistance in dying, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of medication. A patient's capacity is fluid and may change over time. Therefore, physicians must be alert to potential changes in the patient's capacity.

When assessing capacity in the context of a request for medical assistance in dying, physicians are advised to rely on existing practices and procedures for capacity assessments.

3. Grievous and Irremediable Medical Condition

Under federal legislation, an individual has a grievous and irremediable medical condition if:

a) They have a serious and incurable illness, disease or disability;
b) They are in an advanced state of irreversible decline in capability;
c) That illness, disease or disability, or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
d) Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the individual has to live.

The College acknowledges that the above definition of 'grievous and irremediable medical condition' does not follow terminology typically used in a clinical context. In determining whether a patient has a grievous and irremediable medical condition, physicians must use their professional judgement to assess the patient. Physicians may also wish to obtain independent legal advice.[6]

4. Voluntary Request for Medical Assistance in Dying

In accordance with federal legislation and the requirements for consent under the *Health Care Consent Act, 1996*, requests for medical assistance in dying must be voluntary and not made as a result of external pressure or coercion.

The physician must be satisfied that the patient's decision to undergo medical assistance in dying has been made freely, without undue influence from family members,

[6] For further details on interpreting the statutory definition of 'grievous and irremediable', physicians may wish to consult companion resources authored by the federal government, which are available on the Department of Justice website: http://www.justice.gc.ca/eng/cj-jp/ad-am/index.html.

healthcare providers, or others. The patient must have requested medical assistance in dying him/herself, thoughtfully and in a free and informed manner.

5. Informed Consent

In order to receive medical assistance in dying, a patient must provide their informed consent. The process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to medical assistance in dying.

The College's *Consent to Treatment* policy outlines the legal requirements of valid consent as set out in the *Health Care Consent Act, 1996*. In order for consent to be valid it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.[7]

As part of obtaining informed consent, physicians must discuss all treatment options with the patient. With respect to medical assistance in dying specifically, the treatment options discussed with the patient must include all reasonable and available palliative care interventions. The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

As noted above, a patient must be capable of making decisions with respect to their health to meet the criteria for medical assistance in dying. Therefore, consent to medical assistance in dying must be provided by a capable patient and not by a substitute decision maker.

Conscientious Objection

The federal legislation does not address how conscientious objections of physicians, nurse practitioners, or other healthcare providers are to be managed. In the *Carter* case, the Supreme Court of Canada noted that the *Charter* rights of patients and physicians would have to be reconciled. Physicians who have a conscientious objection to providing medical assistance in dying are directed to comply with the College's expectations for conscientious objections in general, set out in the *Professional Obligations and Human Rights* policy.

These expectations are as follows:

- Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must do so in a manner that respects patient dignity. Physicians must not impede access to medical assistance in dying, even if it conflicts with their conscience or religious beliefs.

[7] Section 11(1) of the *HCCA*.

- The physician must communicate his/her objection to medical assistance in dying to the patient directly and with sensitivity. The physician must inform the patient that the objection is due to personal and not clinical reasons. In the course of communicating an objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.

- In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient's clinical needs, concerns, and/or wishes. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.

- Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency.[8] The referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.

The federal legislation does not compel physicians to provide or assist in providing medical assistance in dying. For clarity, the College does not consider providing the patient with an 'effective referral' as 'assisting' in providing medical assistance in dying.[9]

Documentation Requirements

The College's *Medical Records* policy sets out physicians' professional and legal obligations with respect to medical records. The policy requires that physicians document each physician-patient encounter in the medical record. This would include encounters concerning medical assistance in dying. The medical record must be legible, and the information in the medical record must be understood by other healthcare professionals. Where there is more than one healthcare professional making entries in a record, each professional's entry must be identifiable.

[8] The College acknowledges that the number of physicians, healthcare providers, and/or agencies to which a referral would be directed may be limited, particularly at the outset of the provision of medical assistance in dying in Ontario, and that this is relevant to any consideration of whether a physician has complied with the requirement to provide an effective referral. In light of these circumstances, the College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

[9] For more information on and examples of what constitutes an 'effective referral', please see the document titled '*Fact Sheet: Ensuring Access to Care: Effective Referral*', available on the College's website: [LINK].

Each record of a physician-patient encounter, regardless of where the patient is seen, must include a focused relevant history, documentation of an assessment and an appropriate focused physical exam (when indicated), including a provisional diagnosis (where indicated), and a management plan.

Where a patient has requested medical assistance in dying, the physician must document each element of the patient's assessment in accordance with the criteria outlined above, and include a copy of their written opinion in the medical record. Further, all oral and written requests for medical assistance in dying, as well as the dates of these requests, must be documented in the medical record. A copy of the patient's written request must also be included.[10]

In circumstances where a physician declines to provide medical assistance in dying, the physician must document that an effective referral was provided to the patient. This includes documenting, in the medical record, the date on which the effective referral was made and the physician, nurse practitioner and/or agency to which the referral was directed.

Reporting and Data Collection

The federal government has indicated its intention to create a formal oversight and reporting body that would collect data on medical assistance in dying.

The federal legislation empowers the federal minister of health to make regulations defining a monitoring system for medical assistance in dying in Canada. According to the federal government, these regulations could stipulate the types of data to be provided and to whom; the body that would collect and analyze the information; and how often reports would be published, for example.

Until such regulations are in force, the federal government has committed to working collaboratively with the provinces and territories on a protocol for the collection of medical assistance in dying data. The College will keep its members abreast of any developments in this regard.

[10] The Ontario Ministry of Health and Long-Term Care (MOHLTC) is developing resources to support the provision of medical assistance in dying. Physicians are advised to consult the MOHLTC's website for further details.

Process Map for Medical Assistance in Dying

The process map that follows details the steps that physicians must undertake in relation to medical assistance in dying. It complies with federal legislation and outlines safeguards that must be adhered to, by law, prior to the provision of medical assistance in dying. Physicians and nurse practitioners, along with those who support them, are protected from liability if acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.[11]

STEP 1: Patient makes initial inquiry for medical assistance in dying to a physician or a nurse practitioner.

Physicians who have a conscientious objection to medical assistance in dying are not obliged to proceed further through the process map and evaluate a patient's inquiry for medical assistance in dying. As described above, objecting physicians must provide the patient with an effective referral to a non-objecting physician, nurse practitioner, or agency. The objecting physician must document, in the medical record, the date on which the effective referral was made, and the physician, nurse practitioner and/or agency to which the referral was directed.

STEP 2: Physician or nurse practitioner assesses the patient against eligibility criteria for medical assistance in dying.

The physician or nurse practitioner must ensure that the patient meets the criteria for medical assistance in dying. As described above, the patient must:

1. Be eligible for publicly funded health services in Canada;
2. Be at least 18 years of age and capable of making decisions with respect to their health;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability);
4. Make a voluntary request for medical assistance in dying that is not the result of external pressure; and
5. Provide informed consent to receive medical assistance in dying.

[11] Liability protections extend to pharmacists, any individuals supporting physicians or nurse practitioners (not limited to regulated health professionals), and individuals who aid a patient to self-administer the fatal dose of medication, when acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules.

Where the patient's capacity or voluntariness is in question, the attending physician must refer the patient for a specialized capacity assessment.

With respect to the third element of the above criteria, a patient has a grievous and irremediable medical condition, if:

- ✓ They have a serious and incurable illness, disease or disability;
- ✓ They are in an advanced state of irreversible decline in capability;
- ✓ That illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- ✓ Their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that the individual has to live.

If the physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to make a request for medical assistance in dying to another physician who would again assess the patient using the above criteria.

The physician must document the outcome of the patient's assessment in the medical record.

STEP 3: Patient makes written request for medical assistance in dying before two independent witnesses.

The patient's request for medical assistance in dying must be made in writing. The written request must be signed and dated by the patient requesting medical assistance in dying on a date after the patient has been informed that they have a grievous and irremediable medical condition.

If the patient requesting medical assistance in dying is unable to sign and date the request, another person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying, may do so in the patient's presence, on the patient's behalf, and under the patient's express direction.

The patient's request for medical assistance in dying must be signed and dated before two independent witnesses, who then must also sign and date the request. An independent witness is someone who is at least 18 years of age, and who understands the nature of the request for medical assistance in dying.

An individual may not act as an independent witness if they have a financial or other material benefit resulting from the patient's death; own or operate the health care

facility at which the patient making the request is being treated; or are directly involved in providing the patient's healthcare and/or personal care.

The physician must document the date of the patient's request for medical assistance in dying in the medical record. A copy of the physician's written opinion regarding whether the patient meets the eligibility criteria must also be included in the medical record.

STEP 4: The physician or nurse practitioner must remind the patient of his/her ability to rescind the request at any time.

The physician or nurse practitioner must remind the patient that they may, at any time and in any manner, withdraw their request.

STEP 5: An independent second physician or nurse practitioner confirms, in writing, that the patient meets the eligibility criteria for medical assistance in dying.

A second physician or nurse practitioner must assess the patient in accordance with the criteria provided above, and provide their written opinion confirming that the requisite criteria for medical assistance in dying have been met.

The first and second physician or nurse practitioner assessing a patient's eligibility for medical assistance in dying must be independent of each other. This means that they must not:

- Be a mentor to them or responsible for supervising their work;
- Know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, other than standard compensation for their services relating to the request; or
- Know or believe that they are connected to the other practitioner or to the person making the request in any other way that would affect their objectivity.

If the second physician concludes that the patient does not meet the criteria for medical assistance in dying as outlined above, the patient is entitled to have another physician assess them against the criteria.

STEP 6: A 10-day period of reflection from date of request to provision of medical assistance in dying.

A period of at least 10 clear days[12] must pass between the day on which the request for medical assistance in dying is signed by or on behalf of the patient, and the day on which medical assistance in dying is provided.

In accordance with federal legislation, this timeframe may be shortened if both the physician(s) and/or nurse practitioner(s) agree that death or loss of capacity to provide consent is imminent.

STEP 7: Physician or nurse practitioner informs dispensing pharmacist that prescribed substance is intended for medical assistance in dying.

Medical assistance in dying includes where the physician or nurse practitioner provides the patient with the means to end his/her own life, and voluntary euthanasia, where the physician or nurse practitioner is directly involved in administering an agent to end the patient's life.

Physician(s) and/or nurse practitioner(s) must inform the pharmacist of the purpose for which the substance is intended before the pharmacist dispenses the substance. Physicians are advised to notify the pharmacist as early as possible (e.g. at the commencement of the reflection period) that medications for medical assistance in dying will likely be required. This will provide the pharmacist with sufficient time to obtain the required medications.

Physicians must exercise their professional judgement in determining the appropriate drug protocol to follow to achieve medical assistance in dying. The goals of any drug protocol for medical assistance in dying include ensuring the patient is comfortable, and that pain and anxiety are controlled.

College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the College's website.

[12] The term "clear days" is defined as the number of days, from one day to another, excluding both the first and the last day. Therefore, in the context of medical assistance in dying, the 10-day reflection period would commence on the day following the day on which the patient's request is made, and would end the day following the fifteenth day.

STEP 8: Provision of Medical Assistance in Dying.

The patient must be capable not only at the time the request for medical assistance in dying is made, but also at the time of their medically assisted death.

Immediately before providing medical assistance in dying, the physician(s) and/or nurse practitioner(s) involved must provide the patient with an opportunity to withdraw the request and if the patient wishes to proceed, confirm that the patient has provided express consent. This must occur either immediately before the medication is administered or immediately before the prescription is provided.

Physicians and nurse practitioners who provide medical assistance in dying, and those who assist them throughout the process, are protected from liability if acting in compliance with the federal legislation and any applicable provincial or territorial laws, standards or rules. These protections would extend, for example, to pharmacists, any individual who supports a physician or nurse practitioner (not limited to regulated health professionals), or individuals who aid a patient to self-administer the fatal dose of medication.

Where the patient plans to self-administer the fatal dose of medication at home, physicians must help patients and caregivers assess whether this is a manageable option. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.

Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.

STEP 9: Certification of Death

In accordance with the *Coroners Act, 1990*, coroners are required to complete the Medical Certificate of Death in all cases where medical assistance in dying is provided.

Physicians must disclose to their patients that the Office of the Chief Coroner will investigate all medically assisted deaths. The extent of a coroner's investigation cannot be determined in advance, and may or may not include an autopsy.

The Ministry of Health and Long-Term Care is working closely with the Office of the Chief Coroner of Ontario to ensure that all coroners across the province are aware of the unique nature of medical assistance in dying, and the sensitivities that exist for families throughout this process.

Physician-Assisted Death

Introduction

Historically, it has been a crime in Canada to assist another person in ending his/her own life. This criminal prohibition has applied to circumstances where a physician provides or administers medication that intentionally brings about a patient's death, at the request of the patient. This is often termed physician-assisted death.

In the case of *Carter v. Canada*[1], the Supreme Court of Canada (SCC) considered whether the criminal prohibition on physician-assisted death violates the *Charter* rights of competent adults, who are suffering intolerably from grievous and irremediable medical conditions, and seek assistance in dying. The SCC unanimously determined that an absolute prohibition on physician-assisted death *does* violate the *Charter* rights of these individuals, and is unconstitutional.

The SCC suspended its decision for 12 months (until February 6 2016) 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 deadline was later extended to June 6, 2016.[2]

This means that following June 6, 2016, physician-assisted death will be legal in Canada. At that time, subject to any prohibitions or restrictions that may be imposed in future legislation or policy, physicians will be legally permitted to assist competent adults who are suffering intolerably from grievous and irremediable medical conditions to end their lives.

Purpose of Document

This policy complies with the SCC's decision in *Carter v. Canada*, and articulates:

- Professional and legal obligations articulated in 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.

To the extent that there is any inconsistency between the guidance provided in this document and any future government framework developed to govern the provision of physician-assisted death, the latter would take precedence.

Principles

The key values of medical professionalism, as articulated in the College's *Practice Guide*, are compassion, service, altruism and trustworthiness. The fiduciary nature of the physician-patient relationship requires that physicians prioritize patient interests. In doing so, physicians must

[1] *Carter v. Canada (Attorney General)*, 2015 SCC 5.
[2] *Carter v. Canada (Attorney General)*, 2016 SCC 4.

strive to create and foster an environment in which the rights, dignity and autonomy of all patients are respected.

Physicians embody the key values of medical professionalism and uphold the reputation of the profession by, among other things:

- Respecting patient autonomy with respect to healthcare goals and treatment decisions;
- Acting in the best interests of their patients, and ensuring that all patients receive equitable access to care;
- Communicating sensitively and effectively with patients in a manner that supports patients' autonomy in decision-making, and ensures they are informed about their medical care; and
- Demonstrating professional competence, which includes meeting the standard of care and acting in accordance with all relevant and applicable legal and professional obligations.

Policy

Criteria for Physician-Asissted Death

In accordance with the SCC's decision in *Carter v. Canada,* for an individual to access physician-assisted death, he/she must:

1. Be a competent adult;
2. Clearly consent to the termination of life;
3. Have a grievous and irremediable medical condition (including an illness, disease or disability); *and*
4. Experience enduring suffering that is intolerable to the individual in the circumstances of his or her condition.

Physicians must use their professional judgement to assess an individual's suitability for physician-assisted death, against the above criteria.

The College advises that physicians should only provide physician-assisted death to eligible patients within Canada who qualify for Canadian publicly-funded health services.

The content that follows elaborates upon each element of the criteria for physician-assisted death.

1. Competent adult

i) Adult

The wording of the SCC's decision indicates that physician-assisted death is available only to competent adults. The SCC did not expressly define the term "adult" in this context.

ii) Competence

The College interprets the requirement that the adult be 'competent' to refer to decision-making capacity. Under the *Health Care Consent Act, 1996*[3] (and as reflected in the College's *Consent to Treatment* policy), a patient is capable if they are able to understand the information that is relevant to making the decision, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[4] The patient must be able to understand and appreciate the history and prognosis of their medical condition, treatment options, and the risks and benefits of each treatment option.

In the context of physician-assisted death, the patient must be able to understand and appreciate the certainty of death upon self-administering or having the physician administer the fatal dose of medication. A patient's capacity is fluid and may change over time. Therefore, physicians must be alert to potential changes in the patient's capacity.

When assessing capacity in the context of a request for physician-assisted death, physicians are advised to rely on existing practices and procedures for capacity assessments.

2. Clearly consents to the termination of life

A patient who seeks physician-assisted death must clearly consent to the termination of life. The SCC highlighted that the process and requirements for obtaining informed consent in other medical decision-making contexts are also applicable to physician-assisted death.

The College's *Consent to Treatment* policy outlines the legal requirements of valid consent as set out in the *Health Care Consent Act, 1996*. In order for consent to be valid it must be related to the treatment, fully informed, given voluntarily, and not obtained through misrepresentation or fraud.[5]

As part of obtaining informed consent, physicians must discuss all treatment options with the patient. With respect to physician-assisted death specifically, the treatment options discussed with the patient must include all reasonable and available palliative care interventions. The College's *Planning for and Providing Quality End-of-Life Care* policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life, including proposing and/or providing palliative care where appropriate.

The physician must be satisfied, on reasonable grounds, that the patient's decision to undergo physician-assisted death has been made freely, without coercion or undue influence from family members, healthcare providers or others. The patient must have a clear intention to end his/her own life after due consideration. The patient must have requested physician-assisted death him/herself, thoughtfully and in a free and informed manner.

Requests for physician-assisted death must be made by the patient, and not through an advance directive, or the patient's substitute decision maker.

[3] *Health Care Consent Act, 1996,* S.O. 1996, c.2, Sched. A (hereinafter *HCCA*).
[4] Section 4(1) of the *HCCA*.
[5] Section 11(a) of the *HCCA*.

3. Grievous and irremediable medical condition

The SCC indicated that a grievous and irremediable medical condition can include an illness, disease or disability. To determine whether the patient has a grievous and irremediable medical condition, the physician must assess the patient and render a diagnosis and prognosis of the patient's condition.

'Grievous' is a legal term that applies to serious, non-trivial conditions that have a significant impact on the patient's well-being. 'Irremediable' is a broad term capturing both terminal and non-terminal conditions. As stated by the SCC, 'irremediable' does not require the patient to undertake treatments that are not acceptable to the individual.[6]

For instance, the two lead plaintiffs in the SCC case of *Carter v. Canada* suffered from Amyotrophic Lateral Sclerosis (ALS), a terminal neurodegenerative disease, and spinal stenosis, a non-terminal degenerative condition involving progressive compression of the spinal cord. The SCC determined that the prohibition on physician-assisted death violated the constitutional rights of both plaintiffs.

4. Enduring suffering that is intolerable

The criterion that an individual experience intolerable suffering is subjective, meaning it is assessed from the individual's perspective.

When a physician is determining whether a patient satisfies this element of the criteria, the physician must be satisfied that the patient's condition causes them enduring physical and/or psychological suffering that is intolerable to the patient. This may be demonstrated, in part, by communication, by the patient, of a sincere desire to pursue physician-assisted death, or through a dialogue with the patient about their personal experience managing their condition.

Fees

The activities involved in both assessing whether a patient meets the criteria for physician-assisted death, and providing physician-assisted death, are currently insured services. These activities may include, for instance, counselling and prescribing. Accordingly, physicians must not charge patients directly for physician-assisted death, or associated activities. Physicians are advised to refer to the OHIP Schedule of Benefits for further information.

Conscientious Objection

The SCC's decision in *Carter v. Canada* does not compel physicians to provide physician-assisted death. The SCC noted that the *Charter* rights of patients and physicians would have to be reconciled.

[6] *Carter v. Canada (Attorney General)*, 2015 SCC 5 at para 127.

Physicians who have a conscientious objection to providing medical assistance in dying are directed to comply with the expectations for conscientious objections in general, set out in the *Professional Obligations and Human Rights* policy.

These expectations are as follows:

- Where a physician declines to provide physician-assisted death for reasons of conscience or religion, the physician must do so in a manner that respects patient dignity. Physicians must not impede access to physician-assisted death, even if it conflicts with their conscience or religious beliefs.

- The physician must communicate his/her objection to physician-assisted death to the patient directly and with sensitivity. The physician must inform the patient that the objection is due to personal and not clinical reasons. In the course of communicating an objection, physicians must not express personal moral judgments about the beliefs, lifestyle, identity or characteristics of the patient.

- In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient's clinical needs, concerns and/or wishes. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.

- Where a physician declines to provide physician-assisted death for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or agency.[7] The referral must be made in a timely manner to allow the patient to access physician-assisted death. Patients must not be exposed to adverse clinical outcomes due to delayed referrals. [8]

Documentation Requirements

The College's *Medical Records* policy sets out physicians' professional and legal obligations with respect to medical records. The policy requires that physicians document each physician-patient encounter in the medical record. This would include encounters concerning physician-assisted death. The medical record must be legible, and the information in the medical record must be understood by other healthcare professionals. Where there is more than one healthcare professional making entries in a record, each professional's entry must be identifiable.

[7] The College acknowledges that the number of physicians and/or agencies to which a referral would be directed may be limited, particularly at the outset of the provision of physician-assisted death in Ontario, and that this is relevant to any consideration of whether a physician has complied with the requirement to provide an effective referral. In light of these circumstances, the College expects physicians to make reasonable efforts to remain apprised of resources that become available in this new landscape.

[8] For more information on and examples of what constitutes an 'effective referral', please see document titled '*Fact Sheet: Ensuring Access to Care: Effective Referral*', available on the College's website: [LINK].

Each record of a physician-patient encounter, regardless of where the patient is seen, must include a focused relevant history, documentation of an assessment and an appropriate focused physical exam (when indicated), including a provisional diagnosis (where indicated), and a management plan. Where a patient has requested physician-assisted death, the physician must document each element of the patient's assessment in accordance with the criteria outlined above. Further, all oral and written requests for physician-assisted death, as well as the dates of these requests, must be documented in the medical record. A copy of the patient's written request must also be included.

Reporting and Data Collection

The College supports the establishment of a formal oversight and reporting mechanism that would collect data on physician-assisted death, and advocates that a data collection mechanism form part of any government framework. A central data collection agency would help ensure compliance with specific requirements related to physician-assisted death, and help ascertain the prevalence of and circumstances leading to physician-assisted death in Canada.

I. Process Map for Physician-Assisted Death[9]

[Note to Council: the content preceding the 'Sample Process Map' in the *Interim Guidance* document addressing judicial exemptions for physician-assisted death has been removed.]

Physicians who are willing to provide physician-assisted death are advised to follow the process map outlined below. This process map, which has been adapted from guidance provided in jurisdictions outside of Ontario, sets out specific practice-related elements for the provision of physician-assisted death.[10] As described above, where physicians are unwilling to provide physician-assisted death for reasons of conscience or religion, an effective referral to another physician or agency must be provided to the patient.

Stage 1: Patient requests physician-assisted death
FIRST REQUEST o The patient makes the first request for physician-assisted death to the attending physician. o Unless an effective referral to another physician or agency is provided to the patient, the attending physician must assess the patient to determine whether he/she meets the criteria for physician-assisted death. As described above, the patient must: (1) Be a competent adult; (2) Clearly consent to the termination of life; (3) Have a grievous and irremediable medical condition (including an illness, disease or disability); and (4)

[9] In developing this Process Map, the processes in place in established jurisdictions such as Oregon and the Netherlands were reviewed, along with the following guidance documents released by select Canadian medical regulators and the Canadian Medical Association:(1) College of Physicians and Surgeons of Alberta, *Advice to the Profession – Physician-Assisted Death* (January 2016); (2) The College of Physicians and Surgeons of Saskatchewan, *Policy – Physician-Assisted Dying* (November 2015);and (3) Canadian Medical Association, *Principles Based Recommendations for a Canadian Approach to Medical Aid in Dying* (January 2016).

[10] The Ontario Ministry of Health and Long-Term Care (MOHLTC) is developing resources to support the provision of physician-assisted death. Physicians are advised to consult the MOHLTC's website for further details.

Experience enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
- In relation to the first two criterion, the attending physician must assess the patient for capacity and voluntariness, or refer the patient for a specialized capacity assessment where the patient's capacity is in question.
- The attending physician must remind the patient of his/her ability to rescind the request at any time.
- Along with documenting the patient's assessment, the attending physician must document the date of the patient's first request for physician-assisted death in the medical record.
- If the attending physician concludes that the patient does not meet the criteria for physician-assisted death as outlined above, the patient is entitled to make a request for physician-assisted death to another physician who would again assess the patient using the above criteria.

REFLECTION PERIOD
- A period of reflection, between the first and second requests for physician-assisted death is required.
- The period of reflection is intended to provide both the patient and the attending physician an opportunity to consider the request for physician-assisted death.
- The length of the period of reflection will vary, and may depend, in part, on the rapidity of progression and nature of the patient's medical condition. It is essential that the patient has sufficient time to come to an informed and voluntary decision to end his/her life, and that the patient appreciates the consequences of this decision.

SECOND REQUEST
- The patient makes a second request for physician-assisted death to the attending physician. This second request for physician-assisted death by the patient requires formal documentation.
- The second request may be oral and transcribed by another party, or written by the patient.
- The written request, or the transcribed oral request, must be dated and signed by the patient, and countersigned by an independent witness and the attending physician.

Stage 2: Prior to the provision of physician-assisted death

CONSULTING PHYSICIAN
- A second consulting physician must ensure that the requisite criteria for physician-assisted death have been met. As described above, the patient must: (1) Be a competent adult; (2) Clearly consent to the termination of life; (3) Have a grievous and irremediable medical condition (including an illness, disease or disability); and (4) Experience enduring suffering that is intolerable to the individual in the circumstances of his or her condition.
- In relation to the first two criteria, the consulting physician must assess the patient for capacity and voluntariness, or refer the patient for a specialized capacity assessment where the patient's capacity is in question.
- If the consulting physician concludes that the patient does not meet the criteria for physician-assisted death as outlined above, the patient is entitled to have another

consulting physician assess them against the criteria.
- Both the attending and consulting physician must independently document their opinion as to whether the requisite criteria for physician-assisted death have been met.
- The consulting physician must remind the patient of his/her ability to rescind the request for physician-assisted death at any time.

236

Stage 3: Physician-Assisted Death - Self-Administration or Physician Administration

- Physician-assisted death includes both instances in which the physician provides the patient with the means to end his/her own life, and voluntary euthanasia, where the physician is directly involved in administering an agent to end the patient's life.
- The patient must be capable not only at the time the request for physician-assisted death is made, but also at the time of physician-assisted death.
- Where the patient plans to self-administer the fatal dose of medication at home, physicians must help patients and caregivers assess whether this is a manageable option. This includes ensuring that the patient is able to store the medication in a safe and secure manner so that it cannot be accessed by others.
- Further, physicians must ensure that patients and caregivers are educated and prepared for what to expect, and what to do when the patient is about to die or has just died. This includes ensuring that caregivers are instructed regarding whom to contact at the time of death. For further information, physicians are advised to consult the College's *Planning for and Providing Quality End-of-Life Care* policy.
- Physicians must exercise their professional judgement in determining the appropriate drug protocol to follow to achieve physician-assisted death. The goals of any drug protocol for physician-assisted death include ensuring the patient is comfortable, and that pain and anxiety are controlled.
- College members may wish to consult resources on drug protocols used in other jurisdictions. Examples of such protocols are available on the *CPSO Members* login page on the College's website.

237

Stage 4: Certification of Death

- In accordance with the *Coroners Act, 1990*, coroners are required to complete the Medical Certificate of Death where physician-assisted death is provided.
- Physicians must disclose to their patients, and with consent , patients' families, that the Office of the Chief Coroner will investigate all physician-assisted deaths. The extent of a coroner's investigation cannot be determined in advance, and may or may not include an autopsy.
- The Ministry of Health and Long-Term Care is working closely with the Office of the Chief Coroner of Ontario to ensure that all coroners across the province are aware of the unique nature of physician-assisted death and the sensitivities that exist for families

throughout this process.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

COUNCIL BRIEFING NOTE

TOPIC: **ANNUAL FIRE DRILL AND EVACUATION**

FOR INFORMATION

ISSUE: The College is required to hold a fire drill and building evacuation annually. This event will take place during the May meeting of Council.

BACKGROUND:

- The College is required by law to ensure that all fire safety devices are tested and operational. This includes ringing of the fire alarms and a mandatory planned evacuation of the building.
- Staff and Council members are required to participate in the fire drill at the May meeting.

CONSIDERATIONS:

- Council members are frequently in the building for meetings and many have not participated in evacuation procedures. This opportunity will allow councillors to review the evacuation procedures and participate in a fire drill.

NEXT STEPS:

- Participate in the fire drill: evacuate the building and meet at checkpoint

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CONTACT: Krista Waaler, Manager, Facilities & Building Operations, ext 384

DATE: May 12, 2016

Appendices:

EMERGENCY PROCEDURES
COUNCIL & COMMITTEE MEMBERS

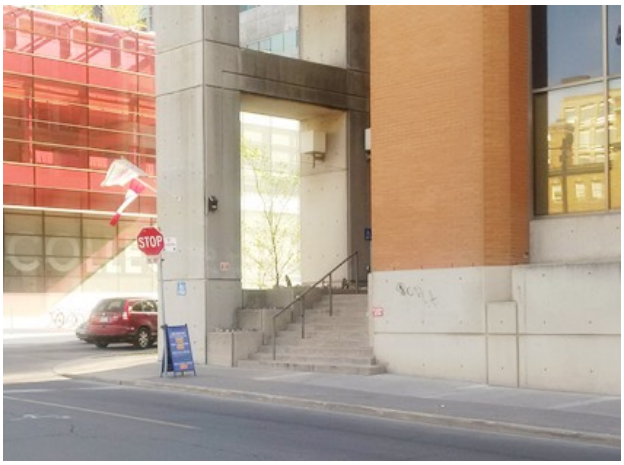
Upon hearing a fire alarm, the Committee Chair will stop the meeting.

With the back of your hand, test the door handle for heat and follow these steps:

- Door/handle is cool to touch
  - Brace yourself against the door and open slightly.
  - If you do not feel a resistance when you open the door, you are safe to leave the room.
  - Take the meeting role call with you to use as attendance
  - Exit with your group and close the door behind you.
  - Proceed to your nearest exit located near the washroom entrances. Do not use elevators.
  - Follow instructions provided by Fire Safety Team leaders and the Fire Department.
  - Once outside the building go to meeting check point (as seen below) and take attendance of your Committee members. If anyone is missing, report to the fire team (green hard hats).
  - Do not return to the building until it is declared safe to do so by the Fire Department or CPSO fire team.

- Door handle is hot or you have difficulty opening the door due to pressure:
  - Close the door and remain in the room.
  - Call the Fire Department at 9-911 and alert them of the address of the building (80 College Street) and your location (i.e. 3rd floor).
  - Call Security at extension 612 with the same information.
  - Seal off all openings, which may admit smoke.
  - Crouch low to the floor if smoke enters the room.
  - Wait for assistance from the fire department.

CHECK POINT – ONA Building



May 2016

COUNCIL BRIEFING NOTE

TOPIC: Planning for and Providing Quality End-of-Life Care – Post Approval Amendments

FOR DECISION

ISSUE:

- The Planning for and Providing Quality End-of-Life Care policy was approved by Council in September 2015.
- Council will recall that the policy content regarding no-CPR orders has received significant attention and criticism largely from physicians in the Critical Care specialty.
- Drs. Kirsh and Gerace recently received additional feedback from two leaders in Critical Care which they, together with Dr. Leet, felt warranted further consideration.
- This new feedback is outlined for Council, together with proposed amendments to the policy and the companion FAQ document. Additionally, some housekeeping amendments are proposed to the policy content relating to physician-assisted death, now called medical assistance in dying, to reflect the most recent information, and College resources.
- Council is asked whether it approves these amendments.

BACKGROUND:

No-CPR Orders

- The Planning for and Providing Quality End-of-Life Care policy was developed by a Working Group[1] chaired by Dr. Carol Leet. It was approved by Council in September 2015.

[1] The Working Group was comprised of Council members Dr. Carol Leet (Chair), Ms. Debbie Giampietri, Mr. Emile Therien, and Dr. Ron Wexler, as well as non-Council members who have specific expertise in end-of-life care issues, Dr. Scott Wooder (Past President Ontario Medical Association), Dr. Adam Rapoport (Medical Director, Paediatric Advanced Care Team, Hospital for Sick Children), and Dr. Camilla Zimmermann (Head, Palliative Care Program, University Health Network). Dr. Eugenia Piliotis (Medical Advisor) and Vicki White (Legal Counsel) also supported the Working Group.

- Council will recall that the policy content regarding no-CPR orders found in Section 5.2 of the policy received critical feedback, largely from physicians in the Critical Care specialty. In particular, criticisms were primarily directed at the following requirement:

    - *"While the conflict resolution process is underway, if an event requiring CPR occurs, physicians must provide CPR."*

- Prior to September Council, the Critical Care specialty submitted proposed policy revisions to the Working Group and ultimately directly to Council. Dr. Leet also highlighted these revisions in her presentation at September Council. The proposed revisions would have prohibited the writing of a no-CPR order while conflict resolution is underway, but would have permitted physicians to make a bedside determination as to whether or not to begin CPR despite disagreement about the writing of a no-CPR order.

- Both the Working Group and Council did not accept the proposed revisions. It was felt that the proposed revisions were contrary to the spirit of the policy and in particular, undermined the spirit and intention of conflict resolution, and departed from the public's expectations for decision-making regarding no-CPR orders. Public polling indicated that the public expects to be a part of the decision-making process and to have a meaningful say in whether or not a no-CPR order is written.

- Following Council's approval of the policy in September members of the Critical Care specialty have continued to express concern and displeasure with the policy position. Many of these concerns are not new, but rather are just reiterations of the concerns that were considered by both the Working Group and Council.

- Critical Care physicians have taken a number of steps to advocate for their position, including:

    - Approaching a senior government official to express their concern, initiating two lobby efforts to write letters of concern and advocate for change to Drs. Leet and Kirsh, publishing a 'Commentary' in the Canadian Medical Association Journal, January 4 2016 to express their concerns with the policy, and seeking informal meetings with Drs. Kirsh and Gerace.

- The Executive Committee was updated on these activities at its January 2016 meeting and decided not to pursue any revisions to the policy at that time.

- The College has now received a letter from Drs. Andrew Baker[2] and Laurent Brochard,[3] two Critical Care physicians who express support for the policy and have

[2] Chief, Department of Critical Care, St. Michael's Hospital; Director, Trauma and Neurosurgery Program, St. Michael's Hospital; Professor, Department of Anesthesia and Surgery, University of Toronto.

proposed a new approach to addressing the concerns expressed by other members of their specialty.

- Drs. Baker & Brochard propose that the policy be clarified to address a potential misinterpretation of the policy expectations as it relates to the provision of CPR when there are physiological impediments to its success.

    - While supportive of the policy, they encourage the College to clarify that in those circumstances where the patient's condition would prevent the intended physiologic goals of CPR (e.g. providing oxygenated blood flow to the brain) from being achieved, that a physician is not required to provide CPR even if there is disagreement with the patient or substitute decision-maker regarding the writing of a no-CPR order.

    - They offered the following examples of when this may be the case: raised or rising intracranial pressure, end stage acute lung injury, and uncorrectable exsanguination.

Physician-Assisted Death

- As the policy was approved in September 2015, in relation to physician-assisted death (PAD), the policy simply notes that PAD is prohibited by the *Criminal Code* but acknowledges that when the *Carter* decision comes into force, these prohibitions will be invalid in specific circumstances. The policy also sets out expectations for physicians regarding the release of medical records to physicians in jurisdictions where PAD is legal.

- At the time of drafting this policy, the intent was for the policy to only reflect the status of PAD at the time, with a plan to amend the policy once there was more clarity regarding the intention of government and the development of College materials.

CURRENT STATUS:

- The proposed clarification presented by Drs. Baker and Brochard has been discussed by Drs. Gerace, Kirsh and Leet. It was felt that Drs. Baker and Brochard brought forward a new perspective on the challenging issue of no-CPR orders, and their proposed approach to clarifying the policy warranted consideration.

    - Unlike previous proposals, in the cases Drs. Baker and Brochard identify, the decision not to provide CPR is a purely clinical one, based on whether the goals of CPR can be achieved, from a physiological perspective. The

[3] Division Director, Interdepartmental Division of Critical Care Medicine; Professor of Critical Care, University of Toronto; Keenan Chair, Critical Care & Respiratory Medicine; Scientists, Li Ka Shing Knowledge Institute, Keenan Research Centre for Biomedical Science.

decisions are not motivated by or informed by judgements regarding the quality or value of the life of the patient.

- In response, staff have worked with the proposed approach to develop policy revisions for Council's consideration.

- Housekeeping revisions to update the policy content on PAD are also proposed.

- The proposed revisions, along with rationale for amending the policy in this manner, are set out below.

A. No-CPR Orders

1. Proposed Amendments

- In response to Drs. Baker and Brochard's proposal, an amended version of the policy has been drafted (a track changes version is included as **Appendix 1**). The amendments:

    - Update the list of instances where a physician may recommend that a no-CPR order be written, identifying those instances where a patient's condition will prevent the intended physiologic goals of CPR from being achieved (Lines 266 to 267 of **Appendix 1**).

    - Retain the prohibition on unilateral decision-making regarding no-CPR orders and the requirement that physicians engage in conflict resolution in all cases of disagreement regarding the writing of a no-CPR order (Lines 269 to 279 of **Appendix 1**).

    - Create an exception to the requirement that CPR be provided while conflict resolution is underway when the patient's condition will prevent the intended physiologic goals of CPR from being achieved, thereby allowing physicians to make a bedside determination about whether or not to provide CPR in just this narrow set of cases (Lines 280 to 285 of **Appendix 1**).

- A minor edit has also been proposed to the definition of CPR contained in the policy: removing explicit reference to "intubation" (Line 44 of **Appendix 1**). Some critics worried that this would result in physicians being required to intubate patients. The definition still includes "artificial ventilation", thereby permitting physician to make a case-by-case assessment regarding the appropriateness of intubation.

- Amendments to the companion Frequently Asked Questions document have also been proposed to ensure alignment with these proposed changes, to provide additional guidance relating to these changes, and to provide clarification regarding questions that have been regularly asked of the College following approval of the policy (see **Appendix 2**).

2. Rationale

- The proposed amendments are minor in nature and are consistent with the spirit of the policy.

- Most importantly, the original prohibition on unilateral decision-making regarding no-CPR orders and the original requirements have not changed: physicians must discuss their recommendation that a no-CPR order be written with the patient and/or substitute decision-maker before writing the order and must engage in conflict resolution when there is disagreement. These requirements exist in all instances where a physician is of the opinion that a no-CPR order should be written.

- The proposed amendments only create an exception to the requirement that CPR be provided during conflict resolution in a very narrow set of circumstances and where it is exclusively a matter of clinical assessment as to whether the intended goals of CPR can be achieved. As such, while the proposed amendments are structurally similar to the Critical Care specialty's proposed revisions considered by Council in September 2015, they are importantly different, as they are much narrower in scope.

B. Physician-Assisted Death

1. Proposed Amendments

- As Council is aware, since September Council when this policy was approved, there have been significant developments regarding PAD:

    - The College has released its Interim Guidance on Physician-Assisted Death ("Interim Guidance") document;

    - The federal government was granted a four-month extension by the Supreme Court of Canada, extending the suspension period regarding the SCC's decision to June 6, 2016; and

    - The federal government has introduced proposed legislation that they are hoping will be in effect by June 6, 2016 and have adopted the terminology of medical assistance in dying (MAID) instead of PAD.

- It is proposed that this section of the policy be revised to acknowledge the implications of the *Carter* decision, adopt the new terminology of MAID rather than PAD, reference the proposed federal legislation, and to direct readers to the Interim Guidance document, or its replacement, for more information and advice (Lines 362 to 373 of **Appendix 1**).

- Additionally, it is proposed that the expectations regarding the release of medical records to other physicians, be amended to apply in both the international and Canadian context (Lines 385 to 389 of **Appendix 1**).

2. Rationale

- While there is currently uncertainty regarding the nature of the regulatory framework that the federal government has committed to establishing and what actions the provincial government will take in response, and while much work remains to be done at the College, the changes in the MAID landscape since September 2015 have been significant. The proposed amendments update the policy to ensure it accurately states recent legal developments and directs readers to the College's Interim Guidance document, or its replacement, for guidance.

- Given this uncertainty and the likelihood of change between the Council submission deadline (May 12, 2016) and May Council, this section will be updated as needed to ensure alignment with any external or internal developments. In particular, Council will consider a revised guidance document regarding MAID at its May meeting and changes made to this document will be reflected, if necessary, in the final version of this policy.

- Additionally, the proposed amendments with respect to the release of medical records are warranted as MAID will soon be legal in this jurisdiction. The College has also received questions from physicians related to this issue, following the approval of our Interim Guidance document.

NEXT STEPS:

- Should Council recommend that the Planning for and Providing Quality End-of-Life Care policy be revised as proposed, 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.

- Additionally, the revised companion Frequently Asked Questions document will be published to the College's website.

DECISIONS FOR COUNCIL:

1. Does Council approve the Planning for and Providing Quality End-of-Life Care policy as amended?

CONTACTS: Craig Roxborough, ext. 339
Lynn Kirshin, ext. 243

DATE: May 12, 2016

Attachments:
Appendix 1: Planning for and Providing Quality End-of-Life Care Amended policy – Track Changes
Appendix 2: Amended Frequently Asked Questions – Track Changes

Planning for and Providing Quality End-of-Life Care

Introduction

Patients are entitled to receive quality end-of-life care that allows them to live as well as possible until they die. Physicians have an important role to play in planning for and providing quality end-of-life care.

Planning for end of life can ensure that the care provided to patients aligns with their wishes, values, and beliefs.

Providing quality end-of-life care involves addressing and managing the physical, psychological, social, and spiritual needs of patients, while being sensitive to their personal, cultural and religious values, and beliefs. Quality end-of-life care also aims to reduce suffering, respect the wishes of patients, and lessen conflict and distress.

When engaging patients in end-of-life planning or when providing end-of-life care, it is important that physicians assist patients or their substitute decision-maker to identify meaningful and realistic goals of care that are compassionate, respectful and that seek to incorporate patient wishes, values, and beliefs.

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:

1. Respecting patient autonomy with respect to health care goals, and treatment decisions;
2. Acting in the best interests of their patients;
3. Demonstrating professional competence, which includes meeting the standard of care and acting in accordance with all relevant and applicable legal and professional obligations;
4. Communicating sensitively and effectively with patients and/or their substitute decision-maker;
5. Collaborating effectively by recognizing and accepting the unique roles and contributions of other physicians, health care providers, and non-health care providers;
6. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

Purpose

This policy sets out the College's expectations of physicians regarding planning for and providing quality care at the end of life.

Terminology

Advance care planning is the process of reflection and communication where people consider what sort of treatment they may want at the end of life. It includes the deliberation and communication of wishes, values and beliefs between the individual, their loved ones, their substitute decision-maker and their health care provider(s) about end-of-life care.[1]

Cardiopulmonary resuscitation (CPR) is a potentially life-saving intervention that is provided with the intention of reversing or interrupting a potentially fatal event (e.g. cardiac or respiratory arrest). CPR is often understood to include chest compressions, artificial ventilation ~~(including, intubation)~~ and defibrillation.[2]

~~**Physician assisted death** occurs when a physician provides[3] or administers[4] medication at the request of the patient that intentionally brings about a patient's death.[5]~~

Medical assistance in dying, in accordance with federal legislation, includes circumstances where a physician or nurse practitioner, at an individual's request: (a) prescribes a substance for an individual to self-administer causing death; or (b) administers a substance that causes an individual's death.

Potentially life-saving treatment is treatment that is provided with the intention of reversing or interrupting a potentially fatal event (e.g., cardiopulmonary resuscitation, etc.).[6]

Life-sustaining treatment is any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function essential to the life of the patient (e.g., mechanical ventilation, medically assisted nutrition and hydration, etc.).[7]

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[1] Adapted from Ontario Medical Association, *End of Life Terminology*. https://www.oma.org/Resources/Documents/EOLC_Definitions.pdf

[2] Adapted from Canadian Medical Association, *Statement on Life-Saving and -Sustaining Interventions*. http://policybase.cma.ca/dbtw-wpd/Policypdf/PD14-01.pdf

~~[3] Often referred to as physician assisted suicide.~~

~~[4] Often referred to as euthanasia.~~

~~[5] Adapted from *Carter v. Canada (Attorney General), 2015 SCC 5* paragraph 40. https://www.canlii.org/en/ca/scc/doc/2015/2015scc5/2015scc5.pdf~~

[6] Adapted from Canadian Medical Association, *Statement on Life-Saving and -Sustaining Interventions*.

[7] Adapted from University Health Network, *Appropriate Use of Life-sustaining Treatment* and Canadian Medial Association, *Statement on Life-Saving and -Sustaining Interventions*.

Palliative care is active total care that improves the quality of life of patients and their families facing life-threatening illnesses or life-limiting chronic conditions, with a focus on relieving pain and other symptoms and addressing psychological, social, and spiritual distress; it is applicable in all phases of illness, from early in the course of illness to bereavement.[8]

Palliative Sedation refers to the practice of relieving intolerable suffering through the proportional and monitored use of opioids and/or sedative medications to intentionally lower a patient's level of consciousness at the end of life.[9]

Substitute decision-maker is someone who makes health care decisions on behalf of a patient if they are incapable of health care decision-making.[10, 11]

Policy

This policy is divided into ten sections addressing a number of issues that relate to end-of-life care:

1. Quality Care
2. Communication
3. Advance Care Planning
4. Consent to Treatment
    - 4.1 No Treatment Without Consent
    - 4.2 Capacity at the End of Life
    - 4.3 Consent on Behalf of an Incapable Patient
5. Interventions and Care Management
    - 5.1 Palliative Care
    - 5.2 Potentially Life-Saving and Life-Sustaining Treatment
    - 5.3 Aggressive Pain Management and Palliative Sedation
6. Dying at Home
    - 6.1 Home Care
    - 6.2 Certification of Death
7. Wishes and Requests to Hasten Death
    - 7.1 Responding to Wishes and Requests to Hasten Death
    - 7.2 ~~Physician-Assisted Death~~Medical Assistance in Dying

[8] Adapted from World Health Organization, *Definition of Palliative Care*. http://www.who.int/cancer/palliative/definition/en/

[9] Adapted from Ontario Medical Association, *End of Life Terminology*.

[10] Adapted from Ontario Medical Association, *End of Life Terminology*.

[11] For more information on substitute decision-makers please see Section 4.3 of this policy or the College's Consent to Treatment policy.

1. Quality Care

There are a number of medical and non-medical elements that comprise quality care at the end of life. Research and clinical experience show that what is important to patients and their families regarding quality end-of-life care may often include, but is not limited to:

- Managing pain and other distressing symptoms, including psychological issues;
- Avoiding the unnecessary prolongation of dying, especially when there is little hope for meaningful recovery;
- Strengthening relationships with loved ones and continuing active involvement in social interactions to the extent that it is possible to do so;
- Attaining feelings of peace or closure, achieving a sense of control and meaning, satisfying spiritual needs, completing important tasks, and preparing for the end of life by resolving conflicts, saying goodbye, and preparing for death;
- Having trust and confidence in a physician and having a physician who is available and takes a personal interest in the patient's care;
- Preserving dignity, being treated with respect and compassion, and being treated in a manner that affirms the whole person;
- Facilitating decision-making through clear, honest, consistent and timely communication, having the opportunity to address personal concerns, and being listened to; and
- Receiving support through the grief and bereavement process.

When planning for or providing end-of-life care, physicians must endeavour to understand what is important to their patient and/or the patient's substitute decision-maker in order to ensure that goals of care are understood and that quality care is provided. This may require providing assistance to patients or substitute decision-makers to help them articulate these goals of care. It is also important for physicians to understand and personally acknowledge that in certain circumstances treatment cannot prevent death.

2. Communication

End-of-life care situations can be highly stressful and difficult for those involved. Therefore, communication is of paramount importance. Physicians must communicate effectively[12] and compassionately with patients and/or substitute decision-makers, in a manner and tone that is suitable to the decisions they may be facing. This includes, but is not limited to, initiating communication as early as possible and as regularly and as often as is necessary to share information, helping patients and/or substitute decision-makers understand the information shared, and answering questions. Communicating effectively and frequently will build trust and confidence in the relationship between the physician and the patient or the patient's substitute decision-maker, help to relieve patient and/or substitute decision-maker anxiety and doubt, and may make future difficult conversations easier.

Patients and/or substitute decision-makers may want to involve family and/or others close to them in the patient's ongoing care. Involving family and/or others close to the patient in the ongoing care of a patient may be beneficial as it can, for example, help the patient understand their diagnoses, prognoses, medications, the tests that are required, and the decisions they have to make about treatment options. Such involvement can also help the family caregivers to provide more effective care at home and mitigate their own distress.

Physicians must obtain consent from the patient or substitute decision-maker to disclose personal health information about the patient[13] and must document this decision accordingly.

3. Advance Care Planning

Advance care planning can lead to improved outcomes and quality of life, can help to ensure that the care provided aligns with the patient's wishes, values and beliefs,[14] and can also encourage realistic treatment goals. Physicians have a professional responsibility to engage patients in advance care planning and to understand their patients' wishes, values, and beliefs regarding end-of-life care.

It is never too early for physicians to discuss advance care planning with their patients. As part of routine care in an ongoing physician-patient relationship, physicians are advised to discuss

[12] See also the College's Consent to Treatment policy and the Consent to Treatment Frequently Asked Questions for advice and guidance regarding communication, including addressing language and/or communication issues.
[13] For more information on physicians obligations regarding the disclosure of patient information see the College's Confidentiality and Personal Health Information.
[14] See for example: Mack, J.W., Weeks, J.C., Wright, A.A., et al. (2010). End-of-life discussions, goal attainment, and distress at the end of life: predictors and outcomes of receipt of care consistent with preferences. *Journal of Clinical Oncology*, 28(7), 1203-1208. Zhang, B., Wright, A.A., Huskamp, H.A., et. al. (2009). Health care costs in the last week of life: association with end-of-life conversations. *Archives of Internal Medicine*, 169(5), 480-488.

with their patients: the importance and the benefits of advance care planning and choosing a substitute decision-maker; the importance of documenting and disseminating advance care plans to their loved ones, substitute decision-maker, and their health care provider(s); and, the importance of reviewing advance care plans throughout one's life.[15]

Physicians are also advised to help their patients engage in such planning by providing necessary medical information and opportunity for discussion. This could include asking patients general questions about their wishes, values and beliefs regarding end-of-life care or discussing specific issues such as preferences for the location of their death, attitudes towards certain medical interventions (e.g. resuscitation, mechanical ventilation, etc.), and, as appropriate, their wishes with respect to organ and tissue donation.[16] Physicians are advised that they may need to initiate these discussions sensitively, over multiple occasions as patients may not always be ready to participate.

Significant life events (e.g. death in the family or serious illness, becoming a parent, etc.) or changes in the patient's medical status (e.g. diagnosis of terminal illness, illness progression, etc.) are opportunities for physicians to confirm that advance care planning has taken place. If the patient has already engaged in advance care planning, physicians are advised to encourage patients to review existing advance care plans. If the patient has not engaged in advance care planning, physicians are advised to remind patients of the importance of this process, to create opportunities for discussion, and to encourage them to engage in the process.

Physicians are advised that advance care plans do not constitute consent; consent must always be given by the patient if the patient is capable with respect to the treatment or from the incapable patient's substitute decision-maker.[17] Advance care plans will help guide a substitute decision-maker in making decisions on behalf of an incapable patient.[18]

4. Consent to Treatment

The requirements for consent to treatment at the end of life are the same as the requirements for consent to treatment in other health care situations. The following is a high level overview

[15] Advance care planning materials and resources intended for both physicians and patients are available from a variety of organizations. For example, Speak Up (www.advancecareplanning.ca or for Ontario specific information http://www.advancecareplanning.ca/making-your-plan/how-do-i-do-advance-care-planning/provincialresources/advance-care-planning-workbook-ontario-version.aspx) and the Ontario Seniors' Secretariat (www.seniors.gov.on.ca/en/advancedcare/index.php)

[16] This could include asking about registering their consent for organ and tissue donation with the Trillium Gift of Life Network. For more information see Section 10. "Organ and Tissue Donation" of this policy.

[17] For more information see Section 4. "Consent to Treatment" of this policy.

[18] For more information on substitute decision-making, see Section 4.3 "Consent on Behalf of an Incapable Patient" of this policy.

of physicians' obligations regarding consent to treatment. For a more detailed discussion of the legal and professional obligations for consent to treatment please see the College's Consent to Treatment policy.

4.1 No Treatment Without Consent

The *Health Care Consent Act, 1996* (*HCCA*)[19] requires that physicians not provide treatment[20] unless consent has been obtained from the patient if the patient is capable[21] or the incapable patient's substitute decision-maker.[22, 23] In certain circumstances, treatment can be provided in an emergency without consent.[24]

In order for consent to be valid it must be obtained from the patient if the patient is capable with respect to the treatment or from the incapable patient's substitute decision-maker, and it must be related to the treatment, informed, given voluntarily, and not obtained through misrepresentation or fraud.[25]

[19] *Health Care Consent Act, 1996*, S.O. 1996, c.2, Schedule A (hereinafter *HCCA*).
[20] Section 2(1) of the *HCCA* defines treatment as anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.
[21] This is the case even if the patient has an advance care plan, as advance care plans do not preclude a capable patient from making a different decision at the time of care and are not directions to a health care provider.
[22] Sections 20(1) and 20(5) of the *HCCA* set out a hierarchy of persons who may give or refuse consent on behalf of an incapable patient. The substitute decision-maker is the highest ranking person on this list who also satisfies the requirements set out in Section 20(2) (see footnote 23 of this policy):

1. Guardian
2. Attorney for personal care
3. Representative appointed by Consent and Capacity Board
4. Spouse or partner
5. Child or parent or individual/agency entitled to give or refuse consent instead of a parent (this does not include a parent who has only a right of access)
6. Parent with right of access only
7. Brother or sister
8. Any other relative (related by blood, marriage or adoption)
9. Public Guardian and Trustee

[23] Section 20(2) of the *HCCA* sets out additional requirements for substitute decision-makers. Specifically, the substitute decision-maker must also be (1) Capable with respect to the treatment; (2) At least 16 years old, unless he or she is the incapable person's parent; (3) Not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf; (4) Available; and (5) Willing to assume the responsibility of giving or refusing consent.
[24] For more information see the College's Consent to Treatment policy.
[25] Sections 10(1) and 11(1) of the *HCCA*.

4.2 Capacity at the End of Life

Physicians are entitled to presume that a patient is capable with respect to a treatment unless there are reasonable grounds to think otherwise.[26]

Physicians are advised to exercise caution regarding the presumption of capacity and to reassess capacity as appropriate, because in the context of end-of-life care the capacity to consent to treatment may be affected by a number of health conditions. As well, capacity is fluid, it can change over time[27] and depends on the nature and complexity of the specific treatment decision.[28]

4.3 Consent on Behalf of an Incapable Patient

A substitute decision-maker must give or refuse consent in accordance with the most recent[29] and known wish expressed by the patient, while the patient was capable and was at least 16 years of age.[30] If no wish is known or the wish is impossible to comply with or not applicable to the circumstances, the substitute decision-maker must make decisions in the incapable patient's best interests.[31]

Wishes can be general or specific in nature and can be expressed in writing,[32] orally or in any other manner.[33] Later wishes expressed while capable, whether written, oral or in any other manner, prevail over earlier wishes.[34] This is the case even if, for example, the earlier wishes are expressed in an advance care planning document.

The Consent and Capacity Board (CCB)[35] can provide assistance to either a physician or a substitute decision-maker when a wish is not clear, when it is not clear whether the wish is applicable, or when it is not clear whether the wish was expressed while the patient was capable or at least 16 years of age. The CCB can also grant permission to depart from a wish in very limited circumstances.[36]

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[26] Sections 4(2) and 4(3) of the *HCCA.*
[27] Section 15(2) of the *HCCA*.
[28] Section 15(1) of the *HCCA*.
[29] Section 5(3) of the *HCCA* states that later wishes expressed while capable prevail over earlier wishes.
[30] Section 21(1) of the *HCCA*.
[31] Section 21(1) of the *HCCA*.
[32] This may include advance care planning documents, what is commonly known as an 'advance directive', in a power of attorney, or in another form. See Section 5(2) of the *HCCA*.
[33] Section 5(1) and (2) of the *HCCA*.
[34] Sections 5(3) of the *HCCA*.
[35] For more information about the Consent and Capacity Board (hereinafter CCB) please visit their website: http://www.ccboard.on.ca/scripts/english/index.asp
[36] Sections 35 and 36 of the *HCCA*. More information can also be found on the CCB's website listed in footnote 35.

When making decisions based on the best interests of an incapable patient, substitute decision-makers must consider the following: any values and beliefs the incapable patient held while capable; any wishes the incapable patient expressed that are not binding according to the above criteria; and the impact of providing and not providing the treatment on the patient's condition or well-being,[37] whether the expected benefit of the treatment outweighs the risk of harm, and whether a less restrictive or less intrusive treatment would be as beneficial.[38]

5. Interventions and Care Management

5.1 Palliative Care

Physicians who propose or provide palliative care must clearly explain to patients what palliative care entails as it is sometimes misunderstood by patients. This includes, but is not limited to, being clear that palliative care involves providing active care focused on relieving pain and other symptoms and addressing psychological, social, and spiritual distress related to the patient's condition, which can be provided in conjunction with other treatments intended to prolong life, or when these treatments have been stopped.

Palliative care can be provided at any stage of a patient's life-threatening illness or life-limiting chronic condition, not just in the final days or weeks of one's life. Physicians are advised that integrating palliative care into the treatment plan as early as possible can lead to improved quality of life for patients.[39] Palliative care does not have to be provided by specialists in palliative care. Physicians are, however, advised to seek the support or involvement of specialists in palliative care and/or referral to hospice care[40] where appropriate and available.

5.2 Potentially Life-Saving and Life-Sustaining Treatment

Physicians are strongly advised to discuss options with respect to potentially life-saving and life-sustaining treatments as early as possible and where appropriate. For example, when there is a change in the patient's medical status, when there are no further treatment options for a life-

[37] Section 21(2) (c) of the *HCCA*. This will include assessing whether the treatment is likely to: improve the incapable patient's condition or well-being; prevent their condition or well-being from deteriorating; reduce the extent to which, or rate at which, their condition or well-being is likely to deteriorate; and whether their condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

[38] Section 21(2) of the *HCCA.*

[39] See for example: Temel, J.S., Greer, J.A., Muzikansky A., et. al. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. *New England Journal of Medicine*, 363(8), 733-742. Zimmermann, C., Swamin, N., Krzyzanowska, M. et. al., (2014). Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial. *The Lancet*, 383(9930), 1721-1730.

[40] In Canada, both palliative care and hospice care are generally used to refer to an approach to care focused on holistic care of the patient with a life-threatening or life-limiting illness and their family. However, some may use hospice care to describe care that is associated with a particular time period (e.g. final few days or weeks of life) or location (e.g. community based) (adapted from the Canadian Hospice Palliative Care Association).

limiting illness or condition, or when a patient is admitted to an intensive or critical care unit. It is beneficial for these discussions to happen before events requiring a decision about potentially life-saving and life-sustaining treatment occur and for these discussions to be informed by any advance care planning done by the patient.

In accordance with physicians' legal obligations under the *HCCA*, physicians must obtain consent to provide potentially life-saving and life-sustaining treatment. However, in certain circumstances, potentially life-saving and life-sustaining treatment can be provided in an emergency without consent.[41]

As part of the consent process, physicians must involve the patient and/or substitute decision-maker in the assessment of the potentially life-saving or life-sustaining treatment options that fall within the standard of care. Physicians are advised that patients and substitute decision-makers may assess the value of these treatment options differently than physicians.

In situations where the outcomes of a potentially life-saving and/or life-sustaining treatment are uncertain, physicians may wish to propose these treatments on a trial basis. This allows for the exploration of a possibly positive outcome while building consensus regarding the circumstances in which potentially life-saving and/or life-sustaining treatment will be withheld or withdrawn. If a trial of treatment is proposed, physicians must be clear regarding the outcomes that would warrant the continuation of treatment and the outcomes that would warrant the discontinuation of treatment.

Physicians must obtain consent in order to withdraw life-sustaining treatment.[42] Physicians cannot make a unilateral decision to withdraw life-sustaining treatment. As a part of the consent process, physicians must explain to the patient and/or the substitute decision-maker why they are proposing to withdraw life-sustaining treatment and provide details regarding any treatment(s) they propose to provide (e.g. palliative care). When a patient or substitute decision-maker does not provide consent to withdraw life-sustaining treatment, physicians must engage in the conflict resolution process as outlined in Section 8 of this policy which may include an application to the Consent and Capacity Board.[43]

[41] For information on when emergency treatment can be provided without consent, please see the College's Consent to Treatment policy.

[42] The Supreme Court of Canada determined in *Cuthbertson v.Rasouli*, 2013, SCC 53, [2013] 3 S.C.R. 341 (hereinafter *Rasouli*) that consent must be obtained prior to withdrawing life-sustaining treatment.

[43] In *Rasouli,* the Supreme Court of Canada determined that when substitute decision-makers refuse to provide consent for the withdrawal of life-support that in the physician's opinion is not in the best interests of the patient, physicians must apply to the Consent and Capacity Board for a determination of whether the substitute decision-maker has met the substitute decision-making requirements of the *HCCA* and whether the refused consent is valid. See in particular paragraph 119 of *Rasouli.*

There may be situations where in the physician's opinion cardiopulmonary resuscitation (CPR) should not be provided to a patient and as such, that a no-CPR order should be written in the patient's chart. This could be for a variety of reasons, including but not limited to: that CPR will almost certainly not resuscitate the patient, that the patient's quality of life will be extremely poor should they survive, ~~or~~ that there are no further treatment options for the patient's underlying illness, or that the patient's condition[44] will prevent the intended physiologic goals of CPR (i.e. providing oxygenated blood flow to the heart and brain) from being achieved.

The law is currently unclear regarding the consent requirements for a no-CPR order.[45]

A decision regarding a no-CPR order cannot be made unilaterally by the physician. Where a physician is of the opinion that CPR should not be provided for a patient and that a no-CPR order should be written in the patient's record, the College requires physicians to discuss this with the patient and/or substitute decision-maker at the earliest and most appropriate opportunity and to explain why CPR is not being proposed.[46] This discussion must occur before a no-CPR order can be written.

If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians must engage in the conflict resolution process as outlined in Section 8 of this policy ~~which may include an application to the Consent and Capacity Board~~.[47] Physicians must allow the patient or substitute decision-maker a reasonable[48] amount of time to disagree before a no-CPR order can be written.

While the conflict resolution process is underway, physicians may not write a no-CPR order. If an event requiring CPR occurs, physicians must provide CPR unless the patient's condition will prevent the intended physiologic goals of CPR (i.e. providing oxygenated blood flow to the heart and brain) from being achieved. In determining whether or not CPR must be provided~~so doing~~, physicians must act in good faith. As well, in those instances where CPR must be

[44] For example, raised intracranial pressure so that blood cannot enter the brain, refractory hypoxemic respiratory failure where it is impossible to oxygenate the blood, or uncorrectable exsanguination where circulation to the brain cannot be attained by chest compressions.

[45] The College is aware of decisions of the Consent and Capacity Board, the Health Professions Appeal and Review Board, and of various Ontario courts which relate to this question, but is of the view that the case law is not yet clear on whether consent is required prior to a physician writing a no-CPR order.

[46] Physicians are advised that patients may not be aware of the limitations of CPR and the potential harms of this intervention and so are advised to clearly explain the reasons and clinical justification for not proposing CPR.

[47] Physicians are advised that the Consent and Capacity Board has heard and ruled on conflicts pertaining to no-CPR or do not resuscitate orders. See for example: Sibbald, R.W. & Chidwick, P. (2010). Best interests at end of life: a review of decisions made by the Consent and Capacity Board of Ontario. *Journal of Critical Care*, 25(1) 171.el-171.e7.

[48] What is reasonable will depend on the specific circumstances of the case (e.g. whether there are two or more substitute decision-makers, whether other family members will be consulted, etc.).

provided, physicians must act in good faith and use their professional judgment to determine how long to continue providing CPR.

Physicians are advised that a patient's or substitute decision-maker's decision concerning potentially life-saving and life-sustaining treatment might change over time. As such, physicians must review these decisions with patients or substitute decision-makers whenever it is appropriate to do so, for example, when the condition of the patient changes.

5.3 Aggressive Pain Management and Palliative Sedation

In some cases, the management of a patient's pain and symptoms at end of life may require the aggressive use of pain medication (e.g. opioids) or palliative sedation (e.g. the use of pharmacological medications to reduce consciousness).[49] The intention of these interventions is not to hasten death. When physicians provide aggressive pain management or palliative sedation, they must provide the treatment in proportion to the pain and/or symptoms and closely follow any changes in the patient's pain and/or symptoms to ensure that appropriate treatment is provided.

6. Dying at Home

6.1 Home Care

At the end of life, patients may express a preference for staying at home as long as possible and/or for dying at home.

In these cases, physicians must help patients and caregivers assess whether home care and/or dying at home are manageable options. This includes, but is not limited to, assessing:

- Patient safety considerations;
- The caregiver's ability to cope with the situation;
- Whether the patient can be provided with the necessary care (e.g., whether round-the-clock on-call coverage is needed and available, whether home palliative care physicians or community based programs are available to assist, etc.); and
- The viability of admittance to hospice or another appropriate institution at a later date if the patient or their caregiver can no longer cope with the situation.

In addition, when considering whether dying at home is a manageable option, physicians must ensure that patients and caregivers are educated and prepared for what to expect and what to do when the patient is about to die or has just died.

[49] Physicians contemplating treating patients using palliative sedation are advised to consult: Dean, M.M., Cellarius, V., Henry, B., et. al. (2012). Framework for continuous palliative sedation in Canada. *Journal of Palliative Medicine*, 15(8), 870-9.

If a patient decides to stay at home as long as possible or to die at home and has expressed a wish to not be resuscitated, physicians are advised to order and complete the Ministry of Health and Long-Term Care "Do Not Resuscitate Confirmation Form".[50, 51] This will help to ensure that if emergency services are called that resuscitation will not be performed and that, to the extent possible, palliative care, will be provided to alleviate pain and keep the patient comfortable. Unless this form is completed and presented, emergency services are likely to use resuscitative measures and transfer the patient to hospital. When the form is completed, physicians must ensure that caregivers are instructed on the importance of keeping the form accessible and the necessity of showing the form to emergency services personnel if called, so that the patient's wishes can be respected.

Physicians must ensure that caregivers are instructed regarding whom to contact when a patient is about to die or has just died. The point of contact may vary depending on, for example, local situations or processes, health care teams, and whether or not the "Do Not Resuscitate Confirmation Form" is completed.

6.2 Certification of Death

A physician who has been in attendance during the last illness of a deceased person, or who has sufficient knowledge of the last illness, is legally required to complete and sign a medical certificate of death immediately following the death,[52, 53] unless there is reason to notify the coroner.[54] Nurse practitioners who have primary responsibility for the care of the deceased are

[50] For more information about the "Do Not Resuscitate Confirmation Form", please visit: http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45

[51] These forms can be ordered by completing and submitting the Ministry of Health and Long-Term Care's "Forms Order Request". For more information please visit: http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-0350-93~2/$File/0350-93.pdf

[52] Section 35(2) of the R.R.O. 1990, Reg. 1094, General, enacted under the *Vital Statistics Act*, 1990; R.S.O. 1990, c. V.4 (hereinafter, *Vital Statistics Act*, General Regulation). The certificate must state the cause of death according to the International Statistical Classification of Diseases and Related Health Problems, as published by the World Health Organization, and be delivered to the funeral director.

[53] Medical certificates of death can be obtained by contacting the Office of the Registrar General: 1-800-461-2156.

[54] Section 10 of the *Coroners Act*, R.S.O. 1990, c. C.37 requires physicians to immediately notify a coroner or police officer if there is reason to believe that an individual has died:

1. as a result of violence, misadventure, negligence, misconduct or malpractice;
2. by unfair means;
3. during pregnancy or following pregnancy in circumstances that might be reasonably attributed to the pregnancy;
4. suddenly and unexpectedly;
5. from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
6. from any cause other than disease; or
7. under circumstances that may require investigation.

also permitted to complete the medical certificate of death in limited circumstances.[55] It is not acceptable to rely on the coroner to certify the death when the coroner's involvement is not required.

When a decision is made for the patient to stay at home as long as possible or to die at home, it is recommended that physicians plan in advance by designating the physician(s) or nurse practitioner(s) who will be available to attend to the deceased in order to complete and sign the medical certificate of death. It is also recommended that physicians inform caregivers of this plan.

Physicians are advised to take into consideration any local or community strategies that are in place to facilitate the certification of death.[56]

7. Wishes and Requests to Hasten Death

Patients at end of life may express a wish to hasten death, and some patients may even request their physician's assistance in hastening death. This may include requests for ~~physician-assisted death~~medical assistance in dying.

7.1 Responding to Wishes and Requests to Hasten Death

A patient's wish or request to hasten death may be a genuine expression of a desire to hasten their death, but it may also be motivated by an underlying and treatable condition such as depression, psychological suffering, unbearable pain or other unmet care needs. Patients may also be attempting to exert control over their lives, expressing acceptance of an imminent death, or seeking information about any options that may exist.

Physicians must respond to these wishes and requests in a sensitive manner. Because these expressions may be motivated by an issue that can be treated or addressed, physicians must be prepared to engage patients in a discussion to seek to understand the motivation for their

[55] Section 35(3) of the *Vital Statistics Act*, General Regulation permits a registered nurse who holds an extended certificate of registration to complete and sign a medical certificate of death when:

(a) the nurse has had primary responsibility for the care of the deceased during the last illness of the deceased;
(b) the death was expected during the last illness of the deceased;
(c) there was a documented medical diagnosis of a terminal disease for the deceased made by a legally qualified medical practitioner during the last illness of the deceased;
(d) there was a predictable pattern of decline for the deceased during the last illness of the deceased; and
(e) there were no unexpected events or unexpected complications during the last illness of the deceased.

[56] For example, many communities in Ontario have an expected death in the home (EDITH) protocol in place that can be accessed through the local Community Care Access Centre (CCAC) or Local Health Integration Network (LHIN). In general, it is good practice for physicians providing palliative care at home to connect with local CCAC and LHIN palliative care resources.

expression and to resolve any underlying issues that can be treated or otherwise addressed. This may include providing more effective treatment, improving pain management strategies, providing or referring the patient for psychological counselling, seeking specialist support, and involving other professionals in the patient's care (e.g., chaplaincy support, social workers, grief counselling, etc.).

7.2 ~~Physician-Assisted Death~~Medical Assistance in Dying

~~Physician-assisted death is prohibited by the *Criminal Code of Canada*[57] and consent of the deceased does not absolve the person who acted to bring, or assisted in bringing, about the death from criminal liability.~~

On February 6, 2015 ~~T~~the Supreme Court of Canada (SCC)[58] released its decision in *Carter v. Canada* (*Carter*), finding that the *Criminal Code* provisions that prohibit~~has determined that the prohibition on physician-assisted death~~medical assistance in dying (referred to by the SCC as 'physician-assisted death')~~is~~ are unconstitutional in certain circumstances. In response, the federal government has introduced proposed legislation to enact amendments to the *Criminal Code* to implement medical assistance in dying in Canada. Physicians seeking guidance or more information on medical assistance in dying are directed to the College's *Interim Guidance on Physician-Assisted Death*.~~when a competent adult person clearly consents to the termination of life and has a grievous and irremediable[59] medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.[60]~~

~~This decision has been suspended until February 6, 2016 to allow government, if they so choose, to develop an appropriate framework for permitting physician-assisted death. During this suspension, the existing prohibitions in the *Criminal Code* continue to apply. Once the suspension has ended the *Criminal Code* provisions prohibiting physician assisted death will be invalid with respect to competent adults who have a grievous and irremediable medical condition and who clearly consent to the termination of life. Subject to any prohibitions or restrictions that may be imposed in future legislation or policy, physician-assisted death will be legally permitted for adults who meet these conditions.~~

~~There are jurisdictions in which physician assisted death is permitted by law.~~ Patients ~~may express interest in travelling to those jurisdictions to seek those services and in doing so~~

~~[57] See sections 14 and 241(b) of the *Criminal Code*, RSC 1985, c C-46.~~

[58] See *Carter v. Canada (Attorney General)*, *2015 SCC 5* (hereinafter *Carter*).

~~[59] The Supreme Court of Canada also added that an irremediable medical condition will not require that the patient undertake treatments that are not acceptable to the patient (see *Carter* paragraph 127).~~

~~[60] See *Carter* paragraph 127.~~

interested in exploring medical assistance in dying either in Canada or internationally~~,~~ may approach physicians to obtain access to their medical records or their personal health information. Patients in Ontario have a right of access to their personal health information[61] and unless the physician determines that an exception to this right is applicable,[62] physicians are required to release the medical records or personal health information to the patient in these circumstances.

8. Managing Conflicts

8.1 Conflict Resolution

The requirements for conflict resolution at the end of life are the same as the requirements for conflict resolution in other health care situations, although emotions may be heightened in the end-of-life care context. As such, it is important for physicians to approach conflicts with sensitivity.

In order to minimize and/or resolve conflicts that arise, physicians must:

- Communicate clearly, patiently, and in a timely manner information regarding:
  - The patient's diagnosis and/or prognosis;
  - Treatment options and assessments of those options;
  - Availability of supportive services (e.g. social work, spiritual care, etc.); and
  - Availability of palliative care resources.
- Identify misinformation and/or misunderstandings that might be causing the conflict and take reasonable steps to ensure that these are corrected and that questions are answered;
- Offer referral to another professional with expertise in the relevant area and facilitate obtaining a second opinion, as appropriate;
- Offer consultation with an ethicist or ethics committee, as appropriate and available;
- Where appropriate, seek legal advice regarding mediation, adjudication or arbitration processes that are available; and
- Take reasonable steps to transfer the care of the patient to another facility or health care provider as a last resort and only when all appropriate and available methods of resolving conflict have been exhausted.[63]

[61] Sections 1(b) and 52 of the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Schedule A.
[62] Section 52 (1) of the *Personal Health Information Protection Act, 2004.*
[63] In following such a course, the physicians must comply with the College's Ending the Physician-Patient Relationship policy.

8.2 Conflicts with Substitute Decision-makers

If a conflict arises between a physician and substitute decision-maker over an interpretation of a wish or an assessment of the applicability of a wish to a treatment decision, physicians are advised to apply to the Consent and Capacity Board for a determination.

If a physician is of the view that the substitute decision-maker is not acting in accordance with the substitute decision-making requirements set out in the *HCCA*,[64] the physician may apply to the Consent and Capacity Board for a determination as to whether this is the case and how to proceed.

8.3 Conscientious Objection

Physicians who limit their practice[65] on the basis of moral and/or religious grounds must comply with the College's Professional Obligations and Human Rights policy.

9. Documentation

The requirements of medical record keeping at the end of life are the same as the requirements in other situations.

Every patient and/or substitute decision-maker encounter and all patient-related information[66] must be documented and dated in the patient's record, in accordance with the College's Medical Records policy. For example, in the context of end-of-life care, patient records must include reference to discussions and decisions regarding treatment, goals of care, and advance care planning (e.g. wishes expressed while capable, advance directives, etc.). When CPR is not to be provided, this must be explicitly and clearly referenced in the patient's record so that the direction is are available to all involved in the patient's care and who have access to the patient's record.

For more information about the legal requirements and professional obligations for documentation see the College's Medical Records and Consent to Treatment policies.

10. Organ and Tissue Donation

As part of quality end-of-life care, physicians can enable opportunities for their patients or substitute decision-makers to affirm an existing decision or make a decision about organ and

[64] Section 21 of the *HCCA*.
[65] This may include, but is not limited to, refusals to provide care, withdraw care, and/or discuss care options.
[66] For more information see the College's Medical Records policy and Ontario Regulation 114/94, General, Sections 18, 19, 20 and 21, made under the *Medicine Act, 1991*, S.O. 1991, c.30.

tissue donation. The *Trillium Gift of Life Network Act*[67] sets out requirements relating to organ and tissue transplantation measures for health facilities designated by the Minister of Health and Long-Term Care.

A designated facility[68] must notify the Trillium Gift of Life Network (TGLN) when a patient in the facility has died or a physician is of the opinion that the death of a patient at the facility is imminent by reason of injury or disease. [69] However, the legislation provides an exception to notification if the TGLN has established exemptions for the designated facility.[70] Notifying TGLN in advance of any withdrawal of potentially life-saving or life-sustaining treatment is required to ensure the patient's family is able to be approached and affirm the patient's donation decision or make a decision about organ and tissue donation on the patient's behalf.

Physicians working in designated facilities must comply with any policies and procedures established in accordance with the legislation.[71]

Physicians who do not work in designated health facilities are advised to provide their patients with the opportunity to make choices with respect to organ and tissue donation, ideally in the context of an ongoing relationship with the patient and before any medical crisis arises. Physicians in these settings may wish to contact TGLN[72] for more information and/or for materials or resources, and physicians may also wish to direct patients to TGLN for more information.

[67] *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20 (hereinafter *TGLNA*).
[68] The *TGLNA* defines designated facility as a hospital, health facility or other entity designated as a member of a prescribed class of facilities under section 8.2 of the *TGLNA*.
[69] Section 8.1(1) of the *TGLNA*.
[70] Section 8.1(2) of the *TGLNA*.
[71] Designated facilities must establish policies and procedures for identifying and approaching potential donors and their families to provide information, and to seek consent for organ and/or tissue donation. See section 8.4 of the *TGLNA*.
[72] For more information please visit the Trillium Gift of Life website (http://www.giftoflife.on.ca/). For general inquiries call toll free 1-800-263-2833 or for Referrals and Notifications call toll free 1-877-363-8456.

The College of Physicians and Surgeons of Ontario

Planning for and Providing Quality End-of-Life Care

Frequently Asked Questions for Physicians

1. **Are there any resources I can use in my practice or that my patients can use to help with advance care planning?**

   Yes. There are a number of organizations that have information on advance care planning or materials to help physicians and patients with this process.

   For example, the Speak Up Campaign's website www.advancecareplanning.ca has information intended for both physicians and patients and includes a workbook tailored to Ontario patients (http://www.advancecareplanning.ca/making-your-plan/how-do-i-do-advance-care-planning/provincialresources/advance-care-planning-workbook-ontario-version.aspx).

   Additionally, the Ontario Seniors' Secretariat has developed a *Guide to Advance Care Planning* to provide valuable information on making choices about personal care, including health care treatment and services. The *Guide* has also been made available in French and Chinese. For more information visit: www.seniors.gov.on.ca/en/advancedcare/index.php

2. **The policy says that palliative care does not have to be provided by specialists in palliative care. Who else can provide palliative care?**

   Palliative care focuses on relieving pain and other symptoms, as well as addressing psychological, social, and spiritual distress and can be provided at any stage of a patient's life-threatening illness or life-limiting chronic condition.

   Many physicians (including most family physicians) may have the knowledge, skill and judgment necessary to provide basic palliative care with the aim to alleviate pain and to keep the patient comfortable. In complex situations or when the palliative care required is beyond the clinical competence of the treating physician, it will be necessary to seek the support or involvement of specialists in palliative care and/or hospice care.

3. **Does the law require that I obtain consent prior to writing a no-cardiopulmonary resuscitation (no-CPR) order? (sometimes referred to as do not resuscitate (DNR) or do not attempt resuscitation (DNAR) orders)**

   The legal requirements regarding consent to a no-CPR are currently unclear. The College is aware of decisions of the Consent and Capacity Board, the Health

Professions Appeal and Review Board, and of various Ontario courts which relate to this question, but is of the view that it is not currently clear whether there is a legal requirement for a physician to obtain consent prior to writing a no-CPR order.

Given this legal uncertainty, the College has set out professional expectations of physicians in relation to no-CPR orders. The College requires physicians to discuss a no-CPR order with the patient and/or substitute decision-maker at the earliest and most appropriate opportunity, to explain why CPR is not being proposed, and to engage in conflict resolution practices if the patient or substitute decision-maker disagrees with the no-CPR order and insists that CPR be provided.

4. If a patient or substitute decision-maker disagrees and insists that CPR be provided, can I write a no-CPR order while conflict resolution is underway?

No. As stated in the College's policy, while conflict resolution is underway physicians are not permitted to write a no-CPR order. ~~I~~If an event requiring CPR occurs while conflict resolution is underway, physicians must provide CPR unless the patient's condition would prevent the intended physiologic goals of CPR from being achieved. In these cases, physicians may make a decision about whether or not to provide CPR while attending to the patient. In those instances where physicians must provide CPR, they must do so in good faith and use their professional judgment to determine how long to continue providing CPR.

5. What are the intended physiologic goals of CPR and when would a patient's condition prevent these goals from being achieved?

The intended physiologic goals of CPR are to provide oxygenated blood flow to the heart and brain. In some cases, the patient may have a condition which would prevent these intended physiologic goals from being achieved. This could include raised intracranial pressure so that blood cannot enter the brain, refractory hypoxemic respiratory failure where it is impossible to oxygenate the blood, or uncorrectable exsanguination where circulation to the brain cannot be attained by chest compressions.

6. If I determine that the patient's condition would prevent the intended physiologic goals of CPR from being achieved but the patient or substitute decision-maker disagrees with my recommendation to write a no-CPR order, what are my obligations?

As stated in the policy, if the patient or substitute decision-maker disagrees with the recommendation that a no-CPR order be written and insists that CPR be provided even when the patient's condition will prevent the intended physiologic goals of CPR from being achieved, physicians may not write the no-CPR order and must engage the patient or substitute decision-maker in conflict resolution. Physicians may wish to note in the patient's record their opinion that the patient's condition would prevent the intended physiologic goals of CPR from being achieved and that conflict resolution regarding the recommendation that a no-CPR order be written is underway. While conflict resolution is

underway, if the patient arrests, physicians may make a decision about whether or not to provide CPR while attending to the patient.

7. Does the policy require that I provide CPR in all instances? For example, am I obligated to provide CPR during an emergency if the patient's wishes are not known and there is no substitute decision-maker to ask?

The policy only requires that CPR be provided in a very narrow set of circumstances: when there has been a recommendation that a no-CPR order be written, the patient's condition will not prevent the intended physiologic goals of CPR from being achieved, the patient or substitute decision-maker has voiced their disagreement with the recommendation to write a no-CPR order, and an event requiring CPR happens before the disagreement has been resolved.

The policy focuses on and sets out expectations for those instances where a physician is of the opinion that a no-CPR order should be written, and so focuses on those instances where there is an opportunity for the patient and/or substitute decision-maker to participate in a discussion about whether or not to write a no-CPR order.

This is different from, for example, an emergency situation where a patient experiencing a cardiac or respiratory arrest presents to a physician and the physician is not aware of the patient's wishes and there is no substitute decision-maker to ask. As in all emergency situations, in this case if there is no reason to assume the patient does not want the treatment and the physician has made a reasonable effort to confirm that there is no substitute decision-maker available to discuss the treatment decision with, then the physician may rely on his or her judgment in determining what care to provide.

8. If a patient or substitute decision-maker disagrees with my recommendation to withdraw life-sustaining treatment or to write a no-CPR order, what can I do to help resolve the conflict?

The policy outlines a number of steps physicians must take in order to resolve conflict, including, identifying and correcting any misinformation or misunderstandings, offering a second opinion, and seeking the support of an ethicist or ethics committee, as appropriate and available.

Physicians may also apply to the Consent and Capacity Board (CCB) for a review of the case and a determination of whether or not the substitute decision-maker is making a decision in accordance with the patient's prior capable wishes or best interests. The CCB is an expert tribunal, comprised of lawyers, psychiatrists, and members of the public and is supported by a full-time legal counsel. The CCB has the ability to convene hearings quickly and has the authority to direct substitute decision-makers to make decisions in accordance with the patient's prior capable wishes or best interests.

The Supreme Court of Canada has identified the CCB as the appropriate authority to adjudicate disagreements between physicians and substitute decision-makers regarding the withdrawal of life-sustaining treatments and the CCB has heard and decided on cases regarding no-CPR orders.

9. How do I apply to have the CCB review my case?

The CCB's website (www.ccboard.on.ca) has information regarding their services and links to the forms required to have a case reviewed.

For a determination of whether or not the substitute decision-maker is making a decision in accordance to the patient's prior capable wishes or best interests, physicians will need to complete and submit a "Form G".

Physicians may wish to contact the CCB directly for more assistance or seek assistance from legal counsel, either from the institution within which they work or from the Canadian Medical Protective Association.

10. Am I required to certify the death of a patient when it would be difficult for me to do so (e.g. distance, length of time away from practice, outside of normal practice hours, etc.)?

By law, the medical certificate of death must be completed by a physician who has been in attendance during the last illness of a deceased person, or who has sufficient knowledge of the last illness. In limited circumstances, nurse practitioners are also able to complete and sign a medical certificate of death.

When death is expected, the policy recommends planning in advance who will be available to attend to the deceased in order to complete and sign the medical certificate of death. The policy also advises physicians to take into consideration any local or community strategies that are in place to facilitate the certification of death.

Where possible, planning in advance may help to overcome any practical challenges associated with completing and signing the medical certificate of death.

11. The Supreme Court of Canada's decision about physician assisted death, or what is now referred to as medical assistance in dying, in *Carter v. Canada* has been well-publicized. What implications does that decision have for this policy? ~~Will the College be setting out professional expectations and guidance regarding physician assisted death?~~

Professional expectations regarding ~~physician assisted death~~medical assistance in dying have not been articulated in this policy ~~as these practices are currently prohibited by the *Criminal Code*~~. Those looking for more information about medical assistance in dying or the Supreme Court of Canada's decision in *Carter v. Canada* should consult the College's *Interim Guidance on Physician-Assisted Death*.

~~In *Carter v. Canada*, the Supreme Court of Canada was asked to consider the constitutionality of existing provisions in the *Criminal Code* that prohibit physician-assisted death in Canada. The Court found that the *Criminal Code* provisions are constitutionally invalid in circumstances where a competent adult clearly consents to the termination of life, and has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstance of his or her condition. *Carter v. Canada* does not take effect until February 2016.~~

~~The Supreme Court of Canada has directed government and other stakeholders to develop legislation, policy and/or guidelines as to how physician assisted death should be provided. The College is actively monitoring the situation and engaging with key partners to prepare for when the *Carter v. Canada* decision comes into effect. The College's position on this issue will be developed as we learn more about whether and how government will respond to the decision.~~

~~In order to support patients and physicians, if there is no legal framework in place when this decision comes into force, the College is planning to have guidelines for physicians in place as an interim measure.~~

12. Are there any resources to help patients make decisions regarding organ and tissue donation? Where can patients register their consent for organ and tissue donation?

Physicians and patients can visit the Trillium Gift of Life Network's website (http://www.giftoflife.on.ca/) for more information on organ and tissue donation in Ontario. The website also includes a link where patients can register to become a donor.

~~**July 2015**~~**May 2016**

May 2016

COUNCIL BRIEFING NOTE
Governance Committee Report

Items for Decision:

I 2017 Executive Committee Vote

Items for Information:

II Completion of 2017 Committee Interest Forms *(for submission at Council Meeting)*

FOR DECISION:

I 2017 Executive Committee Vote

- Nomination Statements received from candidates for the 2017 Executive Committee vote at the May Council meeting are attached (Appendix A).
- Council will vote for the President, Vice President, 1 Physician Council Member and 2 Public Members of Council:

For President:	Dr. David Rouselle
For Vice President:	Dr. Steven Bodley
For Physician Member: *(1 position)*	Dr. Brenda Copps Dr. Akbar Panju Dr. Peeter Poldre
For Public Members: *(2 positions)*	Mr. Sudershen Beri Ms. Lynne Cram Mr. Pierre Giroux

- *Nomination Forms* with signature of nominee, mover and seconder are due at 12 noon on Monday, May 30.
- Nominees will be given the opportunity to address Council prior to the elections.

FOR INFORMATION:

II Completion of 2017 Committee Interest Forms

- All Council members are asked to complete the Committee Interest Form for 2016/2017 committees. (Appendix B)
- Appended to the form, is a description of each committee, a chart that identifies the average time commitment for each committee and Council work, and a committee chair role description.

- Public members are asked to identify a preference for the Discipline Committee or the Inquiries, Complaints and Reports Committee.
- Your completed form will inform the Governance Committee in its deliberations as it develops committee recommendations for the 2017 Council year.
- Please complete the Committee Interest Form and submit your completed form to Debbie McLaren by the end of the Council meeting on Tuesday, May 31.
- Council will make committee appointments at the December meeting.

Attachments:
Appendix A: 2017 Executive Committee Nomination Statements
Appendix B: 2017 Committee Interest Form and attachments

CONTACTS: Carol Leet, Chair
Marcia Cooper
Debbie McLaren
Louise Verity

DATE: May 12, 2016

Appendix A

NOMINATION STATEMENTS
FOR 2017 EXECUTIVE COMMITTEE VOTE

NOMINATION STATEMENT
CANDIDATE FOR PRESIDENT, 2017 EXECUTIVE COMMITTEE

DR. DAVID ROUSELLE

District 5 Representative
Newmarket, Ontario

Principal Area of Practice or Specialty/Occupation:
Obstetrics and Gynecology

Elected Council Terms:
2011-2014
2014-2017

CPSO Committees and Other Work:	
Executive Committee:	2014-2016
Finance Committee:	2012-2014, 2015-2016
Governance Committee:	2015-2016
Inquiries, Complaints and Reports Committee:	Vice Chair: Obstetrics, 2011-2014 Chair: ICRC, 2014-2016 *(Dr. Rouselle has also served as non-council member of Complaints Committee 2008-2009 and ICR Committee 2009-2011)*
Outreach Committee:	2015-2016
Peer Assessor/I&R Assessor:	2007-2009

STATEMENT:

It has been an honour to serve as Vice President this year. The CPSO continues to be challenged by enhanced government and media scrutiny. This is likely to be the new normal. I remain deeply impressed by the capacity of staff, Council and Executive to deal with these challenges proactively.

With challenges there are opportunities. It will be important for us to respectfully consider and to advise government on any proposed changes. The goal is always to position the College to maintain and improve our ability to serve the public interest.

In addition to serving on Council and Executive, I have been privileged to serve on other committees. For example, I have been Chair of ICRC. Operationalization of our Transparency initiative has been largely successful. Further, through membership on Finance Committee I am aware of the financial challenges facing us. We must manage resource issues rationally to avoid interference with our mandate.

We all have a limited time to learn how to add value to the CPSO. I am grateful for the opportunity to serve Council, the College and the public as a member of your Executive Committee. I hope for your support as President next year.

David Rouselle

NOMINATION STATEMENT
CANDIDATE FOR VICE PRESIDENT, 2017 EXECUTIVE COMMITTEE

DR. STEVEN BODLEY

District 8 Representative
North Bay, Ontario

Principal Area of Practice or Specialty/Occupation:
Anesthesia and Pain Management

Elected Council Terms:
2009-2012
2012-2015
2015-2018

CPSO Committees and Other Work:	
Discipline Committee:	2010-2016
Executive Committee:	2015-2016
Fitness to Practise Committee:	2009-2016
Governance Committee:	2012-2014
Methadone Committee:	2009-2011, Chair: 2011-2014, 2014-2016
Premises Inspection Committee:	2010-2013, Co-chair: 2013-2015, Chair: 2015-2016
Quality Assurance Committee:	2014-2016
Policy Working Group: *Delegation of Controlled Acts*	Chair: 2011-2012
Telemedicine Advisory Group (e-Health Statement, and Telemedicine	2012-2015
Interventional Pain Management Working Group on Change in Scope of Practice	2011-2012
"Guide to Applying the Out-of-Hospital Standards in Interventional Pain Premises" Working Group	2010-2011

STATEMENT:

It has been a challenging year for Medical Regulators with dramatic changes to the landscape of medical practice with the introduction of Physician Assisted Death. Both the Federal and Provincial governments have leaned heavily on our work and we should be proud that our College has led the way on this sensitive but essential area of medical care.

Keeping up with the work done by staff and Council in this area, as well as with the initiatives on opioid prescribing and improving our management of complaints involving sexual impropriety and abuse has been challenging, but it also has been a privilege to participate in these discussions. Through Council, your Executive continues to position us as leaders in these areas and has quickly moved to once again, anticipating the future dialogue, ask the questions and review the options in governance for the future of our profession.

As with my first year at Council, my first term on Executive has been marked by a lot of listening and I look forward to my deepening involvement in the next year and ask for your support in being elected to the role of Vice President of the College of Physicians and Surgeons of Ontario.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, 2017 EXECUTIVE COMMITTEE

DR. BRENDA COPPS

District 4 Representative
Hamilton, Ontario

Principal Area of Practice or Specialty/Occupation:
Family Medicine

Elected Council Terms:
2013-2016

CPSO Committees and Other Work:	
Education Committee:	2015-2016
Quality Assurance Committee:	2013-2015, Co-chair: 2015-2016
Quality Assurance Working Group member	2016-Present
Policy Working Group: *Accepting New Patients/Ending the Physician-Patient Relationship*	2015 - Present
FMRAC Annual Meeting Delegate	2015

STATEMENT:

I believe that the combination of my primary care background and range of past leadership experience positions me very well to bring relevance to the work of our executive as we strive to protect the public.

After medical school and a family medicine residency at McMaster, I settled in my hometown of Hamilton where I am in my 35th year of practicing full scope, full time family medicine. I grapple with issues of end of life, use of opioids and care continuity on a daily basis.

My career has included leadership positions at all levels of the local health care system including, a term as Chief of the Department of Family Medicine at St. Joseph's Hospital, Board Member, and eventual Chairmanship of the Hamilton Family Health team with its 150 physician membership and 20 million dollar budget.

My college activity has included that of Peer Assessor and Medical Inspector and since my election to Council I have immersed myself in a broad range of board, committee and policy work in an earnest and progressive way.

On a personal level I would bring the perspective of a generalist, a strong team and work ethic, and a genuine enthusiasm for self-regulation.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, 2017 EXECUTIVE COMMITTEE

DR. AKBAR PANJU

University Representative – McMaster University
Hamilton, Ontario

Principal Area of Practice or Specialty/Occupation:
Internal Medicine

Appointed Council Terms:
2014-2016

CPSO Committees and Other Work:	
Education Committee	2014-2016 *(non-voting academic member)*
ICR Committee:	2014-2016 *(Dr. Panju has also served as non-council member of Complaints Committee 2008-2009 and ICR Committee 2009-2011)*
Registration Committee:	2014-2016

STATEMENT:

After completing internship, I practiced family medicine in northern Ontario town of Ignace, followed by working in Thunder Bay. Subsequently, I trained in internal medicine, cardiology and thrombosis at McMaster.

In 1985, I joined Hamilton Hospitals and the Department of medicine at McMaster University; presently Professor of Medicine and Division Head of Internal Medicine. I hold 2 endowed Chairs. I was Physician in Chief of Hamilton Health Sciences for 10 years, past president of the medical staff of Hamilton Health Sciences, past president of Hamilton Academy of Medicine and past president of Canadian Society of Internal Medicine. I combine clinical, education and administrative activities.

My involvement at CPSO has included work on the Complaints, ICR, Registration and Education Committees, as well as Council. I have reached a stage in my career that allows me to devote more time and energy to CPSO activities. I feel my previous experiences in working in non-academic and academic practices and in rural and large city settings, and my previous leadership roles at multiple levels, would serve me well in my work on the Executive Committee of the CPSO and I would do my best in doing the job. I hope you support my nomination.

NOMINATION STATEMENT
CANDIDATE FOR PHYSICIAN MEMBER, 2017 EXECUTIVE COMMITTEE

DR. PEETER POLDRE

District 10 Representative
Toronto, Ontario

Principal Area of Practice or Specialty/Occupation:
Haematology/Internal Medicine

Elected Council Terms:
2012-2014
2014-2017

CPSO Committees and Other Work:	
Discipline Committee:	2012-2014, Co-chair: 2014-2016
Governance Committee:	2015-2016
Policy Working Group: *Physicians' Relationships with Industry, Practice, Education and Research*	Chair: 2013-2014

STATEMENT:

Listening post, sounding board, amplifier, harmonizer – these acoustic metaphors capture the role of the Physician member of the Executive in relation to Council, which itself is the orchestra attuned to the public interest and to a healthy care system.

Having served for a decade as vice president medical affairs at Sunnybrook, I will contribute my own insights and experience to the complex matters that will arise for the College. My career has had a significant focus on education. I was the hospital's first vice president health sciences education (an inter-professional role) for 20 years, during which I also served as the inaugural academy director in the undergraduate curriculum.

As co-chair of Health Force Ontario's Inter-professional Care Strategic Implementation Committee, I strongly espoused the central role of the patient and family as members of the health care team. I am deeply committed to emphasizing the many educational roles that the College plays, including our robust processes of policy development and review, which provide valuable guidance to our physicians and which can also inform our patients about their expectations for the very best health care.

I thank you for considering my candidacy.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2017 EXECUTIVE COMMITTEE

MR. SUDERSHEN BERI

Public Member of Council
Toronto, Ontario

Occupation:
Financial Advisor

Appointed Council Terms:
2007-2016

CPSO Committees and Other Work:	
Discipline Committee:	2007-2016
Executive Committee:	2011-2014
Governance Committee:	2009-2011
Premises Inspection Committee:	2010-2016
Quality Assurance Committee:	2007-2016
Registration Committee:	2009-2016

STATEMENT:

Having served on the Executive Committee in the past I have made considerable contribution on various issues from the perspective of public representation and public protection.

As can be seen from my personal profile, I have continuously served on Discipline, Quality Assurance, Registration and Premises Inspection Committees. In addition, I have also had served on the Governance Committee. In the process I have gathered considerable knowledge, skills and knowledge as regards policy development within the college system.

I come with a very strong background in public administration, having served in various administrative and accounting positions in the public service in Kenya. Furthermore, for the past two decades, I have been involved in the financial industry in Canada as a Financial Advisor. In addition, I have a great track record in the community having taken a leadership role in establishment of a Community Centre in Markham at a cost of over $ 5 million, which today stands as a landmark in the City of Markham.

I have always taken work on various committees with a lot of dedication and enthusiasm, and shall continue to do so in the future. I hope I can count on your support.

181

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2017 EXECUTIVE COMMITTEE

MS. LYNNE CRAM

Public Member of Council
London, Ontario

Occupation:

I retired in 2007 as Executive Vice President with Windjammer Landing Resort in St. Lucia. During my 16 years with the company, I lived in the Caribbean for 8 years and worked from Canada for the balance. Prior to Windjammer I enjoyed challenging careers with Xerox, Four Seasons and Hyatt Hotels. I am most proud of my community involvement in London for over 25 years. I am currently past Chair of Kings University College and have been on the board for 11 years. I have been on the Board of Goodwill Industries London for 7 years and am currently Vice Chair.

Appointed Council Terms:
2012 – 2018

CPSO Committees and Other Work:	
Governance Committee:	2015-2016
ICR Committee:	2012-2016
ICR Committee-Settlement Panel:	2015-2016
Outreach Committee:	2013-2015, Chair: 2015-2016
Joint Policy Working Group: MD Relations with Drug Companies/Conflict of Interest: Recruitment of Research Subjects	2013-2014
Policy Working Group: Blood Borne Viruses	2014-2015
Policy Working Group: Physician Assisted Death	2015-present

STATEMENT:

Serving as a Public Member on Council, ICRC, policy working groups and committees has given me insight into the magnitude of the college's mandate and the complexity of self–governance. Excellence in medical care must evolve and the College needs to be on the leading edge while also providing guidance to its membership through the changes. An example of this is the innovative work recently completed by Staff and Council to approve the guidelines for Physician Assisted Death.

Recent policy revisions and college initiatives have addressed major issues such as professional behaviour, boundary issues, refining the definition of sexual abuse, end of life care, human rights and doctor's relationships with industry. These policies challenge our members but also encourage them to excel in quality of care, compassion and communication.

Self-governance is a contentious issue, therefore Council needs to provide strong guidance on how CPSO can be accountable and transparent so that the public understands not only the college's mandates but its accomplishments.

I request your support for my candidacy on the Executive Committee so that I can challenge myself and fellow council members to be innovative as we continue to evolve.

NOMINATION STATEMENT
CANDIDATE FOR PUBLIC MEMBER, 2017 EXECUTIVE COMMITTEE

MR. PIERRE GIROUX

Public Member of Council
Toronto, Ontario

Occupation:
Sales and Marketing

Appointed Council Terms:
2012-2016

CPSO Committees and Other Work:	
Discipline Committee:	2013-2016
Executive Committee:	2015-2016
Finance Committee:	2013-2014, Chair: 2014-2016
Quality Assurance Committee:	2013-2016

STATEMENT:

In a working career spanning over forty years, I held senior management and executive positions in industry, government and banking. Those roles required several domestic and foreign relocations, including lengthy periods in Mexico City, Rome, Paris and London. Throughout these transfers, I learned the value of community, flexibility and self-reliance.

Since joining the College in 2012, I have been a vocal supporter of its mission; to ensure that the regulation and practice of medicine reflects and advances the interests, not only of those practising medicine, but also the public. I presently serve on three College Committees, Quality Assurance, Discipline and Finance, where I am currently the Chairman.

Since the beginning of 2016, I have been on the Executive Committee which has been a great learning experience. I believe I have been an engaged participant, not only reflecting the views and interests of the public members of Council, but also ensuring that balance and thoughtfulness are provided on all matters brought before the Executive Committee.

I am asking for your support for my re-election to the Executive Committee.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMORANDUM

To: All Council Members

From: Dr. Carol Leet, Chair, and the Governance Committee

Date: April 12, 2016

Subject: **Nomination/Election Process for the 2017 Executive Committee Vote at the May Meeting of Council**

At the May meeting of Council, an election will be held for the positions on the 2017 Executive Committee. The Committee consists of the President, Vice President, Past President, one physician member and two public members of Council.

As per the General By-Law, s. 39(1)(b), the immediate Past President is a member of the Executive Committee without the need to be elected to that position. If the immediate Past President is unwilling or unable to serve, there would be a vote for two physician members for the Executive Committee as per the General By-Law.

All Council members who wish to be nominated for a position on the Executive Committee are invited to submit an optional **Nomination Statement.** The Statement should be limited to 200 words. In addition, **Nomination Statements** will also include brief biographical information and the candidate's picture. N**omination Statements** will be emailed to all Council members and circulated, as an attachment, to the Governance Committee Report to Council.

Nomination Statements will assist Council members to identify candidates who are running for election, and provide more information regarding a candidate's background, qualifications and reasons for running for an Executive Committee position.

In addition, to a **Nomination Statement**, a completed **Nomination Form** is due on the first day of the Council meeting at noon. Each Nomination requires the signatures of a nominator, a seconder, and the agreement of the nominee. Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions. Governance_Process_Manual.pdf

A chart identifying the current Executive Committee members is attached. I have also attached a sample **Nomination Statement** template, and the **Nomination Form(s)** for you to complete, should you wish to be nominated for a position on the 2017 Executive Committee.

Timeframe and Process for Executive Committee Nominations:

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

2. **The deadline for submission of your completed Nomination Statement is Wednesday, May 4, 2016 at 5 p.m. Nominations Statements that are submitted by the deadline will be circulated to all Council members and included with the Governance Committee Report to Council. Submitted Nomination Statements will be reviewed by the Chair of the Governance Committee, prior to circulation to Council.**

3. **The deadline for your completed Nomination Form *(with signature of nominee and 2 nominators)* is Monday, May 30, 2016 at 12 noon.**

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

5. **The Executive Committee that is voted in at this meeting, will officially take office at the adjournment of the annual meeting of Council on December 2, 2016.**

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

Thank you,

Carol Leet, MD, FRCPC
Chair, Governance Committee

att.

2016 EXECUTIVE COMMITTEE MEMBERS:

This committee's composition is prescribed in the General By-Law. Council will vote for the President, Vice President, 1 physician member of Council and 2 public members for the 2017 Executive Committee at the May 2016 Council meeting.

Executive Committee Members	Length of Committee Appointment	Current position and years on Committee
Dr. Steven Bodley	**1 year**	**Physician Member 15/16**
Mr. Pierre Giroux	**1 year**	**Public Member 15/16**
Dr. Joel Kirsh - Chair	**3 years**	**President 15/16** Vice President 14/15 Physician Member 13/14
Dr. Carol Leet	**4 years**	**Past President 15/16** President 14/15 Vice President 13/14 Physician Member 12/13
Mr. Ron Pratt	**3 years**	**Public Member 13/14, 14/15, 15/16** ***(previous Executive Committee appointment 2007-2011)***
Dr. David Rouselle	**2 years**	**Vice President 15/16** Physician Member 14/15

[Length of Committee appointment reflects current term expiring on December 2, 2016]

NOMINATION STATEMENT
CANDIDATE FOR PRESIDENT/VICE PRESIDENT/PHYSICIAN MEMBER/PUBLIC MEMBER
FOR THE 2017 EXECUTIVE COMMITTEE
[SAMPLE TEMPLATE]

Please request your personalized template from Debbie McLaren at dmclaren@cpso.on.ca by phone: 416-967-2600, ext. 371, toll free phone: 1-800-268-7096, ext. 371.

Please type your nomination statement on your *personalized* template. If you prefer, you may e-mail your nomination statement (200 words or less) to Debbie McLaren at: dmclaren@cpso.on.ca

The submission DEADLINE for completed Nomination Statements is Wednesday, May 4, 2016 at 5 p.m.

Photo will be inserted here:	**NAME** **District Rep/Academic Rep/Public Member** **City, Ontario** **Principle Area of Practice or Specialty/Occupation:** **Elected/Appointed Council Terms:**

CPSO Committees/Positions Held and Other CPSO Work:

NOMINATION STATEMENT:
(200 words or less)

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR PRESIDENT:

I _____ am
Print name here

willing to be nominated for President.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR VICE PRESIDENT:

I _____ am
Print name here

willing to be nominated for Vice-President.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR PHYSICIAN MEMBER:

I _____ am
Print name here

willing to be nominated for Physician Member on the Executive Committee.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

EXECUTIVE COMMITTEE
NOMINATION FORM

FOR THE 2 PUBLIC MEMBERS ON THE EXECUTIVE COMMITTEE: (You may nominate 1 or 2)

I _____ am
Print name here

willing to be nominated for the Public Member on the Executive Committee.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

Please fill out below for 2nd public member if you are nominating 2 public members.

I _____ am willing to be
Print name here

nominated for the Public Member on the Executive Committee.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

2017 COMMITTEE INTEREST FORM
for 2017 Committee Appointments
[2016-2017 COUNCIL TERM]

Appendix B

The Governance Committee follows Council's Nomination Guidelines in developing leadership and membership recommendations to Council. To assist the Governance Committee in its appointment of Councillors to committees for the 2016-2017 session of Council, please complete the form. A document entitled "College Committees" is attached to assist you in making your choices, as well as an Average Time Commitment Chart for Committee and Council Work.

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

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

NAME: _____
[PLEASE PRINT]

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

Committee Name	Prefer Not to Serve on	Willing to Serve	Very Interested	Interested in Chairing**
STATUTORY COMMITTEES				
Discipline*				
Fitness to Practise*				
Inquiries, Complaints and Reports (ICR)*				
Quality Assurance*				
Registration				
BY-LAW COMMITTEES				
Council Award Selection *(this committee is available to public members only at this time, as physician member composition is prescribed in the General By-Law)*				
Education				
Finance				
Methadone				
Outreach				
Premises Inspection Committee				

Potential Committee Conflicts:
ICR committee members will not be appointed to the Discipline Committee and/or Fitness to Practise Committee or the Quality Assurance Committee and vice versa.
It is recommended that whenever possible, Quality Assurance Committee members are not members of the Discipline and/or Fitness to Practise Committee and vice versa.
****Please complete the back of this form to outline your competencies to serve on the committees you have marked above, and if applicable, your competencies for chairing a committee.**

……continued on next page

Please note that there is a paper nomination process and a council vote for the 2017 Executive Committee that will take place at the May 2016 Council meeting.
There is also a paper nomination process and Council vote for the 2017 Governance Committee that will take place at the annual meeting of Council in December.

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

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

GENERAL COMMENTS:

COLLEGE COMMITTEES

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

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

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

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

- Council Award Selection Committee
- Education Committee
- Finance Committee
- Governance Committee
- Methadone Committee
- Outreach Committee
- Premises Inspection Committee

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

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Committee Mandates

Discipline Committee

The Discipline Committee hears matters of professional misconduct or incompetence.

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

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

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

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

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

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

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

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

Education Committee

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

The Education Committee is responsible for:

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

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

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

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

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

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

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

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

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

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

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

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

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

Methadone Committee
The Methadone Committee was established to oversee a program to improve the quality and accessibility of methadone maintenance treatment in the treatment of opioid dependence. The College actively manages the practise of methadone prescribing as a formal partner with the Mental Health & Addictions Branch of the Ministry of Health and Long-Term Care. The program receives full funding for all methadone registry, staff, physician assessments and other activities.

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

Patient Relations Committee

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

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

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

Premises Inspection Committee

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

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

Quality Assurance Committee

The Quality Assurance Committee develops, establishes and maintains:

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

Registration Committee

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

AVERAGE TIME COMMITMENT FOR COMMITTEE AND COUNCIL WORK					Revised: May 3, 2016	
Committee Name	**How many days of meetings/hearings per year?**	***Preparation Time (per meeting/hearing)***	**Attendance at CPSO per meeting/hearing**	**Additional Teleconferences per year?**	**Decision/Report Writing for Committee Members?**	**Average approximate time commitment per meeting/hearing** *(includes prep and attendance at meeting)*
Council Award Selection Committee	1 (may be done by teleconference)	8 hours	¼ day	Not usual and rarely required	No	15 hours
Council Meetings ***(all Council members attend Council meetings)***	8	10 to14 hours per 2-day meeting	1 one-day meeting 1 day orientation 3 two-day meetings	Not usual, but sometimes required	No	22 to 28 hours per 2-day meeting
Discipline Committee	250 to 400 days scheduled 150 to 300 days cancelled due to settlement 80 to 120 hearing days Payment for late cancellation (<10 business days' notice) 2 days of business meetings 2 to 3 days of education	0 to 2 hours for meetings 0 prep for most hearings 2 to 6 hours for motions 2 to 6 hours for closing submissions	1 day up to 5 to 10 days a month 70% of hearings proceed on an uncontested basis and complete in ½ day Contested hearings range from 3 days to several weeks Lengthy hearings are booked with 1 to 3 weeks in between in each hearing week There is an expectation that committee members commit to as many hearings panels as their schedules permit, including lengthy hearings. Active members commit to 70 to 80 days per year and, due to cancelled days, sit for 30 to 50 hearing days per year. Others commit to 8 to 18 days and sit for 5 to 15 days per year.	Sometimes required for motions or panel deliberation	Yes One person on the 5 person hearing panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours *(could be more depending on hearing)*
Education Committee	5	3 hours	3 half-day meetings 2 full-day meetings	No	No	9 hours

Committee Name	How many days of meetings//hearings per year?	*Preparation Time (per meeting/hearing*	Attendance at CPSO per meeting/hearing	Additional Teleconferences per year?	Decision/Report Writing for Committee Members?	Average approximate time commitment per meeting/hearing *(includes prep and attendance at meeting)*
Executive Committee	7	6-8 hours	1 day	4 scheduled – but usually hold approx. 2/year (as required)	No	14 hours
Finance Committee	3	2 hours	1 half-day meeting 2 full-day meetings	Not usual, but sometimes required	No	6 to 8 hours
Fitness to Practise Committee	60 to 70 days scheduled 50 to 60 days cancelled Hearings rarely occur - 1 to 5 days of hearing possible ½ day business education meeting	0 to 2 hours for meetings 0 prep for most hearings 2 to 6 hours for motions	Hearings rarely proceed as cases tend to resolve with health and practice monitoring agreements Uncontested hearings complete in ½ day Contested hearing when they occur range from 3 to 5 days	Rare. Hearings are closed to the public, so may proceed by teleconference if uncontested.	Committee practice to issue a written decision. One person on the 3 person panel writes the initial draft. The entire panel provides input and approves the final decision.	8 to 40 hours
Governance Committee	5	3 hours (8 hours for 1 nominations meeting)	½ day 1 full-day meeting for committee nominations	2 x 2 hours (as required)	No	4 to 11 hours
Inquiries, Complaints and Reports Committee ***(Note: Individual members are not required to participate in all ICRC meetings.)***	*For total committee:* 24 General panel meetings (a non-panel Chair would attend on average 4 - 6 panels per year) 50 half-day Specialty panel meetings (a non-panel Chair would attend on average 6-10 half days per year)	*Prep Per Meeting:* General Panel meetings average 36 to 48 hours or 6-8 days prep (1 day = 6 hour periods) Specialty Panels meetings average 24 - 36 hours or 4-6 days prep (ie. 6 hour periods)	*Attendance Per Meeting:* General Panel meetings: (1 day) (x 4 – 6 per year) Specialty panels: ½ day (x 6-10 per year)	*Assignments rotated for a quorum of 3 mbrs.* Approximately 40 x 1 hour weekly teleconference/ad-hoc meetings Approximately 12 x 2 hour Medium Track Panel meetings. Approximately 12 x 1 hour Settlement Panel meetings	Need to review cases in advance of meeting and submit "members' notes"; panel chairs need to review decisions from their meetings.	General Panel Meeting: 42 to 54 hours or 7-9 days(1 day =6 hour periods) Specialty panels: 28 - 40 hours 4 ½ - 6 ½ days Teleconferences: Weekly :6-12 hours MT: 6-12 hours Settlement: 8 hours

Committee Name	How many days of meetings//hearings per year?	Preparation Time (per meeting/hearing	Attendance at CPSO per meeting/hearing	Additional Teleconferences per year?	Decision/Report Writing for Committee Members?	Average approximate time commitment per meeting/hearing *(includes prep and attendance at meeting)*
Inquiries, Complaints and Reports Committee (continued)	30-40 half day Verbal Caution panels (with attendance for 4-5 half days per year) 24 half day Health inquiry panels meetings (a non-panel Chair with attendance at 12 half days per year) 2 days yearly to discuss Business and Policy matters relating to member specific issues (with attendance at 2 days per year)	Verbal caution panels: Approx. 3 hours Health inquiry panels: Approx. 5-6 hours Business meetings: Approx. 3-4 hours	Verbal caution panels: ½ day (x 4 - 5 per year) Health inquiry panels: 2 hours or ½ day (x 12 per year) Business/Policy meetings: (1 day) (x 2 per year)			Verbal caution panels: 6 hours Health inquiry panels: 8 hours Business/Policy meeting: 12 hours
Methadone Committee	There are 5 combination half-day MSI and half Policy meetings and one half-day MSI and half-day Education meeting	3 hours	Full Day	Not usual, but sometimes required *(max. of 3)*	No	9 hours
Outreach Committee	4 half-day meetings per year	2 hours	½ day	No *(Note: Committee members have the option to participate on meetings by teleconference)*	No	6 hours

Committee Name	How many days of meetings//hearings per year?	Preparation Time (per meeting/hearing	Attendance at CPSO per meeting/hearing	Additional Teleconferences per year?	Decision/Report Writing for Committee Members?	Average approximate time commitment per meeting/hearing *(includes prep and attendance at meeting)*
Patient Relations Committee	1 meeting + 4 to 5 teleconference meetings	1 hour	½ day	4 to 5 ½ hour to 1.25 hour teleconferences	No	1½ to 3 hours
Premises Inspection Committee	Estimate 3 to 4 ½ day business/ policy meetings - Estimate 6 + panel meetings per year (by teleconference)	Up to 10 hours to review premises reports and submissions	½ day for policy meetings 1-2 hours for member-specific teleconferences	Possibly extra meetings held by teleconference for review of urgent cases	No	Up to 12 hours
Quality Assurance Committee (meets in panels)	Each committee member attends, on average, 10-15 panels per year + expected to attend the 5 policy and one Education Day meeting, held annually	9-12 hours for member-specific panel meetings	1 day	Up to 6 per year	No	19 hours
Registration Committee	10 days for MSI and 2 days for policy meetings - 12 panel meetings per year	12-16 hours	1 day	None	No	20 to 24 hours

Committee Chair

Reports to (Title): Council

Administratively to President

Updated: February 2010

Overview:

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

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

Major Responsibilities:

Leadership and Direction of the Committee

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

- Prepares for committee meetings by reviewing materials. Works with assigned staff in support of the successful fulfillment of the committee's mandate.

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

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

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

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

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

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

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

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

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

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

Collaborative Linkage between the Committee and the College Management Staff

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

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

Key Representative of the Committee

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

Role Outcomes:

- Uphold policies and standards of the College in the fulfillment of committee duties.

- Decisions comply with appropriate legislation and CPSO policies.

- Reports to the College Council are made, as required, representing committee activities.

- Risk as it relates to the committee's mandate is managed, and Council is alerted to pertinent issues in a timely manner.

- New policies are recommended to the Council, as required.

- Committee members are evaluated to support and promote the improvement of committee effectiveness.

- Interaction with College staff occurs by provision of information regarding the committee's work. Interaction with staff is managed in a respectful, collegial manner.

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

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

Principle Interfaces:

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

Desirable Behavioural Competencies

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

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

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

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

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

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

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

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

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

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

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

May 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 at Appendix A. The 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 (Appendix B). The Dashboards provide an overview of performance against targets set for each area.

This is the first quarter dashboard for 2016, reflecting information from January to March.

The Strategic Initiatives were defined as follows: Quality Management Partnership, Education, Transparency and Information Management. Of these, QMP has generated a dashboard indicator, although data is not yet available.

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

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Maureen Boon, extension 276

DATE: May 12, 2016

Appendix A: Strategic Framework
Appendix B: Strategic Update Q1 2016

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

CPSO Strategic Framework 2015-2018

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

Appendix B

Strategic Dashboard – Q1 2016

Strategic Priority	Objective	Measure/Target	Status	Comments
Optimize Registration	Target to be developed for 2017			
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year		641 assessments initiated - 24.65% of target for Q1 2016 – and tracking to 2564.
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology		Data not yet available Initial reports will be provided to physicians later in 2016/17

Operational Dashboard – Q1 2016

Strategic Priority	Objective	Measure/Target	Status	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks		Credentials Applications: 1051 of 1052 applications (99%) Registration Committee Applications: 268 of 271 applications (99%)
Assure/Enhance Physician Competence	Increase input in policy	130 responses/policy		Three policy consultations have taken place to date, with an average of 242/policy. Physician-Assisted Death (533 responses); Physician Behaviour in the Professional Environment (46 responses); and Changing Scope of Practice (147 responses).
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years		82% are either current (have been reviewed in the last 5 years) or under review.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.		90% of high risk investigations were completed in an average of 242 days, (10 investigations involving 8 unique physicians).

[1] Does not include registration policies

Strategic Priority	Objective	Measure/Target	Status	Comments
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year		90% of hearings (4) began on average, 463 days (15.2 months) from the NOH date
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>		90% of uncontested decisions (3) were released 47.7 days (1.6 months) from the last hearing date
		<u>6 months for contested (C)</u>		90% of contested decisions (4) were released 107.8 days (3.5 months) from the last hearing date
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)		A&C 5,607 of 6,954 is 81% live answer PPAS 11,402 of 12,546 is 91% live answer Combined 17,009 of 19,500 is 87%
	Improve service level targets	10% call abandonment		A&C 1,347 calls abandoned (16%) PPAS 697 calls abandoned (6%) Combined is 2,044 calls abandoned 11%
	Media coverage	80-100% positive or neutral		Of 328 news items (extremely high volume), 85% were positive or neutral and 15% negative

LEGEND

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

Corporate Services Division

2015 ANNUAL REPORT

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Corporate Services Division
Report to Council – 2015

<u>Corporate Services Division includes the Following Departments</u>:

A. Human Resources:

- HR strategic alignment, recruitment, annual performance, total rewards, legislative compliance, workforce planning, employee engagement and retention, training, development and orientation, health and wellness, HR online services and employee relations.

B. Records Management and Archives:

- Services include: provision of direction to staff for the effective management of records via approved policies and procedures and provision of training in these best practices; organization of departmental shared drives to facilitate retrieval of information; creation of records retention schedules to improve accountability and record availability; management of all College contracts and agreements; file retrieval from on-site and off-site (including PC, MIF, Evidence records & Registration files), library reference and retrieval, and general assistance in locating information across the College.

C. Facilities:

- Maintenance Services
  - Facilities helpdesk is a central maintenance service that deals with all building-related maintenance items such as temperature issues, plumbing, lighting, custodial duties, offices moves, meeting room arrangements, life safety testing and ergonomics installations.

- Meeting/Event Services
  - Services include: all aspects of on-site meetings for committees, council and other College-related business. This includes teleconferencing equipment/set-up, projection equipment, video conferencing, food and beverage service and all lunches.
  - There continues to be a trend to provide extensive planning for meetings and events that take place in the building. Many events now include external organizations with which the College is connected to improve relations with external stakeholders.
  - This department has taken on additional responsibilities in organizing external conferences for the QM Division. In particular, the Methadone and Assessor Conferences were all arranged and organized by Meetings and Events Services.

- Security/Reception
    - Services include: reception - greet visitors and handle incoming complainants, media and physicians on front line; security - issue security ID and communicate security procedures; coordinate parking requests for meetings and staff; answer inquiries from the membership regarding application processes; provide assistance in all emergencies whether medical, fire safety or building closures.

D. Finance and Business Services:

- Financial Services
    - Financial Services include: Budgeting, Investments, Accounts Payable, Accounts Receivable, Payroll, Financial Statements, Financial Information and Purchasing.

- Business Services – Print Shop
    - Print Shop services include: photocopying, scanning, changing toners in printers, changing toners and drums in fax machines, point of contact for floor photocopiers and the delivery of paper.

- Mail Room Services
    - Services include: the delivery and pick-up of mail and tracking courier packages and hand-delivered items that arrive at the front desk.

A. HUMAN RESOURCES

Human Resources Mandate

Develop and implement HR policies and processes that are transparent, seamless and current, and that provide value added services to support the College's core business.

Administer Human Resources policies, procedures and programs in a consistent, timely and effective manner while respecting the confidentiality of all employees.

Support and advance an internal working environment that fosters the values outlined in the College's Code of Conduct.

2015 Overview

For the eighth year in a row, the College was named a top GTA employer. These prestigious awards are granted to those organizations that meet high standards in eight key areas:

GREATER TORONTO'S TOP 2016 EMPLOYERS	(1) Physical Workplace; (2) Work Atmosphere & Social; (3) Health, Financial & Family Benefits; (4) Vacation & Time Off; (5) Employee Communications; (6) Performance Management; (7) Training & Skills Development; and (8) Community Involvement.

Changes to Compensation Plan – roll out January 1, 2016
Human Resources undertook a major restructuring of the College's salary plan placing more emphasis on performance and base salary progression. It is conservatively estimated that salary costs will be contained by 7M over the next ten years.

2015 Human Resources Metrics

Head Count (FTE's)

	2011	2012	2013	2014	2015
Permanent	290	323	334	352	362
Contract	25	22	21	17	26
PPT	Included in permanent				13
TOTAL:	**315**	**345**	**355**	**369**	**401**

Full time Employee Turnover

	2011		2012		2013		2014		2015	
Voluntary	7	2.4%	13	3.8%	13	3.9%	17	4.8%	16	4.4%
Involuntary	7	2.4%	7	2.3%	6	1.7%	5	1.4%	3	0.8
Retirements	4		2		1		0		0	
TOTAL	**18**		**22**		**20**		**22**		**19**	

Number of Positions Recruited

2011	2012	2013	2014	2015
47	55	55	69	53

Maternity/Parental Leaves

2011	2012	2013	2014	2015
19	14	7	16	6

Average Number of Sick/Personal Days

(12 eligible days)

2011	2012	2013	2014	2015
5.9	4.9	5.1	5.4	5.6

Short Term Disability Claims

	2011	2012	2013	2014	2015
Number of new claims	12	17	17	21	23
Absent days at full pay	440	419	485	788	644
Average days per claim	36.6	24.6	28.5	37.5	28.1

A total of 19 cases were closed in 2015. The majority of these cases resulted in the employee returning to full time, regular duties
In 2015, the majority of new cases received were within the 50-59 age category

The average duration of cases based on cases closed in 2015 was 28.1 working days

The top categories of diagnosis among new cases reviewed in 2015 were:

- Surgeries, representing 54% of new cases
- Psychiatric, representing 17% of new cases
- Neurological, representing 12% of new cases

2015 Staff Performance Results

	Development Required	Meets Expectations	Exceeds Expectations
Staff	1%	75%	24%
Average salary increase	1.4%	2.8%	3.8%
2015 Merit Range (%)	0 – 1.5	2.0 – 3.0	3.5 – 4.5

B. RECORDS MANAGEMENT AND ARCHIVES (RMA)

RMA objectives and activities are directed by the CPSO's 4th strategic priority: "maintain ongoing operations and continuous quality improvement". Within this strategic priority, the specific mandate for the RMA department is to develop and implement a comprehensive management program for all College records with the purpose of realizing the following objectives:

a. Support College accountability and efficiency,
b. Ensure that all legal and business requirements with regards to record keeping are met,
c. Mitigate legal risks and
d. Support staff in their work by providing direction for best records practices that will facilitate quick access to required information.

The components of this comprehensive records program and the program activities undertaken and completed by the RMA department in 2015 are as follows:

1. Develop and implement strong corporate records polices to provide staff with direction on the management of College information; and provide training on implementation of these policies:

    - Developed, communicated and implemented a corporate evidence policy which guides staff on the management of I&R evidence from the minute it is collected to its final destruction according to CPSO schedules.

- Developed, communicated and implemented a corporate Contracts and Agreements policy which guides staff on the management of all contracts and agreements which bind the College.
- Developed, communicated and implemented a corporate Confidentiality Agreements policy which guides staff on the use and management of all confidentiality agreements which are signed by any external person/organization working for or with the College.
- In conjunction with the Privacy Officer and the IT department, developed, communicated and implemented guidelines for allowing committee members to use their own personal device for CPSO work.
- Developed, communicated and implemented a guideline on the Best Practices for Providing Links to Published Information which supports staff who recommend specific published information to external stakeholders.
- Developed in conjunction with the IT Trainer and implemented RMA online training modules that provide web based training mandatory for all new hires in the records management best practices and procedures advocated by this department.

2. Facilitate access to, and retrieval of, College information found in all formats and media:

    - Migrated electronic evidence records relating to physicians referred to discipline to a stable platform and format to ensure accessibility and readability for the full 30 year retention period as per legal requirement.
        - **Number of electronic files migrated: 1159**
    - Reorganized the directories on the W drive so that they more effectively reflect CPSO current business processes and facilitate the retrieval of information.
    - Continued working on classification of departmental shared drives on the W drive in order to improve retrieval of information and to enable compliance with business, legal and retention requirements.
    - Implemented our annual process for destruction according to approved retention schedules of off-site paper records, of all in-office paper files and all electronic College files on shared drives as well as destruction according to signed data sharing agreements of electronic data received from, or shared with external sources.
        - **Number of boxes destroyed in compliance with our records retention schedules: 399 boxes**
        - **Number of records groups for which the electronic documents were eligible for deletion: 71 record groups**
    - Implemented a process for confirming that retired council and/or committee members and assessors have destroyed or deleted all CPSO information in their possession.

- Implemented the addition of TABFusion software to manage the records of the Hearings Office in order that these records can be easily identified and tracked.

3. Facilitate access to, and retrieval of, information found in external journals, newspapers, databases and other external sources to support College activities and decision-making:

    - Populated and maintained the CPSO virtual library which at the end of 2015 provided staff access to **38 journals, 12 databases** and corporate subscriptions to 2 internationally acclaimed newspapers.
    - Conducted **204 literature searches**.
    - Conducted 24 training sessions on use of CPSO virtual library.
    - Published a bi-weekly newsletter on relevant publications and disseminated it to 100 stakeholders.
    - Sent out table of Contents e-alerts for 35 key healthcare research and policy journals.
    - Reviewed the references in the Quality Improvement Resources for Walk-in Clinics, for Endocrinology and for Hospitalists.

4. Provide staff timely access to all on-site and off-site records required to execute business functions and take strong measures to ensure that documentation of corporate record holdings are accurate:

    - Provided staff with registration files as required 3 times daily.
        - **Number of transactions in the first floor file room: 94,551.**
    - Provided staff with on-site investigative files and evidence files as required twice a week.
        - **The number of transactions for these files was 15,931**
    - Provided staff with off-site files as required at least once a week.
        - **The number of retrievals of off-site files: 2253.**
    - Conducted annual registration file recall to ensure that all registration files are accounted for, resulting once again in **0 registration files unaccounted for.**
    - Conducted an audit of off-site complaint and registration files to ensure that our documentation and tracking systems were accurate and that all files are accounted for.
        - **Number of boxes/files stored off site: 12, 112 boxes/ 168,861 files**
    - Worked with facilities to create a new temperature controlled file room in B2 and implemented the move for onsite complaint files from the 6th floor file room to the basement B2 room making sure that new locations for all files were tracked on our tracking system.

5. Conducted outreach activities to communicate records management awareness to internal and external stakeholders:

    - Organized and attended the annual Records Management Special Interest group at the FMRAC 2015 Annual General Meeting.
    - Participated in the annual FHRCO annual records management meeting.
    - Held the annual RMA Open House with a record attendance of **125 staff**.
    - Working with Communications staff in preparing exhibit for the College's 150th anniversary.

C. FACILITIES

Facilities Services supports the work of the College through planning, operating and maintaining our facilities and by fostering pride in the building environment.

Facilities Services supports the mission of CPSO by providing a functional and safe environment to ensure high quality service for staff and visitors. This is accomplished by providing technical guidance, administrative support, and the coordination of design and construction for the facility.

The Facilities Department will provide quality and timely service for our clients within a Class B building with a variety of services and amenities: Reception, Security, Meeting and Events, and Maintenance.

Strategies for Facilities:

Provide a Safe Physical Working Environment

- Security staff monitor all people entering the building throughout the day. All guests and staff are required to wear ID badges while on the premises and guests are escorted to and from meetings to ensure they leave by the appropriate exit.
- Regular sampling of cooling tower and humidifier pans for legionella. This sampling takes place 3 times per year for the safety of staff and guests. As well, indoor air quality testing is conducted triennially.
- Meet requirements for Accessibility for Ontarians with Disabilities Act.

Mitigate Risk

- Continued to test emergency evacuation procedures and annual testing. Completed annual life safety testing required by code.
- Housekeeping and maintenance staff increased sanitation of "hand-touch points" throughout the building during the epidemic and flu season.

- All public areas are clean and well maintained. Snow removal annually to handle exterior challenges in winter. Potential hazards are identified by building staff or health and safety committee members and dealt with quickly.

Planned Capital Projects

- 1st Floor – due to the need to accommodate growth of staffing in the copy room (and a new position that was approved by Council); the copy room had insufficient space to house an additional employee. This required the retrofit of the copy room and part of the finance department.
- Loading Area – Using the copy room as the receiving area presented a problem with confidentiality as there is always confidential information accessible. This put the privacy of this information at risk so it was decided to relocate the receiving area to the hallway beside the copy room.
- Growth projections for the Quality Management Division indicated that there would be insufficient space to accommodate future staffing in 5-years' time. In fact, the current staffing complement was sharing space in a couple of areas. The options for their management team to select were to relocate part of the division to 800 Bay or redesign all cubes on the floor to adapt for the next 5 years. The division chose to redesign their floor and keep everyone together.
- Completed audio visual upgrades for several meeting rooms to adapt to new technologies.
- 6th Floor – to accommodate growth projections for two divisions on the 6th floor, a file room was relocated to the basement level and new cubes/offices constructed. Several small meeting rooms were demolished in addition to the file room to open space for expansion of cubes, construction of offices and construction of an amenity room. These changes allowed for an additional 7-8 staff members, which is the limit of expansion opportunity on the 6th floor.
- B2 – to support the expansion for staffing on the 6th floor, we relocated the filing room to the basement level. Basement construction was a tendered project under the College's architectural consultant. After a detailed assessment it was determined that the new space and the current space would also require fresh air intakes installed (which would be subject to heating and cooling as per appropriate code standards).

Keep property Clean and Well-Maintained

- With the increase in work orders and time spent between two site locations, hired a maintenance assistant. Most maintenance work is completed in house to save time and money. This allows better management of work orders.
- Storm water drains – as part of biennial maintenance, the storm water drains on the roof and parking levels are inspected to determine if there is evidence of blockages or leaks. This project entails a full flushing of the storm drains and catch basins.

- Water Pipe Lining – Domestic hot & cold water piping in the building was over 30 years old. In recent years, we have had *to* repair a few small leaks to the original piping. To prevent further leaks, we applied an epoxy lining throughout all water lines and risers, thus eliminating the small leaks and extending the life of the piping for 20 years.

Find Ways to Reduce Our Carbon Footprint

- HVAC system and lighting adjusts based on occupancy load and reduces energy outside regular business hours. New occupancy sensors are being introduced to control lighting more effectively in lower-use areas (i.e. storage and washrooms).

Accommodate Variety of On-Site Meetings

- In 2015, Meetings & Events coordinated 3,201 meetings serving 25,189 people. Compared to last year, on-site meetings increased by almost 20% and attendees increased by almost 18%. Approximately 65% of these meetings utilized teleconferencing and about 75% require tech equipment.
- Meetings included: business meetings, interviews, committee meetings, council meetings, discipline hearings, FHRCO events and other external groups.

Public & Physicians

- Continued to manage high profile hearings, which require additional staffing and security screening protocols.
- Liaised with police services with regard to a couple of problem complainants that were of concern to CPSO staff.
- Reviewed and implemented ways to provide additional excellent customer service to external clients. Training with Advisory Services, Credentials, Inquiries, Membership Services and Corporation takes place annually to ensure that front desk staff is able to handle many inquiries without delaying the clients.

D. Finance and Business Services

Finance Department

The underlying purpose of the Finance Department is to provide financial information that is needed by management to help them plan and monitor the activities of the College.

Business Services

The Business Services Area exists to support the College with coping, scanning and binding requests.

Finance

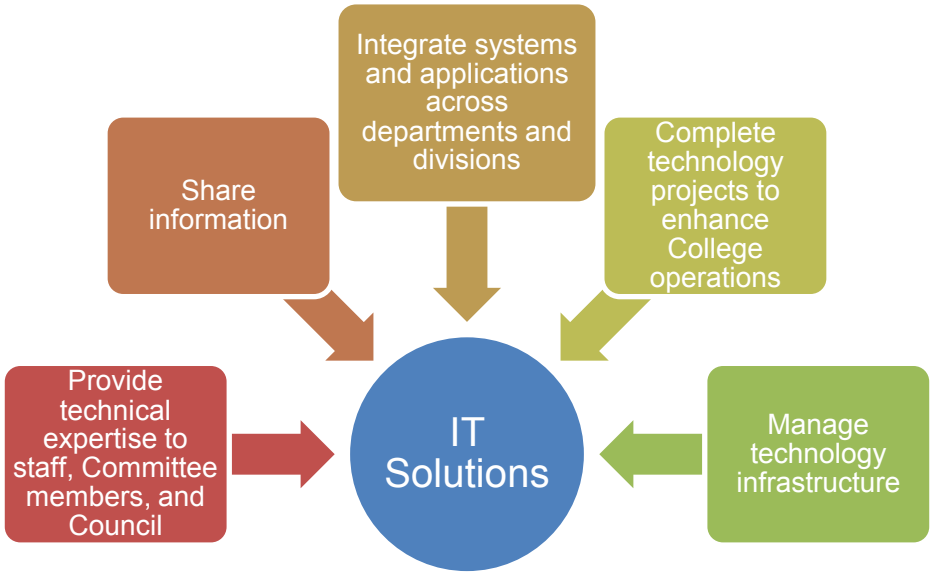
- Annual external audit was completed and it was a clean audit
- Continued to work with various departments and organizations to collect outstanding IHF payments
- Discussion regarding the 2017 budget has begun
- The longer-term investment portfolio was transferred to GICs as approved by Council
- Request for Proposal for the College's external auditors was completed
- Request for Proposal for the College's general banking relationship was completed and the decision was made to move from TD Canada Trust to Scotiabank. This process will be completed by the end of April 2016.
- Continued our core functions – Accounts Payable, Accounts Receivable, Payroll and Financial reporting
    - Accounts Payable – processed approximately 15,000 items for payment, an increase of 8.72% over 2014, processed approximately 10,000 cheques
    - Accounts Receivable – On top of the regular mail received, also received 38,130 packages through the Front Desk, an increase of 11.5% from 2014

Business Services

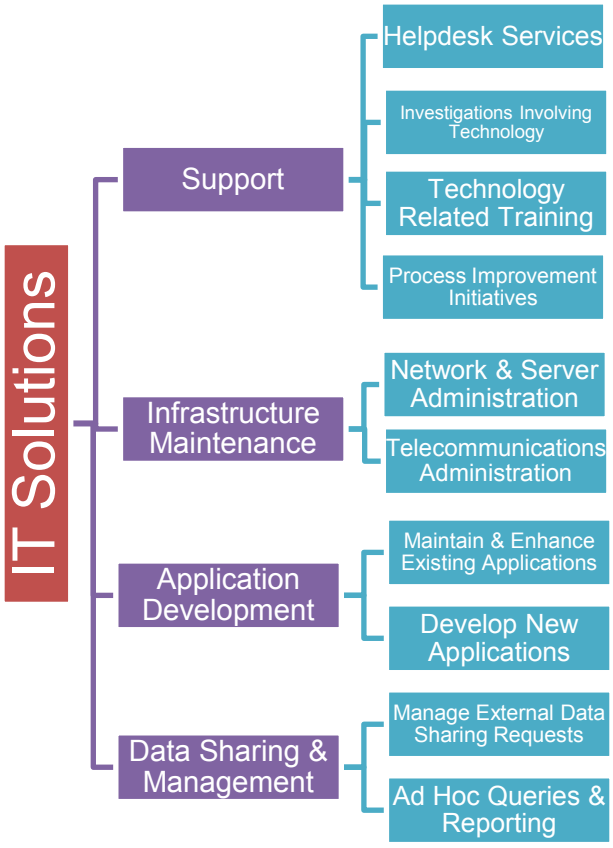
- Negotiated new leases for the equipment in the print shop and recognized a substantial savings over three years
- Continued with our core functions – photocopying, scanning, binding and electronic generation of agendas and committee material
    - Produced approximately 13.8 million copies which is an increase from the 5.3 million copies in 2014. 40% of the 13.8 million copies where related to Registrar's Investigations

Information Technology Solutions 2015 Departmental Report

WHAT WE DO



SERVICES WE PROVIDE



OUR STRATEGY

Our strategy for 2015 is based on four key assumptions:

1. Technology will evolve – we need to keep up to date and consistently re-invest so that we do not fall behind
2. We standardize on a Microsoft platform – not because it is the best, but because it is supportable and mainstream – we will always be able to find resources that are familiar with it
3. Our project priorities are set by the IT Steering Committee – based on the overall strategic and operational priorities of the organization
4. Where necessary, and in areas where we are lacking expertise, we will bring in experts to work with us.

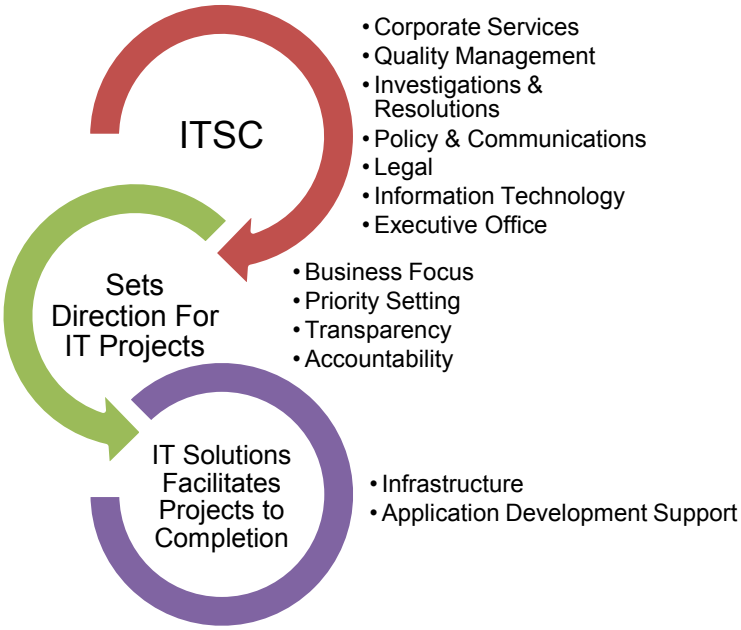
We support the College's strategic plan by:

- Improving and maintaining infrastructure
- Standardizing equipment and software where possible
- Ensuring that appropriate security and data protection is in place
- Developing, enhancing, and supporting enterprise or program-specific systems

Our process for undertaking new projects involves input from College functional areas.

All College departments are represented on the IT Steering Committee. The Committee meets monthly to ensure that:

- IT strategy is aligned with the strategic and business goals of the College
- There is full participation by functional areas of the College in decisions about major IT projects and their potential impact on operational processes
- IT project decisions are regularly reviewed, monitored, prioritized and approved



SUPPORT

We offer a variety of support services. Helpdesk, the "first line" of support, is the most widely used. Requests for problem resolution or services are submitted online, by phone or email. We also provide support to users of technology tools in various ways; by providing access to training modules on Microsoft Office tools through Lynda.com, developing and providing customized in-house training and guides for processes and applications. Through our online library, *IT Online,* we are able to ensure that technology related information is widely available. We also provide assistance in process improvement techniques, along with support for investigations using electronic records.

Helpdesk

Helpdesk is committed to ensuring that its stakeholders, both internal and external to the College, are provided with efficient and effective support.

In 2015, we had a total of ***4164 Helpdesk requests*** of which ***4034*** were closed—a 97% closure rate. Over the year, the team managed a workload that closed an average of 336 tickets every month. The types of requests are described below:

1) *Technical Services*
    - Access/Security/Set-up
    - Equipment Bookings
    - Installing a New Software Application
    - New Computer Requirements
    - New Hires & Departures – computer and telephone requirements

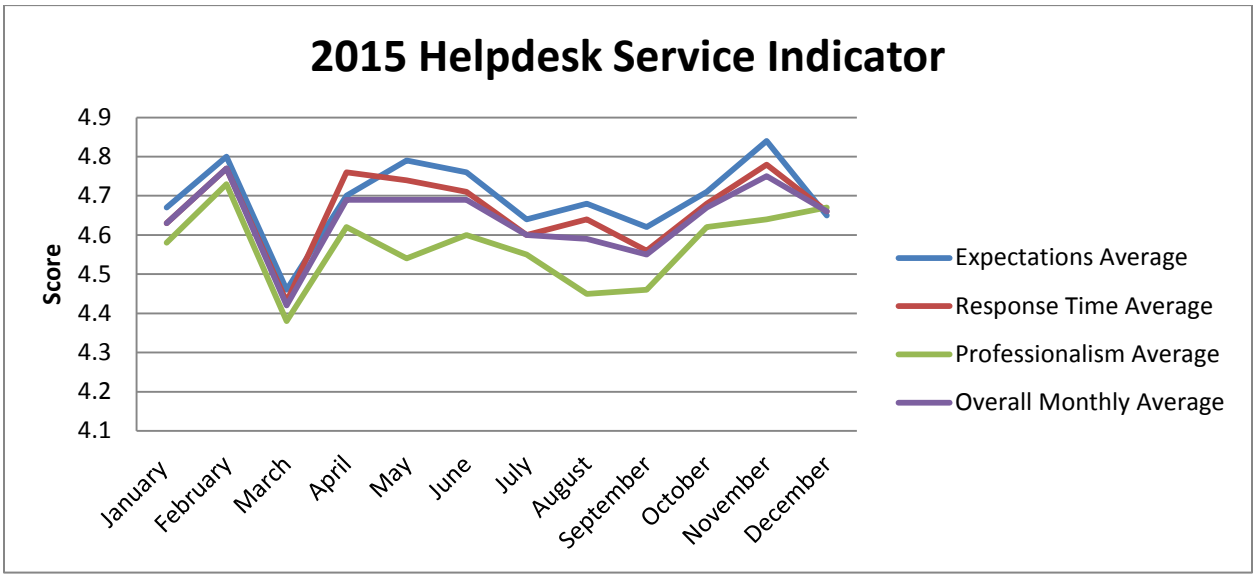
2) *Technical Problems & Incidents*
    - Folder Access Problem
    - Application Not Working Properly
    - Blackberry Problem
    - Desktop or Laptop Problem
    - Information/Data Change Request
    - Printer/Scanner/Copier Problem
    - Restoring Files Or Mailbox

3) *Training*
    - CPSO Custom Applications
    - Other CPSO Training
    - Windows/Office Application

Although we strive to resolve all requests effectively, it is also important that we continuously improve. Good customer service is extremely important—we measure our success through an indicator calculated based on responses to a survey presented upon resolution of a Helpdesk request. The survey asks respondents to rank (on a 5 point scale where 5 is most positive) their experience relating to three aspects of service:

1. *Meeting Expectations*-"The request resolution met my expectations"
2. *Appropriate Response Time*-"My request completed in a timely manner"
3. *Professionalism*-"I was kept up to date on what was happening"

Below are the results of our 2015 Helpdesk Survey:



The table above provides a comparison of how each aspect of service changed throughout the course of the year.

Overall, for 2015 we had high scores in all of the components of our Customer Service Indicator; scoring an aggregate expectations average of 4.69, a response time average of 4.66, a professionalism average of 4.57, and a total category average of 4.64. Our goal for 2016 is to maintain these strong service scores consistently throughout the year. In addition, we will focus on initiatives to increase our *Professionalism metric* by making a concerted effort to keep individuals up to date on their request status.

Learning & Development

We continue to focus on how people at the College do their work, and how the tools that we use can help us in this regard.

Below are some highlights from 2015:

- In partnership with the RMA and PA&E departments, IT developed four interactive e-learning scenarios to help staff organize, store, and retrieve College records.
- IT developed workshops and performance support materials on email best practices, published interactive guides on Bring Your Own Device policies, and created reference materials for a new Secure Email tool.

INFRASTRUCTURE

Infrastructure is the hardware, software and network structure that helps support the computers and phones that sit on desks, and the servers that our applications run on. Below are some infrastructure "facts" and 2015 project highlights relating to our technology environment:

Infrastructure Projects:

Implementations:

- BES 10 and 12 (Blackberry Server)
- Fortigate (Firewall and Web Filter)
- SCOM 2012 (Monitoring tool)
- SCCM 2012 (Deployment tool)
- ePO 5.3 (Security management tool)
- Attunity (Secure File Transfer)

800 Bay move, 7th to 8th Floor

2nd Floor Retrofit

Windows 2003 server migration

Meeting Room Upgrades

Interesting Security Facts:

Our Web Filtering appliance blocked over 180,000 malicious Web addresses in 2015

Our Email Gateway allowed over 635,000 external emails to be delivered to CPSO in 2015 while blocking more than 1,820,000 that were deemed spam and malicious

Our Anti-Virus software has blocked more than 3,150,000 threat events on our PCs while catching and deleting 430 viruses

Hardware Support By The Numbers:

We manage and support:

- 405 Desktop PCs
- 271 Laptops
- 141 Blackberries
- 54 Printers
- 494 Telephones
- 15 Physical and 110 Virtual servers
- 10 B&W and 2 Colour Canon scanners/copiers
- 12 Projectors
- 2 Office locations, 80 College and 800 Bay
- 550 Users

APPLICATION DEVELOPMENT- IT PROJECTS

Our Applications Development group builds and maintains custom software applications. We often work with external partners who bring specific technical expertise to our project teams. The projects we work on are prioritized by the IT Steering Committee, ensuring that our efforts are aligned to the strategic and operational needs of the College. Much of the work that we do stems from, and is in support of, process Improvement initiatives.

Below is a listing of the projects we successfully completed in 2015…

Annual Renewal 2015
Annual Renewal 2015 – PGEs (aka PGE Renewal Application Process)
Assessor Training Module
Auditor's Reports and T4As
BBP/EPP Data Analysis
Bring Your Own Device (BYOD) For Committee Members
CaRMs Match
CATS/AMS Changes To Track Infection Control Issues
Changes to Physician Questionnaire to support Physician Factors project
Council Elections 2015
Discipline Costs - Review follow-up and collection process
Governance Committee Assessment Forms
OHP - Online Reporting: Adverse Events Tier 1
OHP Online Reporting: Adverse Events Tier 2
OHP - AMS Workflow and Reporting Improvements
OHP Online Notification Forms
PA&E Process Review
RMA Training Module
SharePoint Troubleshooting
Support for Sexual Abuse Task Force - compiling data for CPSO submission
Transparency 2 - Criminal Charges, Convictions/Findings, Bail conditions
Transparency 2 - Discipline Findings and Licences in Other Jurisdictions
Transparency 2 - Oral Cautions, SCERPS

A preview of 2016 priority projects…

AMS - Compliance Monitoring and Reporting
AMS - PA&E Business & Technology Improvements - Phase 1
AMS - PA&E Business & Technology Improvements - Phase 2
Annual Renewal 2016, includes PGE Renewals
Auditor's Reports
CATS Replacement
I&R - Deactivate old detail entries for CATS
I&R - New Detail entries for CATS
Maintenance and Infrastructure - Batch machine replacement
Maintenance and Infrastructure - DMS database separation
Maintenance and Infrastructure - SQL Server Upgrade
PCI Compliance

Physicians Apply Process Mapping
Scotiabank Changes to Positive Pay File for Cheque Reconciliation
Secure Email and File Transfer - Implementation
Security and Privacy Awareness Program
SharePoint Upgrade Committee Support
Solomon Upgrade
T4As
Transparency 2 - Usability Improvements

DATA SHARING & MANAGEMENT

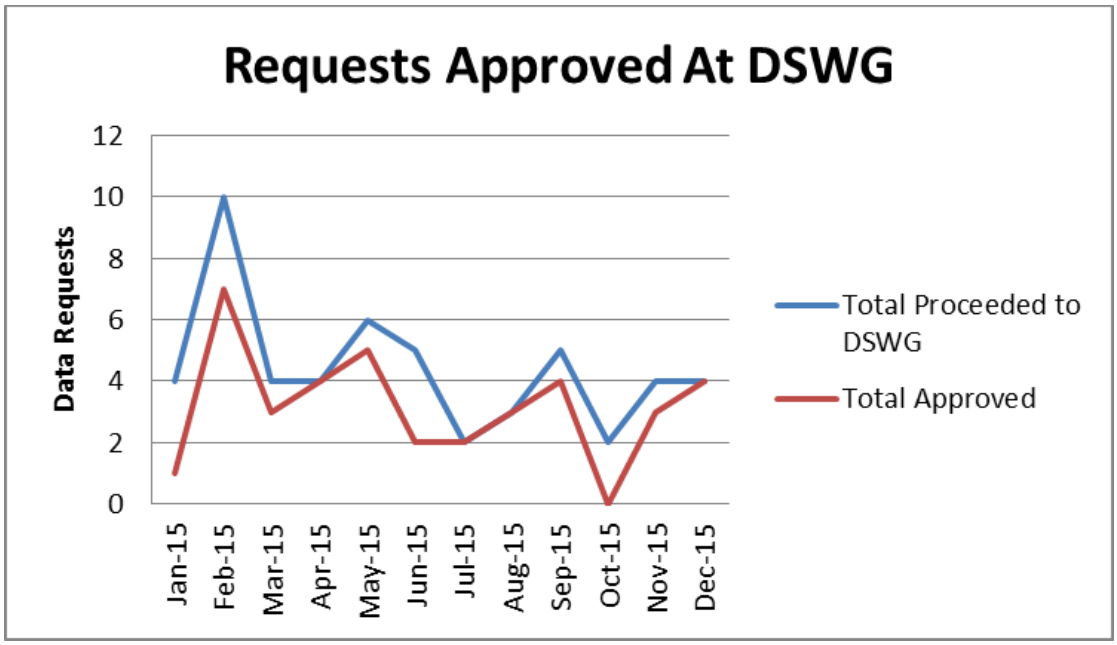
The College generates and manages a wide range of data which can be used in the broader health system. Whether it is for research, statistics, human health planning, we accept requests from an assortment of groups. Data is available on a “one-time” basis, annually or quarterly for a fee that covers our costs. Once a request is submitted, it is assessed through a formal process by the Data Sharing Working Group. This Working Group is a committee composed of members from all areas of the College who provide guidance on the approval of these requests. Requests are reviewed using a decision framework that incorporates a risk and resource impact assessment and also considers whether it falls within the Objects of the College. IT has direct involvement in this data sharing process. In most instances, our team is responsible for managing the relationship with the requestor, facilitating the request process through the working group, communicating with the stakeholders of this process, and ultimately fulfilling the requests.

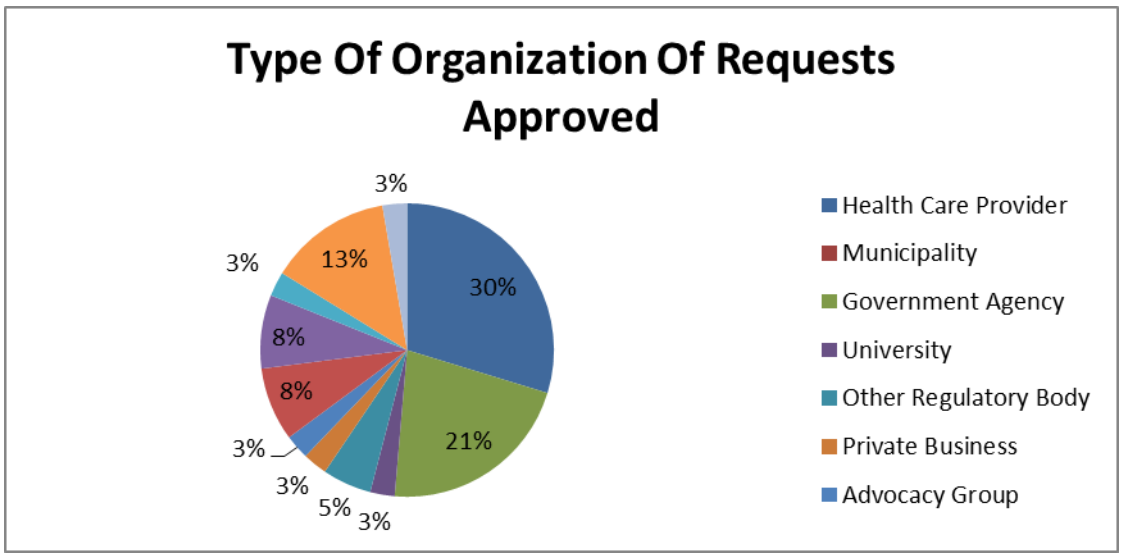
Data Sharing Requests:

In 2015, we received a total of 61 new requests, 37 were approved and we ultimately fulfilled 17. There were several factors that contributed to gap between requests approved, and those fulfilled. The main factors were as follows:

- Once approved, requestors were unwilling to pay a fee causing the request to become withdrawn after approval. This will be reduced in 2016 due to the changes in the Request for Information Form, which asks requestors to declare that they are willing to pay a minimum fee should their request be approved.
- There were cases where we required additional information from the requestor in which we received no additional correspondence. These cases were considered withdrawn due to the lack of response received.
- Other cases progressed to 2016 (i.e. the request was approved in 2015, however by the time the DSA or ethics approval were received and signed, the request was not fulfilled until 2016)

See below for Data Sharing highlights from 2015:





The majority of our requests for data sharing in 2015 came from health care providers, closely followed by government agencies. Our approval rate varies depending on the type of request, and the purpose of data usage. We do not approve requests for commercial usage, and the Data Sharing Working Group will only approve a request if it furthers a College object. In 2015, we had an approval rate of 69%. From the requests that were approved, the main objects furthered were:

Object 3- To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession, and

Object 8- To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.

For 2016, we will continue to provide governance in establishing data processes and definitions.

Ad Hoc Queries & Reporting:

We regularly receive requests from program areas of the College to provide information extracted from our administrative databases that are used to help inform decision making, and provide context in presentations or reporting. We do this by clearly identifying the conditions/criteria used when providing query results. In 2015 we received delivered over 50 requests for Queries and Reports.

LOOKING FORWARD

In 2016, along with continuing to support our existing technology environment (network, hardware and software), successfully delivering priority projects that support the goals of the College, and supporting the Data and Information Management Strategic Initiative, we plan to focus on expanding our customer service indicators to include project-related measures, including enhancing our formal project debrief process to incorporate peer and customer feedback.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Investigations, Resolutions, Hearings, Compliance Monitoring and Supervision, Department

2015 Annual Report

TABLE OF CONTENTS

Mandate

- Support the College's efforts to enhance quality of medical care and ensure patient safety.
- Conduct comprehensive and timely investigations and hearings.
- Monitor compliance with Orders, Undertakings, and Specified Education and Remediation Programs.
- Compile and analyze aggregate case data about care, conduct, capacity, and system delivery issues.
- Provide information to the profession to assist in minimizing complaints.

Structure

- An Intake/Triage area that assesses all member-specific information. Intake/Triage streams cases and directs specific investigative action. The area also follows up on positive responses to the questions on the annual renewal form, which include jurisdictional issues, civil litigation issues, criminal charges, and members' status regarding blood-borne pathogens if they perform exposure-prone procedures.
- An on-call investigator to answer complainants' system questions and concerns.
- Four specialized investigation teams.
- A Committee Support area that provides administrative assistance to the Inquiries, Complaints and Reports (ICR) Committee and supports the Committee in its case review and quality assurance activities.
- A Hearings Office that supports the two adjudication committees, the Discipline and Fitness to Practise Committees. The Office also prepares notices of suspension, revocation and restrictions.
- A central Compliance Monitoring and Supervision unit to ensure members fulfill agreements, undertakings, Orders and Specified Continuing Education and Remediation Programs (SCERPs) required by College committees, including: the Inquiries, Complaints and Reports (ICR), the Discipline, the Fitness to Practise, the Quality Assurance, and the Registration Committees.
- A statistical unit conducts in-depth analyses of closed investigative files to identify and assess factors that were influential in the outcome of investigations. Extracted information is entered into a central database that contains more than 400 unique coding factors. The analysis of these data can be used to identify trends in physician practices and guide policy initiatives.

Strategic Priorities

The department's work supports Council's Strategic Priorities by optimizing the fairness, effectiveness and efficiency of the Investigations, Discipline and Monitoring Processes. The department's objective is to reduce risk, support physicians to enhance their knowledge and skills, and improve health care.

In 2015 staff and committees focused attention on:

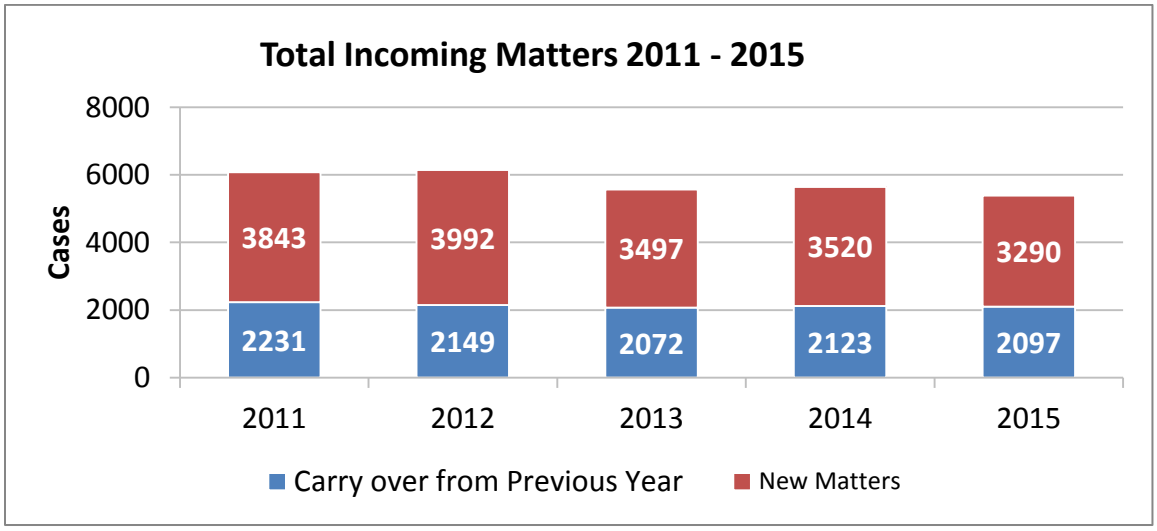
- Continued work related to the Transparency Initiative;
- Identifying specific investigative actions that result in timeline delays;
- Reviewing internal processes and practices related to investigations and prosecutions of sexual abuse as part of an internal working group;
- Assessing the impact of new case management strategies to enhance the hearings process; and
- Improving processes of the Compliance Monitoring and Supervision unit.

Investigations and ICR Committee Support Areas

The ICR Committee oversees all investigations into physician care, conduct, and capacity. The Committee oversees Public Complaint Investigations, broader practice (Registrar's) Investigations, and inquiries into a member's incapacity.

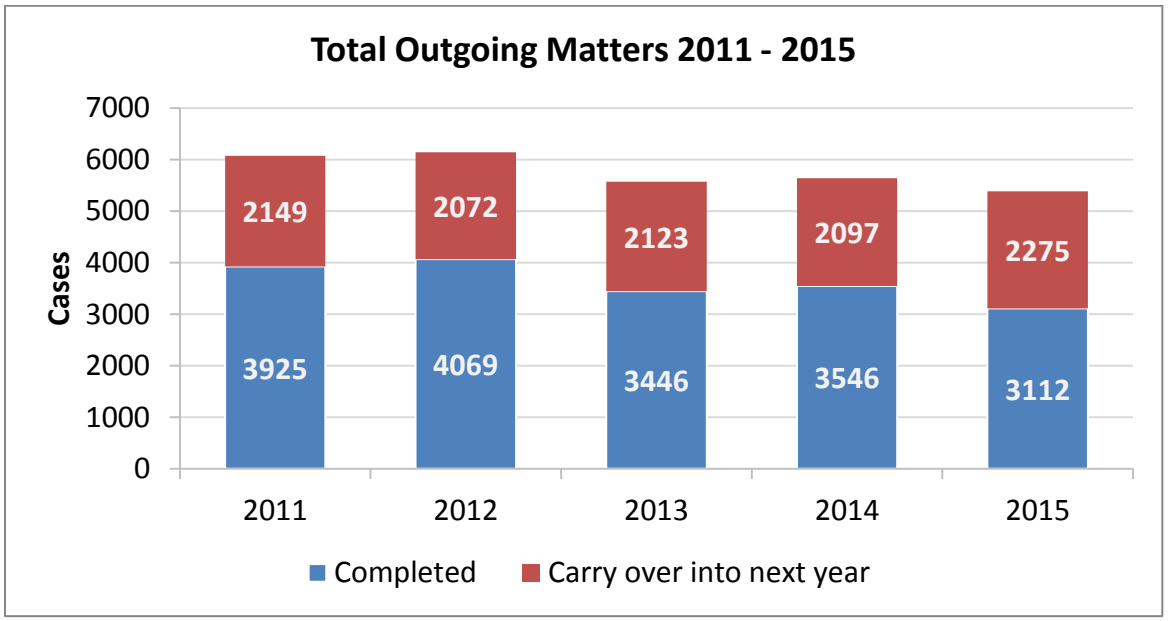
Registrar's Investigations and Incapacity Investigations remain small in numbers proportional to Public Complaints. They are, however, often more intricate than most patient-related complaints, which require looking at the patient's record and relevant information related to the patient (complainant's) concerns. Registrar's Investigations include review of 25 patient charts by an external assessor, interviews, and often observation. Incapacity Investigations include various types of external health assessments, interviews, and review of records.

Caseload



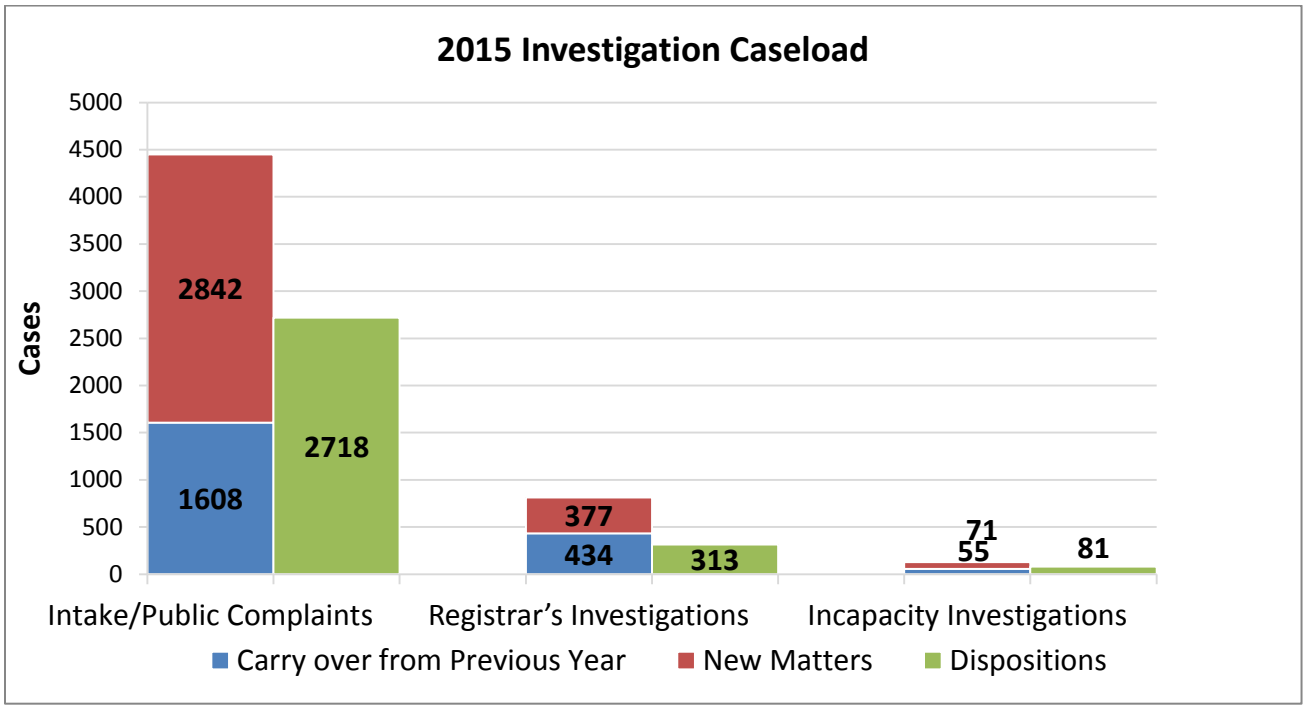
As of December 31st, 2015

- New investigations decreased by 7% in 2015 as compared to 2014.



As of December 31st, 2015

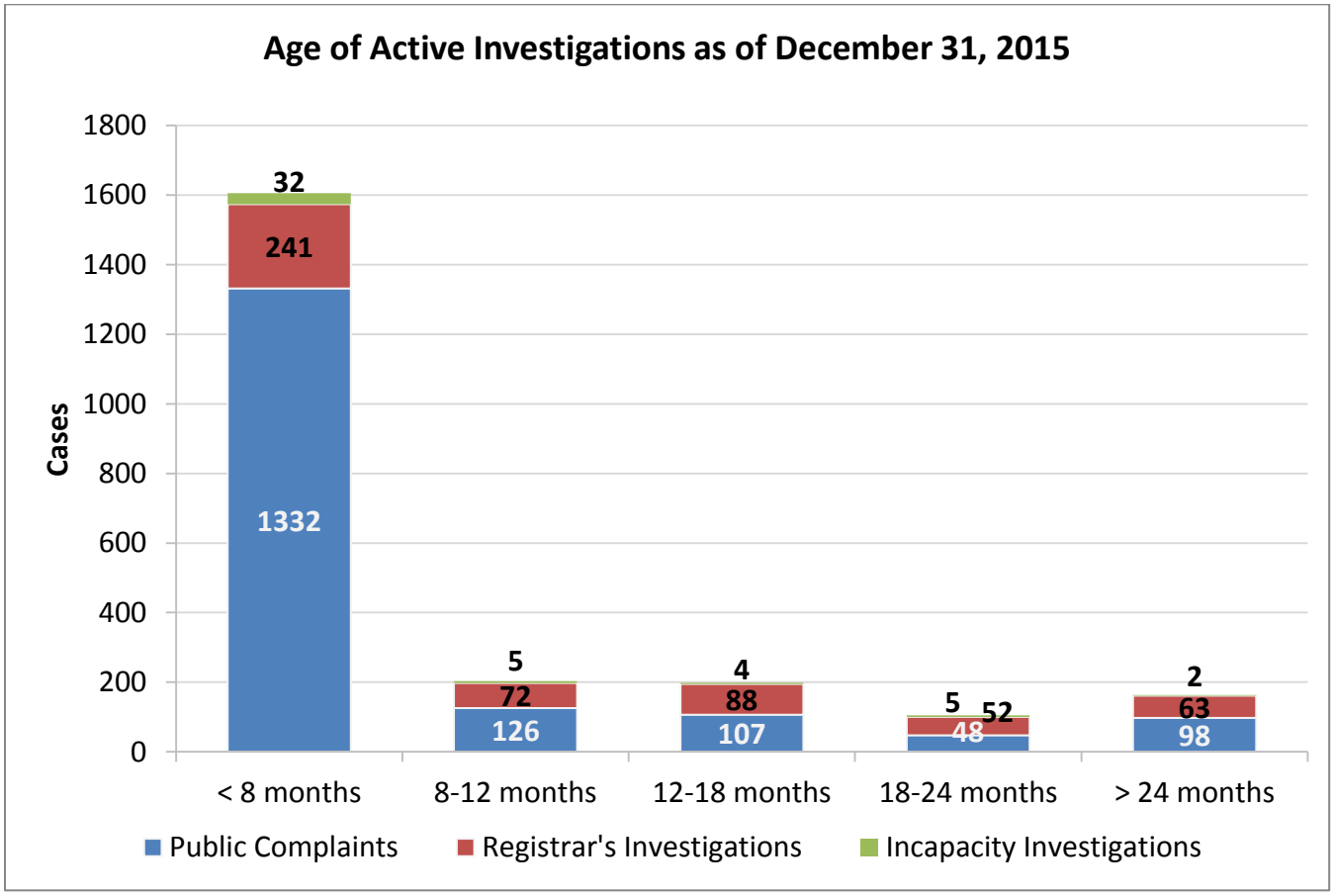
- Completed investigations were less than in 2014 and as a result did not reduce the caseload carried over into 2016.



Carry over from previous year as of December 31st, 2015

- New Intake matters decreased by 37% (437).
- New Public Complaint Investigations increased by 2% (2,405). Sixty-one percent of Public Complaint investigations (new and carryover from 2014) were disposed.
- New Registrar's Investigations decreased by 1% (377). Thirty-nine percent of Registrar's Investigations (new and carryover from 2013) were disposed.
- New Incapacity Investigations decreased by 15% (71). Sixty-four percent of Incapacity Investigations (new and carryover from 2014) were disposed.

Age of Investigations



Compared to 2014, the number of Public Complaints (PC) investigations age 8 months or less increased by 23%; those age 8-12 months decreased by 16%. The number of PC investigations age 12-18 months decreased by 40%.

Registrar's Investigations experienced a decrease of 4% for investigations age 8-12 months, but an increase of 52% for investigations age 12-18 months. Incapacity investigations had a decrease of 55% in investigations age 8-12 months, and also 50% drop in investigations age greater than 24 months.

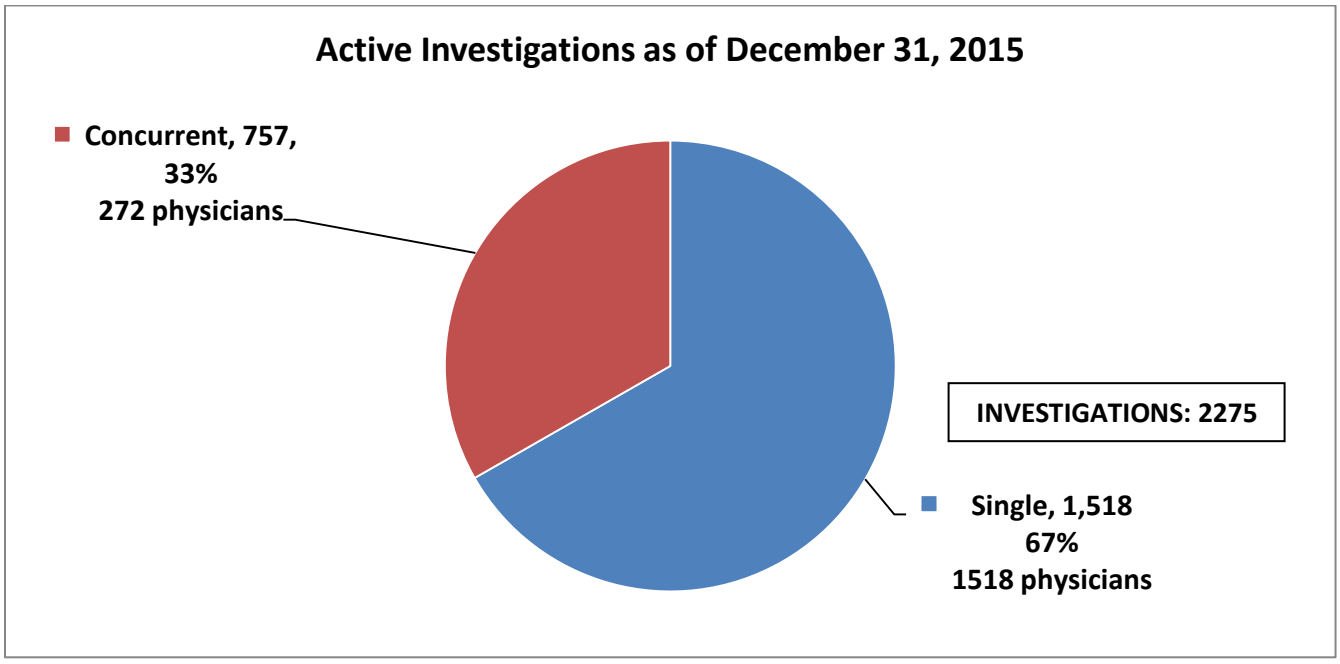
The ICR Committee and staff strive to reduce the proportion of older cases. High-risk investigations are given priority. However, it is recognized that there will always be matters that take longer to complete for any one or a combination of reasons, which can include:

- The Investigator has to wait for evidence from a third-party source e.g. OHIP data, hospital records.

- Many investigations require an external assessor or expert to opine on the matter. Rrecruitment challenges, clarity and completeness of reports, and time to complete work lead to longer investigations.

- Investigations into sexual misconduct are typically very detailed and require extensive Investigator resources, given the mandatory revocation penalty if these allegations are proven at a discipline hearing. Witnesses must be interviewed and the information they provide must be corroborated or refuted. If concurrent criminal charges have been filed or if the police have investigated, records must be obtained from the Crown and the courts.

- Concurrent investigations involving a physician are, for the most part, brought to the same ICR panel for review and decision per the Committee's practice. ICR Committee reviews matters simultaneously so that, if necessary, one discipline referral can be made. Thus, completed investigations may "wait" until other investigations are complete before being sent to the Committee. In addition, some physicians may be involved in three different investigation streams (i.e. Public Complaint(s), Registrar's Investigation(s) and Incapacity Investigation(s). Managing concurrent investigations requires coordination and review by Medical Advisors and legal counsel.



- As of December 31st, 2015, 33% of open investigations involved a physician with more than one active investigation.

Analysis of Factors that Cause Delay

The department reviewed 5002 completed investigations to specifically identify the factors that contributed to increased investigative timelines in 2013 and 2014.

The median timeline for all investigations was 189 days and the average timeline was 243 days.

Using a multivariate analysis, the independent contribution of each variable to investigative timelines was estimated while holding all other variables constant; actions completed during the investigation and direction received from the ICRC were included as variables in the model. The analysis showed:

- The need to transfer files to a new investigator during an investigation independently increased the length of an investigation by 14.8%

- The larger the number of medical records requested, the larger the impact on timelines. Requesting medical records one to two times resulted in a 26% increase in time to complete the investigation as opposed to a 50% increase when 5 or more medical records were requested.

- Other external reports also independently increased investigative timelines with significant increases of 13.1%, 15.1% and 22.3% for OHIP records, Crown or court documents and phone records, respectively.

- Locating, scheduling and conducting witness interviews also significantly impacted the length of investigation with the need for 4 or more interviews increasing timelines by 24.2% when compared to investigations that did not require an interview.

- Assessor opinions for public complaints (IO) and registrar's investigations (MI) had a similar impact on their respective timelines with an estimated 26% increase in completion time.

- Incapacity inquiries requiring a health assessment resulted in a 28.4% increase in time to completion when compared to incapacity investigations that did not require such an assessment.

- Negotiating an undertaking increased timelines by 10.3% when compared to similar investigations in which an undertaking was not obtained.

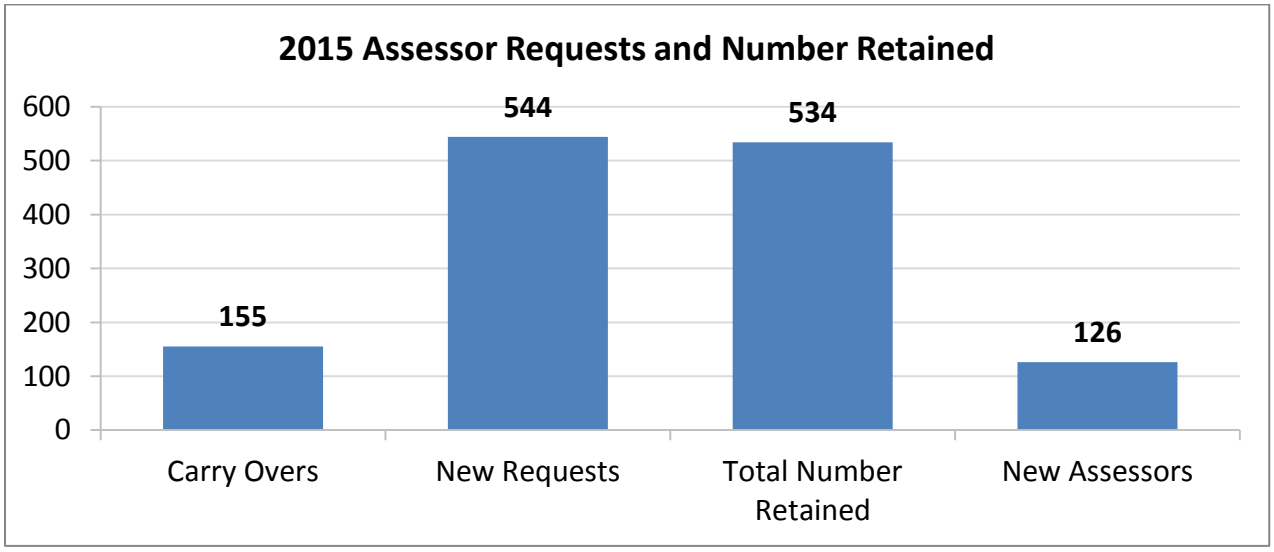
- Waiting for the completion of a concurrent investigation had one of the largest impacts on timelines with an increase of 52% when compared to investigations that did not have to wait for the completion of another investigation.

- Submitting an investigation to the ICRC and waiting for a listing date had the largest impact on investigative timelines. Submitting an investigation to the ICRC 2, 3 or 4 or more times increased the length of an investigation by 18.5%, 38.5% and 65.7%, respectively, when compared to investigations that were submitted a single time.

Based on the results, staff have begun to consider new ways to reduce timelines associated with these pressure points while conducting comprehensive investigations.

Assessors

Assessors for public complaints (Independent Opinions, (IOs), registrar's investigations (Medical Inspectors (MIs) and capacity inquiries play a critical role in many investigations. The Department continued its efforts to expand recruitment of new assessors and training and resources provided to assessors. In 2015 there were 544 Assessor requests made, 14% more than in 2014 (477).



- 219 were for Independent Opinions on single public complaints;
- 160 were for Medical Inspectors to conduct broad reviews of a physicians practice;
- 59 for Assessors to conduct Capacity Assessments of physicians directed by the Health Inquiry Panel.
- 106 for Assessors to conduct reassessments based on SCERPS or Undertakings

The top ten requests by specialty were:

Speciality of S.P.	Requests
Family Physician	253
Psychiatry	35
Anaesthesiology	32
General surgery	26
Diagnostic Radiology	21
Ophthalmology	19
Obstetrics/Gynaecology	19
Paediatrician	18
Urologist	17
Orthopaedics	16

Assessor Challenges

There continued to be some difficulty in finding assessors for particular areas of practice, including Complementary Medicine, Narcotic Prescribing, Chronic Pain and Bio-identical Hormone Replacement.

The ICR Committee continued to identify issues with the quality of some Assessor Reports.

Committee Support: ICR Committee

Matters Considered and Decisions Issued:

YEAR	MSI Considered	MSI TRENDS	Decisions Issued	Decision TRENDS
2010	3189	---	2237	---
2011	3794	↑ 19%	2660	↑19%
2012	3871	↑ 2%	2696	↑1%
2013	3652	↓ 6%	2435	↓10%
2014	4206	↑ 15%	2660	↑9%
2015	**3802**	**↓ 10%**	2527	↓5%

MSI = Total of all Member Specific Matters that went before all ICRC panels
Decisions = Written Decision and Reasons
The Committee administered cautions to 124 physicians.

Deferrals

- The ICR deferred 12% of investigations reviewed in 2015, 4% higher than 2014. The top three reasons for deferrals were requests for IOs, requests for further investigation, and directions to negotiate an undertaking.

Matters considered by Specific ICR Committee Panels:

Meetings	2010	2011	2012	2013	2014	2015
ICRC General Panels	1409	1500	1377	1141	1302	**1189**
ICRC Teleconferences	608	632	675	704	1056	**957**
ICRC Specialty Panels	501	1037	1166	1339	1242	**1032**
ICRC HIPs	112	119	108	94	125	**98**
ICRC Fast Track Panels	430	352	395	270	217	**229**
ICRC Medium Track Panels	n/a	n/a	n/a	n/a	137	**173**
Executive MSIs	24	25	7	1	3	**0**
Totals	**3189**	**3794**	**3871**	**3652**	**4206**	**3802**

Transparency Initiative Update

On May 29, 2015 Council approved a range of by-laws as part of its Transparency Initiative that provides more information on the public register. The new information includes criminal charges, cautions-in-person, specified continuing education or remediation program ("SCERP"), and discipline findings and licences in other jurisdictions.

An updated version of transparency Risk Continuum Questions was created to deal with both Clinical and Professionalism investigations (see page 12).

Remedial Agreements

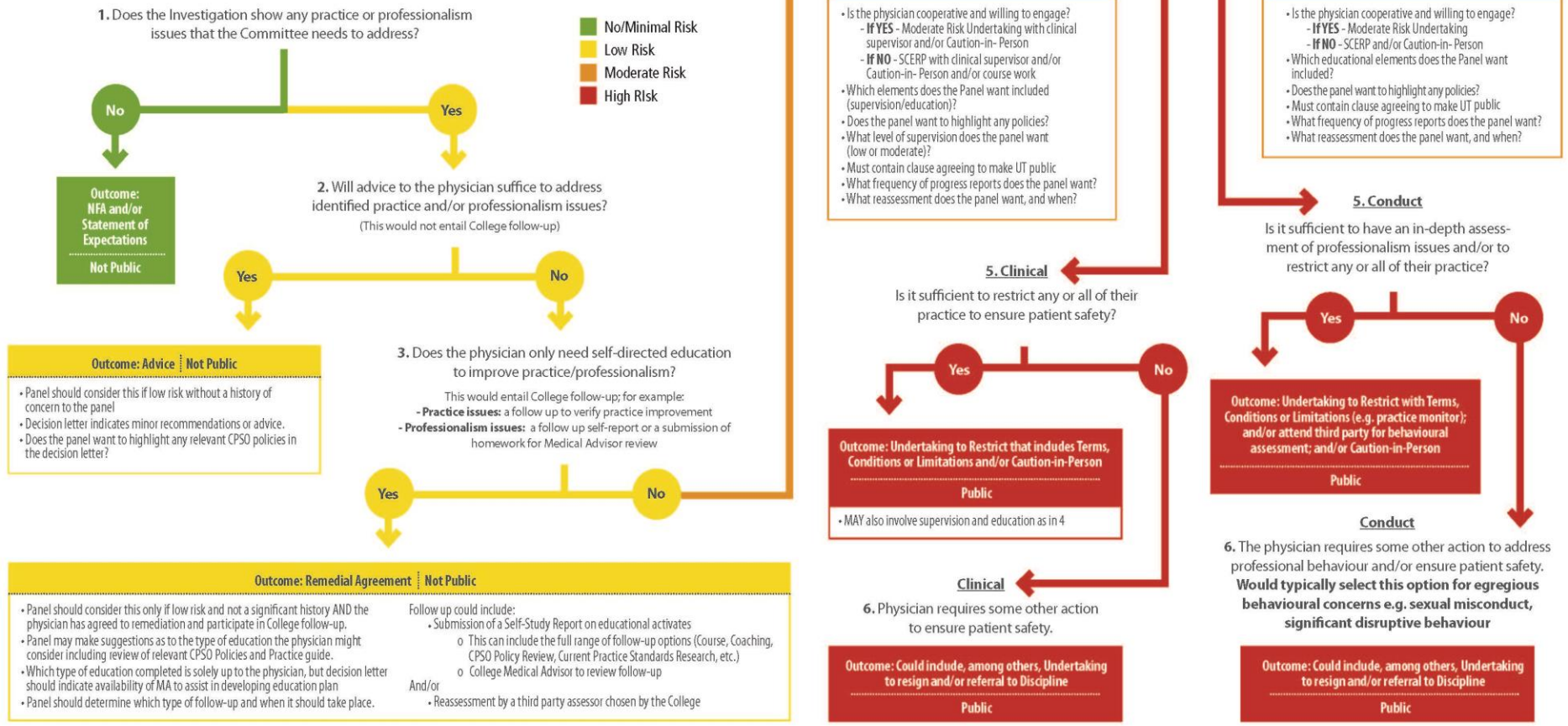
Under the new transparency initiative, the ICR Committee proposes Remedial Agreements in low risk cases where minor education needs are identified, and where the Committee would like confirmation (follow-up) that those needs have been addressed by the physician.

Public Summaries

Committee Support has been tasked with drafting public summaries for SCERPs and Cautions since June 2015. As of December 2015, the total of public summaries required was 51. The College posted 34 public summaries in 2015 of which 6 related to SCERPS and 28 related to Cautions. The remaining 17 public summaries from 2015 (10 SCERPS and 7 Cautions) have either been posted in early 2016 or will be soon.

Proposed Transparency Risk Continuum Questions For Clinical or Conduct Issues

Having reviewed the investigation (case), ICRC asks: Does the physician pose a risk to patient safety? What professionalism issues exist?



Piloting the "Risk Assessment Scale"

The pilot involves using a risk- based approach to committee decision-making. Panel members use a simple tool to assist them in deciding whether to take action on a matter with a view to minimizing potential risk to a future patient.

The tool consists of 9 questions about the physician's clinical care, insight, professionalism, record-keeping and complaints history.

Members are asked to consider and evaluate these factors and rate how concerning they perceive them to be i.e. no, low, moderate or high risk. Answers to the nine questions aim to guide discussion to determine overall risk and appropriate outcome according to the Transparency Risk Continuum pictured on page 12.

The Leadership Team tested the tool in June 2014 using active cases. Results showed 90% congruency between level of risk and outcome -- a positive result. In 2015, members of the ICR Committee's Surgical, Family Practice, Mental Health, Obstetrics and Internal Medicine Panels piloted the tool for both Public Complaints and Registrar's investigations on the results were equally positive.

The pilot will continue in 2016, aiming to automate it on Sharepoint by 2017 for use by every panel.

Settlement Panels

In autumn 2014, the MOHLTC struck a task force to review the RHPA and sexual abuse. The department participated by providing data concerning sexual abuse investigations and other information concerning the College's practice and process to the task force.

The Task Force review coincided with a 2015 intra-CPSO review, in which a group of staff reviewed the College's internal processes and practices related to investigations and prosecutions of sexual abuse matters. As Discipline Committee outcomes are dependent upon ICR Committee instructions to College prosecutors, the group recommended the formation of a specialized ICR Committee panel for considering post discipline referral settlement proposals and penalty instructions.

The goal of the panel is to enhance consistency in settlement and penalty instructions through standardizing the legal case memos and materials that are reviewed and enhancing the panel's training in discipline processes and penalty principles.

This specialized panel consists of standard membership of 12 physician and public members, representing varied specialties, genders, and those with experience with discipline or legal matters. This group received training in August 2015 from Legal that focused on the discipline process and penalty principles. The half days training included utilizing and discussing practical cases examples.

The first panels were held in November and December. Meetings will be held bi-monthly in 2016.

Nature of Issues

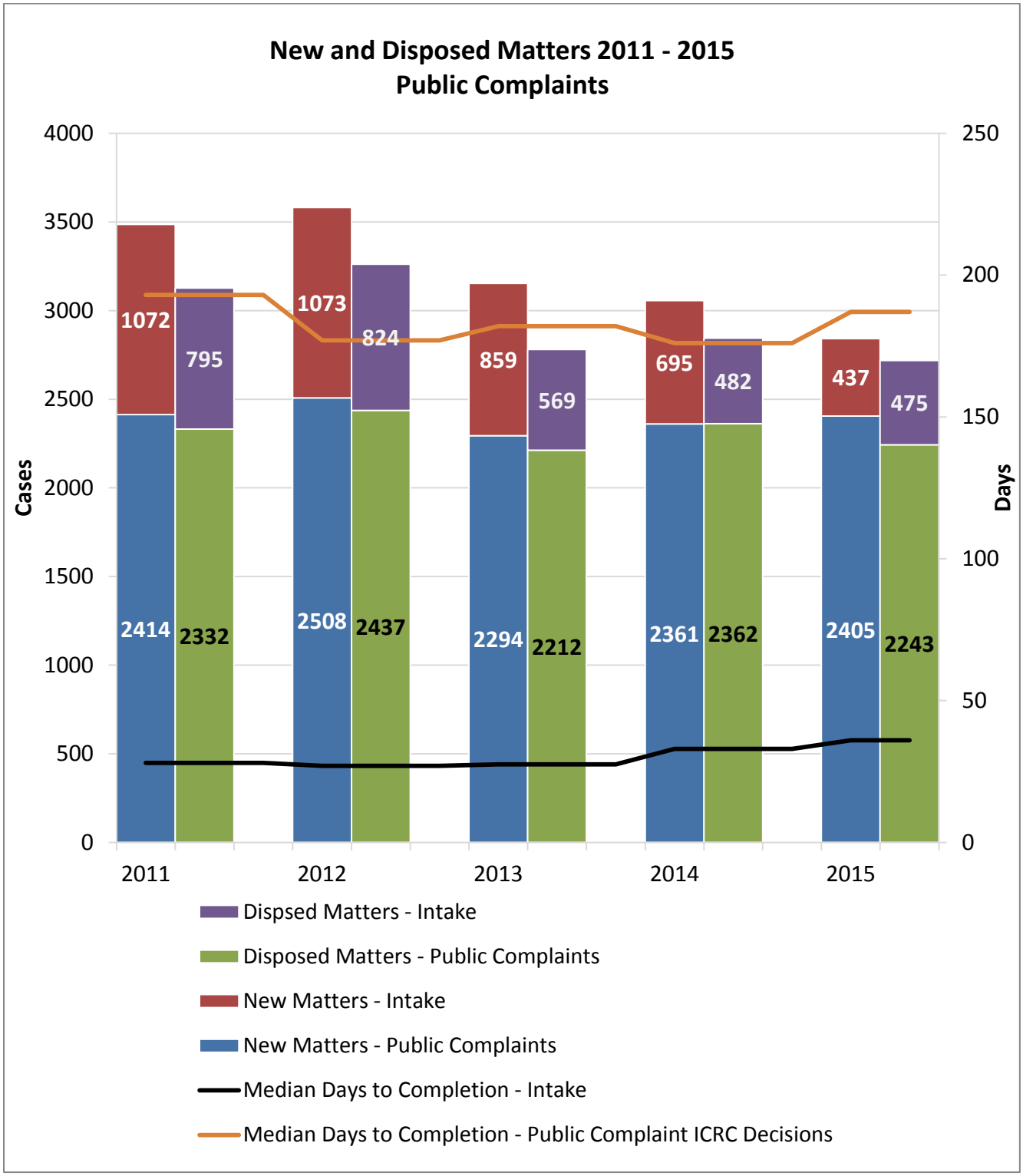
In 2015, the ICR Committee analyzed investigations completed the previous year to identify the nature of the issues based on panels' review and decisions. Issues were categorized into 13 distinct categories, namely assessment/examination, diagnosis, treatment, medication, clinical communication, record keeping, ethics and behavior, professional communication, patient consent, accessing care, systemic/office practice management, capacity and other. The table below provides examples for each category.

Nature of Issue	Examples of Issues Included
Clinical Issue	
Assessment/Examination	History taking, physical examination, selection of appropriate investigations, interpretation of results
Diagnosis	Diagnose the clinical condition given the results of examination and investigations
Treatment	Appropriate management of diagnosed clinical condition
Medication	Selection, prescription and management of medications
Communication	Clinical communication
Record Keeping	Issues relating to entries in a patient charts
Professionalism	
Ethics & Behavior	Advertising, conflict of interests, breaches, sexual abuse and/or boundary violations
Communication	Rude, inappropriate communication
Patient Consent	Consent
Accessing Care	Waiting times, accepting patients, termination, visit limits
Office Practice Mgmt/Systems	Protocols, staff issues, record transfer
Capacity	Health-related matters
Other	Annual renewal, delegated acts

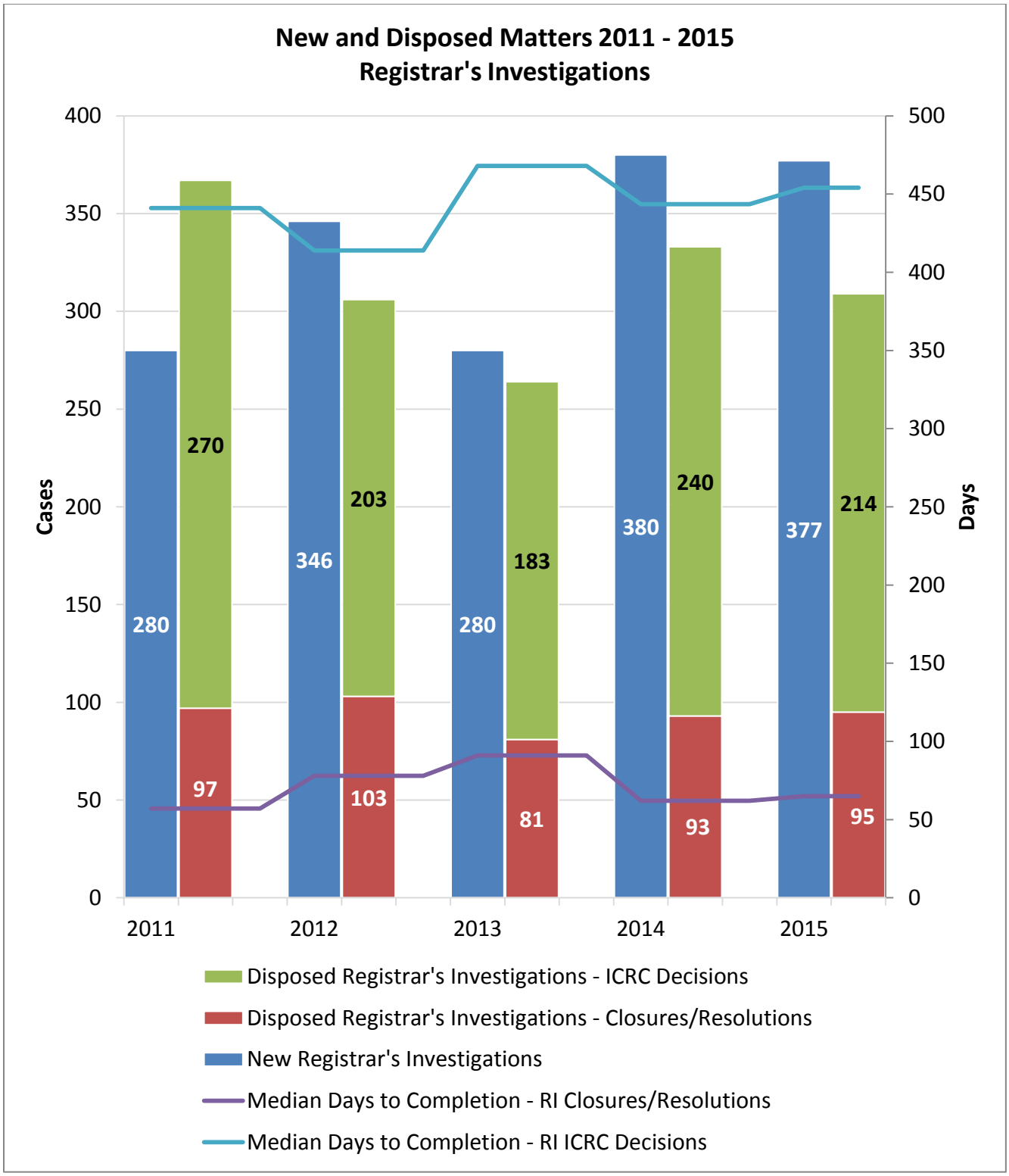
The number and percentage of investigations and the ICRC outcome pertaining to each issue is shown in the table below. Percentages sum to greater than 100 as one investigation may contain more than one issue.

Nature of Issue	Issue Identified in 2014 (N)	% of 2014 Investigations with this Issue	No Action	Advice	Caution in Writing	Caution in Person	SCERP	Undertaking	Discipline	Fitness to Practice
Clinical Issue										
Assessment/Examination	1014	38.1	783	97	77	28	9	7	13	0
Diagnosis	364	13.7	306	17	27	10	1	0	3	0
Treatment	1010	38.0	787	89	71	29	8	16	10	0
Medication	481	18.1	385	32	25	8	11	11	9	0
Communication	602	22.6	500	62	17	12	8	0	3	0
Record Keeping	516	19.4	255	125	44	21	49	12	10	0
Professionalism										
Ethics & Behavior	624	23.5	414	58	39	40	7	25	41	0
Communication	544	20.5	443	57	12	13	11	3	5	0
Patient Consent	242	9.1	164	42	21	12	0	1	2	0
Accessing Care	256	9.6	211	22	14	3	0	1	5	0
Systems/Office Practice Mgmt	419	15.8	323	56	18	9	4	2	7	0
Capacity	58	2.2	21	0	0	0	0	33	0	4
Other	56	2.1	28	6	10	2	1	3	6	0

Investigations and ICR Committee Statistics



As of December 31st, 2015



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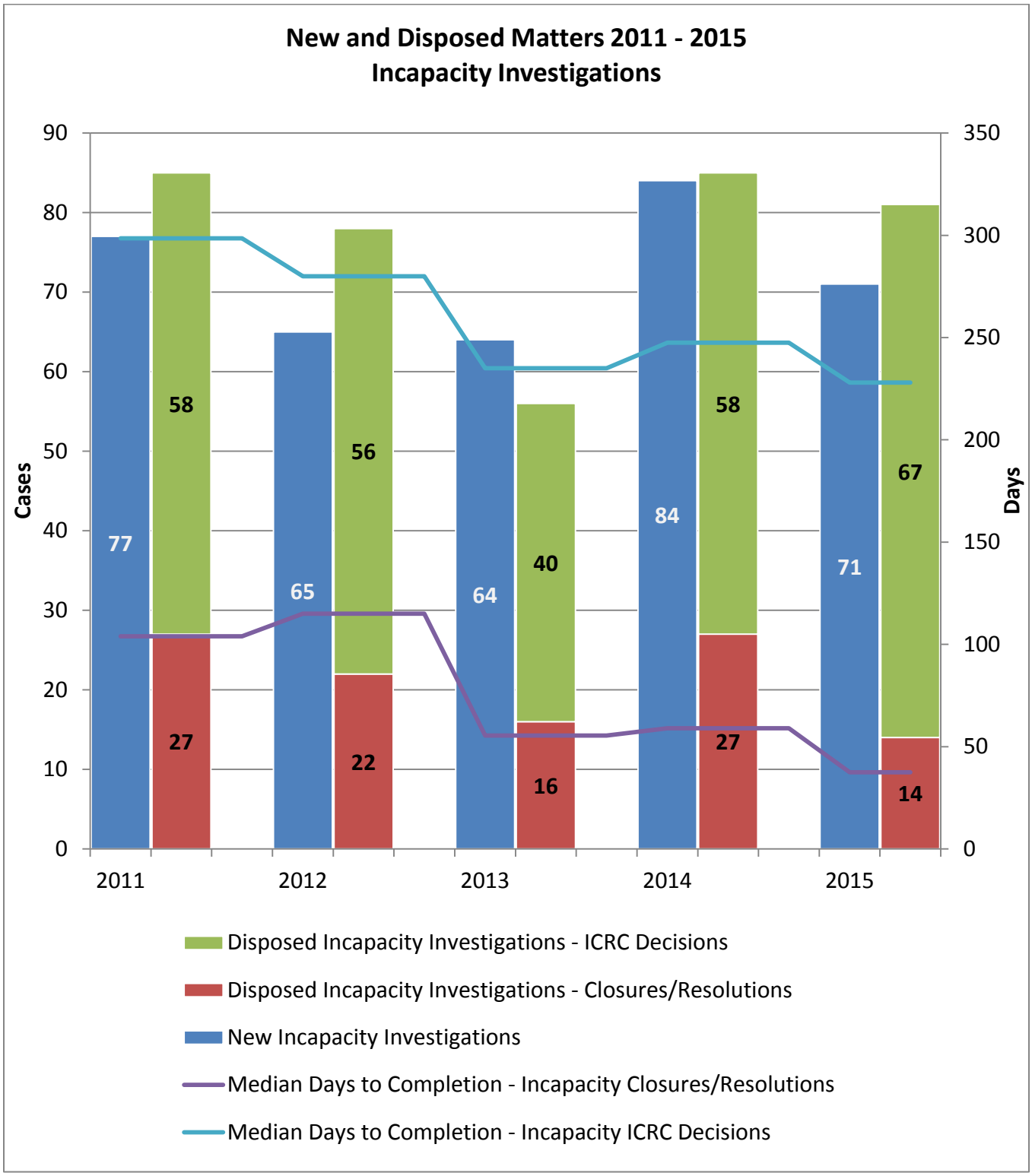


As of December31st,2015

Public Complaints - ICRC Decisions 2011 - 2015

	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N		N	
ICRC: No Action	1942	83%	1941	80%	1322	60%	1530	65%	1365	61%
ICRC: Advice	-		119	5%	461	21%	421	18%	542	24%
ICRC: Remedial Agreements									59	3%
ICRC: Caution in Writing	178	8%	190	8%	203	9%	202	9%	51	2%
ICRC: SCERP	68	3%	57	2%	76	3%	73	3%	56	2%
ICRC: Caution in Person	77	3%	75	3%	88	4%	77	3%	76	3%
ICRC: Undertaking	21	1%	17	1%	10	0%	19	1%	13	1%
ICRC: Referred to Discipline Committee	46	2%	38	2%	52	2%	37	2%	81	4%
ICRC: Referred for Incapacity Inquiries	-		-		-		1		-	
Total	**2332**	**100%**	**2437**	**100%**	**2212**	**100%**	**2359**	**100%**	**2243**	**100%**

As of December 31st 2015

Public Complaints - ICRC Decisions breakdown for 2015

	Jan 1st - May 31st	June 1st - Dec 31st
	N	N
ICRC: No Action	563	802
ICRC: Advice	203	339
ICRC: Remedial Agreements	0	59
ICRC: Caution in Writing	51	0
ICRC: SCERP	25	31
ICRC: Caution in Person	28	48
ICRC: Undertaking	7	6
ICRC: Referred to Discipline Committee	13	68
Total	**890**	**1353**

As of December 31st 2015

The Committee discontinued the decision 'Caution in Writing', and introduced 'Remedial Agreements' starting June 1, 2015.

Public Complaints ICRC Decisions No Action Breakdown 2011 - 2015

	2011		2012		2013		2014		2015	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No Action	1,257	65%	1,176	61%	906	69%	933	61%	1246	91%
Statement of Expectations	146	8%	207	11%	350	26%	397	26%	-	-
Reminder	106	5%	74	4%	-	-	-	-	-	-
Counsel	394	20%	371	19%	-	-	-	-	-	-
F&V No Action	39	2%	113	6%	66	5%	200	13%	119	9%
Total	**1,942**	**100%**	**1,941**	**100%**	**1322**	**100%**	**1530**	**100%**	**1365**	**100%**

As of December 31st, 2015

Registrar's Investigation ICRC Decisions 2011 - 2015

	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
ICRC: No Action	98	36%	69	34%	32	17%	57	24%	50	23%
ICRC: Letter from Registrar	-	-	-	-	-	-	1	0%	-	-
ICRC: Advice	-	-	2	1%	15	8%	15	6%	21	10%
ICRC: Remedial Agreements									5	2%
ICRC: Caution in Writing	17	6%	20	10%	22	12%	24	10%	7	3%
ICRC: SCERP	51	19%	32	16%	35	19%	33	14%	33	15%
ICRC: Caution in Person	12	4%	13	6%	8	4%	17	7%	15	7%
ICRC: Undertaking	60	22%	38	19%	46	25%	57	24%	51	24%
ICRC: Referred to Discipline Committee	31	11%	29	14%	25	14%	35	15%	32	15%
ICRC: Referred for Incapacity Inquiries	1	0%	-	-	-	-	-	-	-	-
Total	**269**	**100%**	**203**	**100%**	**183**	**100%**	**239**	**100%**	**214**	**100%**

As of December 31st, 2015

Registrar's Investigation - ICRC Decisions breakdown for 2015

	Jan 1st - May 31st	June 1st - Dec 31st
ICRC: No Action	18	32
ICRC: Advice	4	17
ICRC: Remedial Agreements	0	5
ICRC: Caution in Writing	7	0
ICRC: SCERP	18	15
ICRC: Caution in Person	10	5
ICRC: Undertaking	24	27
ICRC: Referred to Discipline Committee	12	20
Total	**93**	**121**

As of December 31st, 2015

The Committee discontinued the decision 'Caution in Writing', and introduced 'Remedial Agreements' starting June 1, 2015.

RI ICRC Decisions No Action Breakdown 2011 - 2015

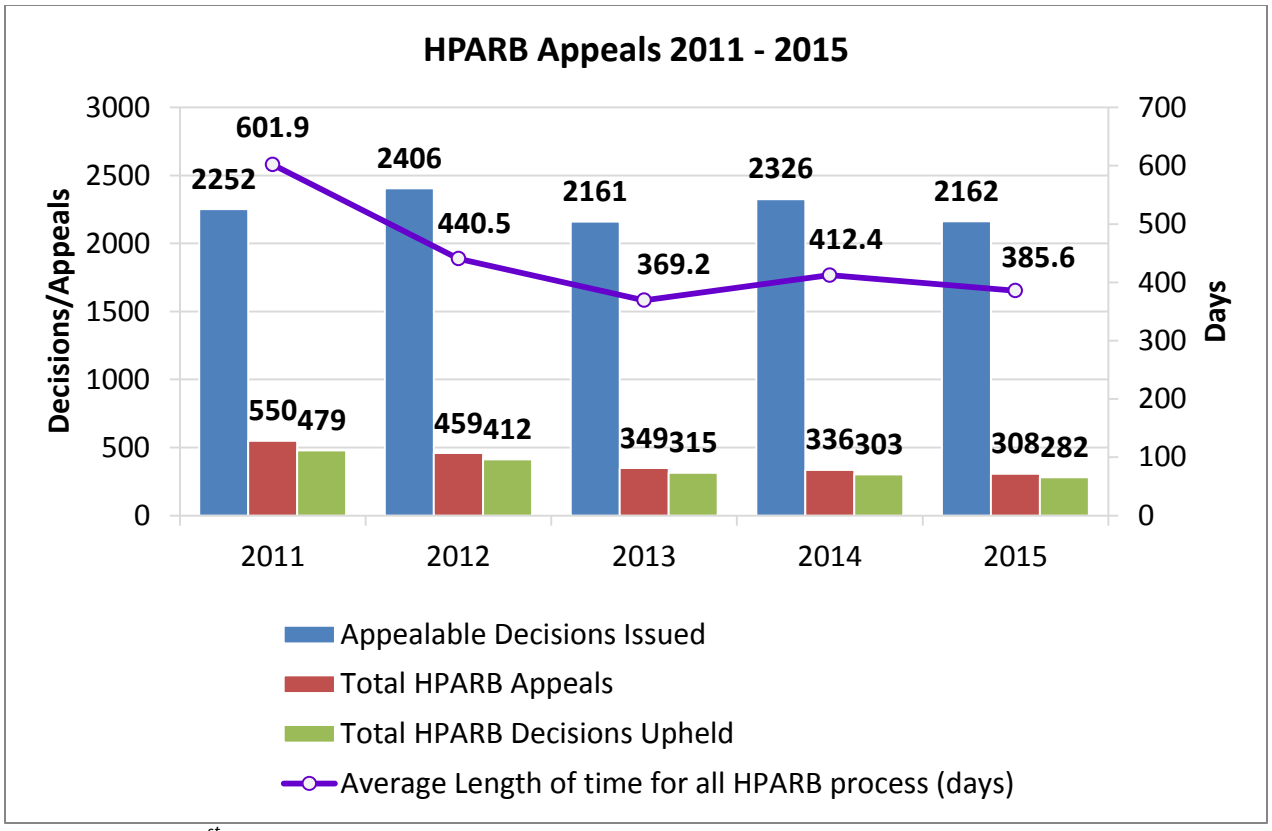
	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
No Action	67	68%	47	68%	28	15%	44	77.2	50	100%
Statement of Expectations	11	11%	4	6%	4	2%	13	22.8	-	-
Reminder	4	4%	-	-	-	-	-	-	-	-
Counsel	16	16%	18	26%	-	-	-	-	-	-
Total	**98**	**100%**	**69**	**100%**	**32**	**100%**	**57**	**100%**	**50**	**100%**

As of December 31st, 2015

Incapacity Investigations ICRC Decisions 2011 - 2015

	2011		2012		2013		2014		2015	
	N	%	N	%	N	%	N	%	N	%
ICRC: No Action	17	29%	22	39%	21	53%	21	36%	18	27%
ICRC: Undertaking	33	57%	30	54%	19	47%	33	57%	47	70%
ICRC: Referred to incapacity inquiry	-	-	1	2%	-	-	-	-	-	-
ICRC: Referred to Fitness to Practice	8	14%	3	5%	-	-	4	7%	2	3%
Total	**50**	**100%**	**52**	**93%**	**40**	**100%**	**54**	**100%**	**67**	**100%**

As of December 31st, 2015



As of December 31st, 2015

Note: HPARB returns are not necessarily based on Committee Decisions issued in the same year.

HPARB Appeals Based on 2014 and 2015 Dispositions

Year	Appealable Decisions Issued	Decisions that were Appealed	Appealed decisions that indicate the source of the appeal	Appealed decisions that were appealed by the Complainant*	Appealed decisions that were appealed by the Subject Physician*	Total HPARB Reviews Received thus far	Total HPARB Decisions Upheld**
2014	2326	370 (16%)	92 (25%)	82 (89%)	10 (11%)	265 (72%)	243 (92%)
2015	2162	431 (20%)	431 (100%)	340 (79%)	91 (21%)	Too few received	Too few received

As of December 31st, 2015

*Only includes data for appealed decisions in which there is information relating to the source

**Only includes data for appealed decisions that were received

Hearings Office: Discipline Committee and Fitness to Practise

The Discipline Committee manages each case from the time of referral to decision. The Discipline Committee's goal is to eliminate unreasonable delay in the process and where appropriate, to facilitate case resolution.

The stages of the process regarding allegations of professional misconduct and incompetence are:

- Referral of specified allegations by the Inquiries, Complaints and Reports Committee
- Disclosure by the College to the Member of all relevant non-privileged information and disclosure by the Member to the College of the names of experts and a summary of or expert reports, if any
- Pre-hearing processes, including case management conferences and pre-hearing conferences
- Potential resolution resulting in withdrawal of all allegations or an uncontested hearing
- Hearing
- Written Decision and Reasons for Decision

Pre-Hearing Processes and Case Management

Pre-hearing conferences (PHCs) have both a case management function and a case resolution function.

Pre-hearing conferences (PHCs) have both a case management function and a case resolution function. The purpose of the PHC is to determine:

- Whether any or all of the issues can be settled
- Whether the issues can be simplified or clarified
- Whether there are facts that can be agreed upon
- Whether further disclosure or pre-hearing motions are required
- The scheduling of motions and the hearing

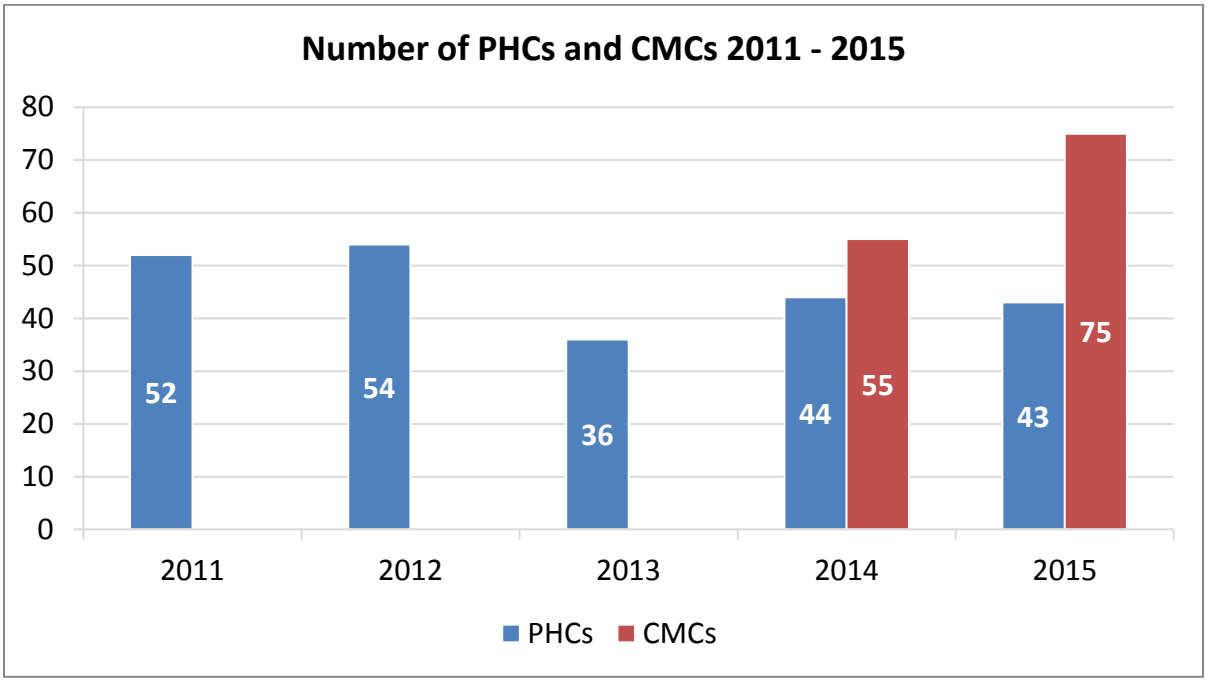
The Discipline Committee conducts four types of Case Management Conferences (CMCs):

- Early Case Management Conference (E-CMC): if a pre-hearing conference (PHC) is not scheduled within 120 days of referral, an E-CMC is held to determine steps needed for an effective PHC to take place and, if appropriate, to schedule a PHC date.

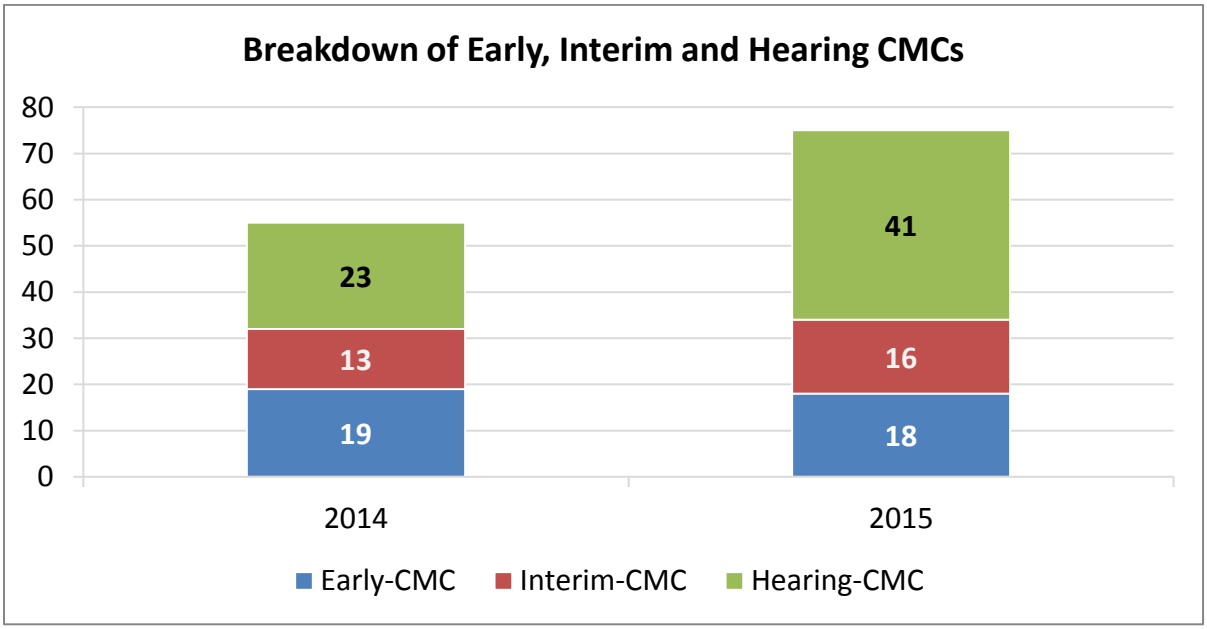
- Interim Case Management Conference (I-CMC): may be scheduled after a PHC to provide continuing periodic oversight based on the needs of the case.

- Hearing Case Management Conference (H-CMC): scheduled three weeks before the commencement of a contested multiple-day hearing to identify any new issues and to ensure an adequate number of hearing days and the efficient use of hearing time.

- Penalty Hearing Case Management Conference (PH-CMC): scheduled if the hearings office cannot agreement to a penalty hearing date within two weeks of the release of a decision on finding in a case.



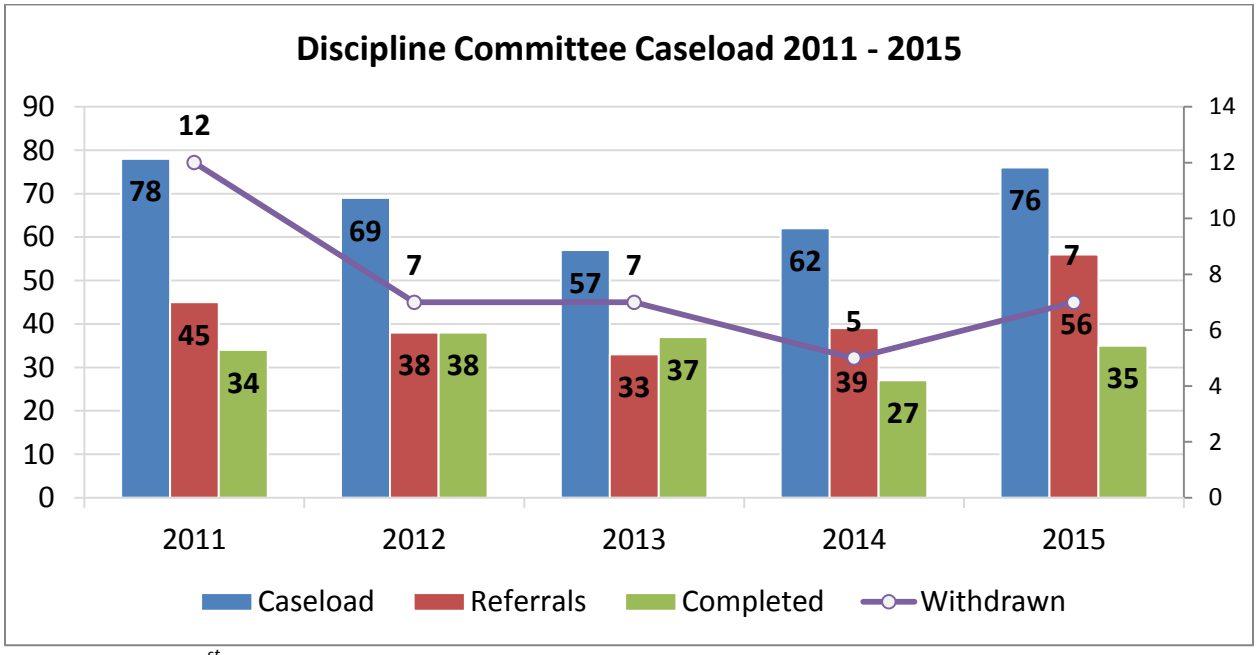
As of December 31st, 2015



As of December 31st, 2015

- From 2011 to 2015, the Discipline Committee has more than doubled its case management activity.

Caseload – Referrals, Completed and Withdrawn Cases



As of December 31st, 2015

Note: in 2015, ICRC referred 113 cases to the Discipline Committee, involving 56 Notices of Hearings.

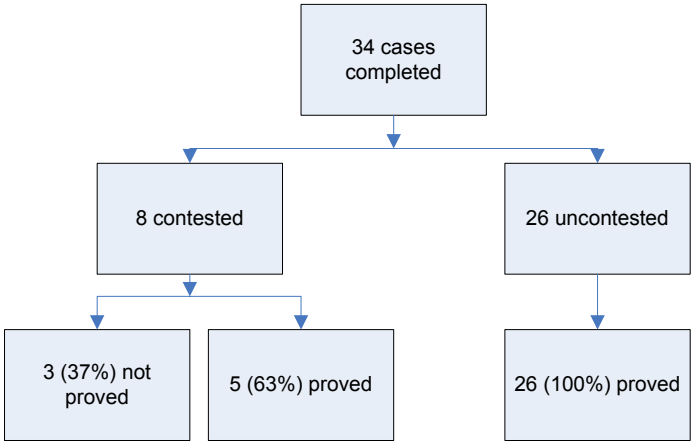
The Discipline Committee's caseload is increasing. The caseload at the end of 2015 was 76 coming from 56 referrals, the highest received since 2009.

In 2015, the College withdrew all allegations in seven cases. In five of those cases, the physician signed an undertaking to resign and not reapply. In two cases, the main witness did not wish to testify; therefore, there was no prospect of a finding.

Discipline Findings, Penalties and Current Referrals

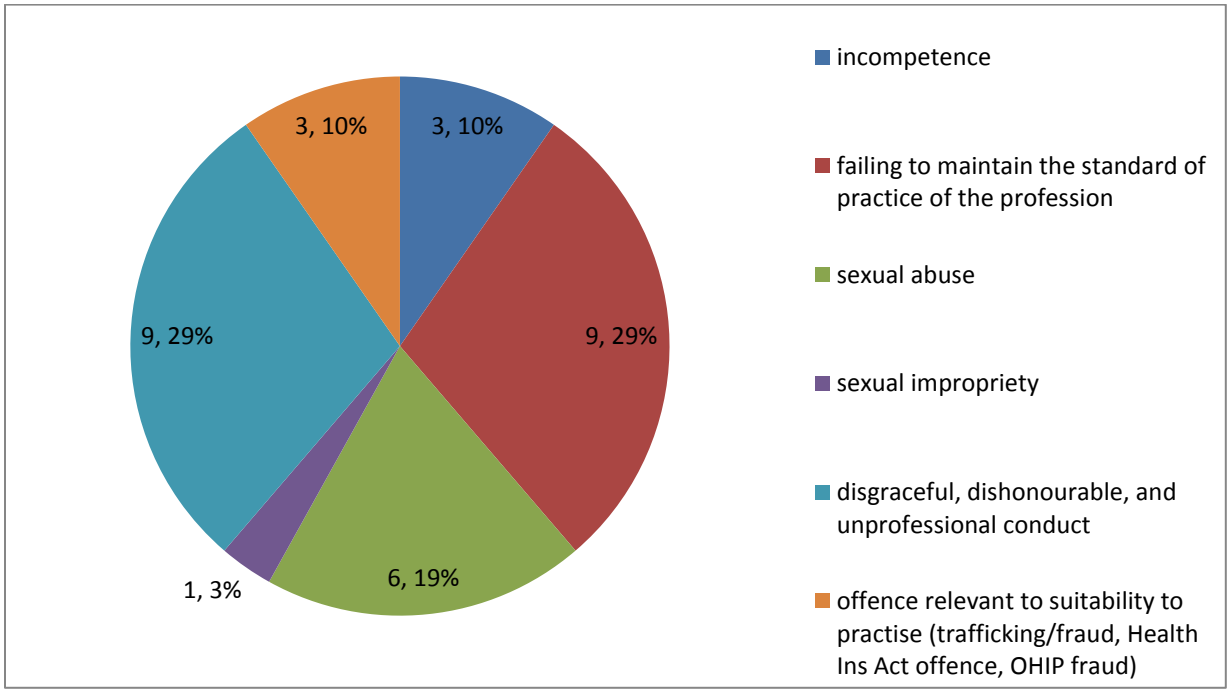
In 2015, the Discipline Committee completed 35 cases.

- 1 case was a motion to vary the terms of a prior order (granted); and
- 34 cases involved allegations of professional misconduct and /or incompetence, as follows:



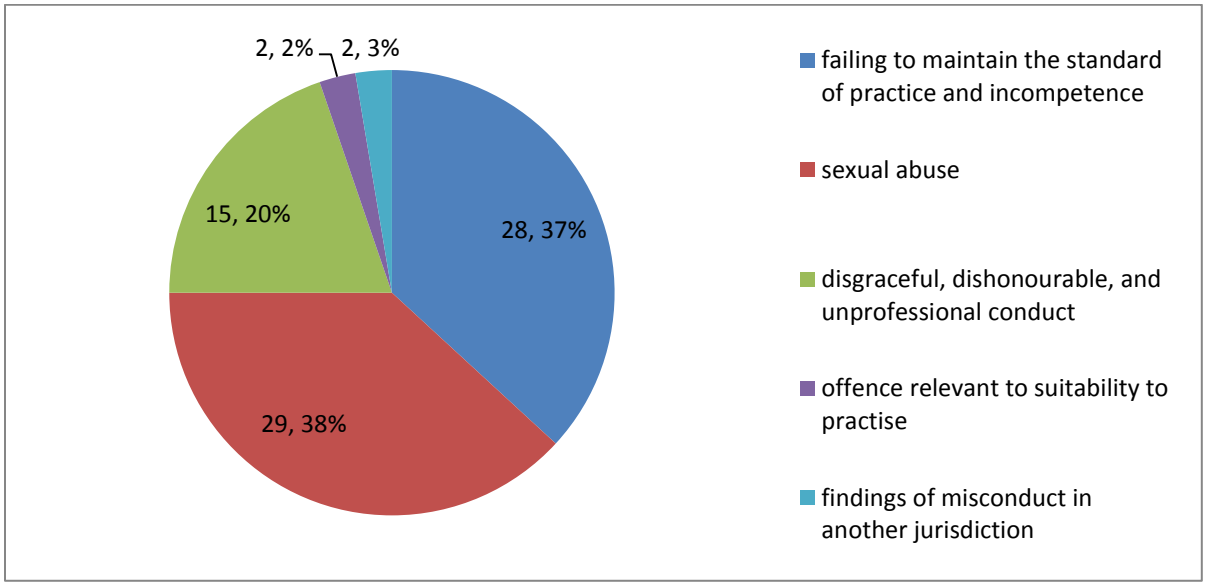
5 proved contested cases + 26 proved uncontested cases = 31 cases or 91% where some or all allegations were proved.

Findings of 31 Proved Cases:



Current Referrals

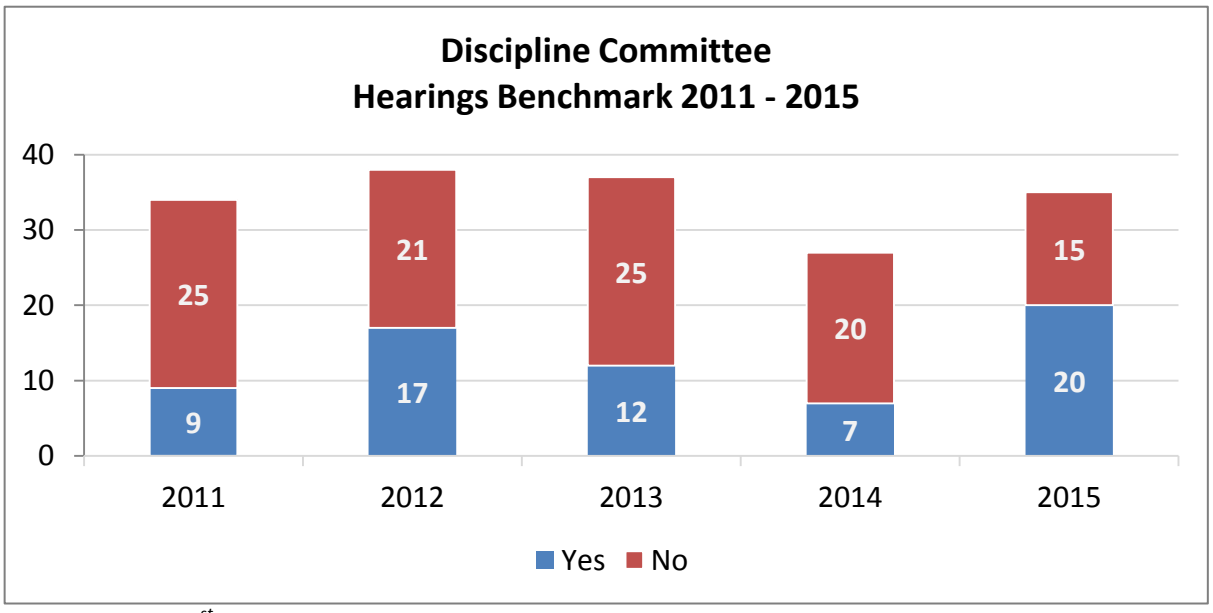
At the end of 2015, there were 76 cases before the Committee. Allegations were as follows:



Hearings and Decision Benchmarks

Hearings Benchmark

The Discipline Committee has a hearings benchmark to commence and, if possible, complete hearings within 1 year of referral.



As of December 31st, 2015

Analysis of the reasons for variance indicate that cases are over benchmark for legitimate reasons and based primarily on factors external to the Committee.

Common case specific factors external to the Committee include: the parties' readiness for a pre-hearing conference; concurrent proceedings which add to case complexity (concurrent discipline referral, fitness referral, criminal proceeding, judicial review or appeal); postponements due to further investigation and the referral of additional allegations; and, ongoing case negotiations.

Factors internal to the Committee include: the availability of days in the hearing calendar; and, panel availability

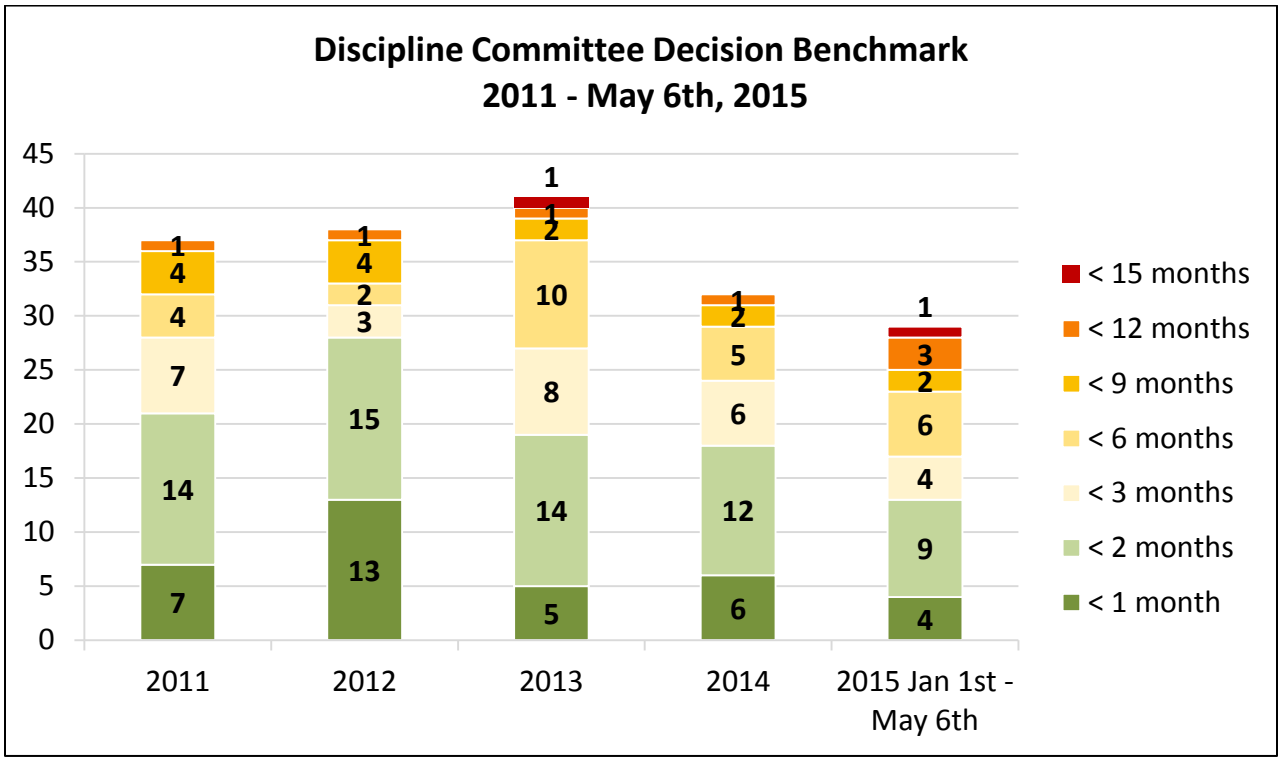
Decision Benchmark

In 2002, the Discipline Committee established a two-month decision benchmark, i.e., to release its written decision and reasons within two months of the last hearing date. This applied to all cases.

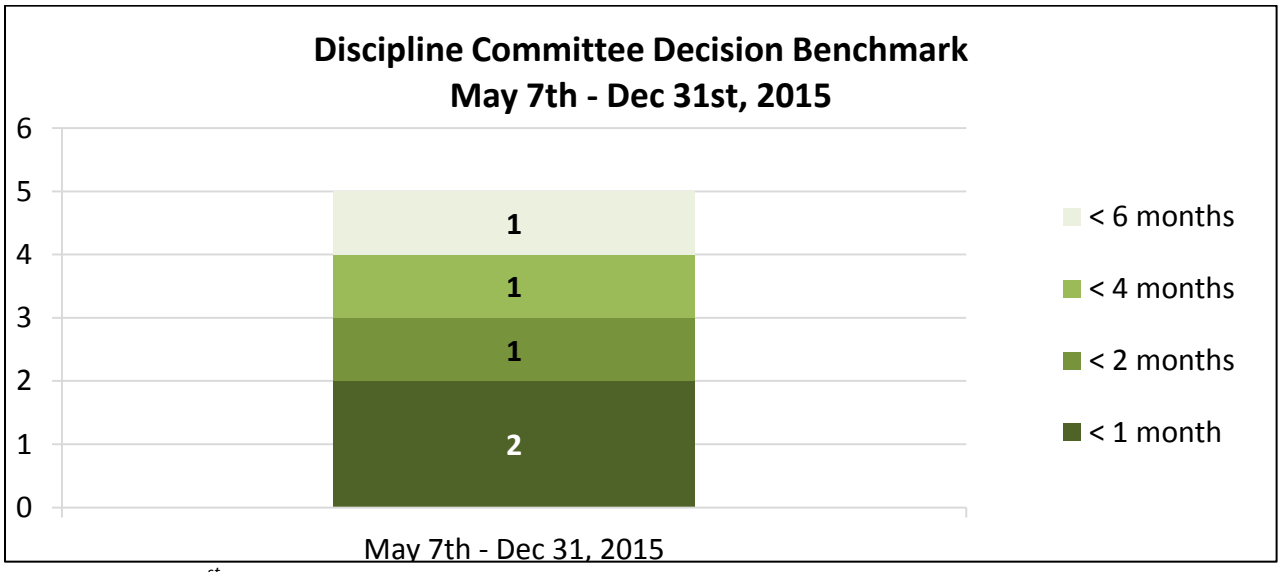
In 2015, the Committee changed this to two decision benchmarks to acknowledge differences in case complexity:

- 1 for uncontested cases, which proceed on the basis of agreed or uncontested facts and joint submission on penalty.
    - Benchmark: release written decision and reasons within 2 months of the last hearing date;
- 1 for contested cases, in which the allegations or penalty are in dispute.
    - Benchmark: release written decision and reason within 6 months of the last hearing date - absent extenuating circumstances.

The Committee reviews its performance against the hearings and decision benchmarks, provided on the next page.



As of December 31st, 2015



As of December 31st, 2015

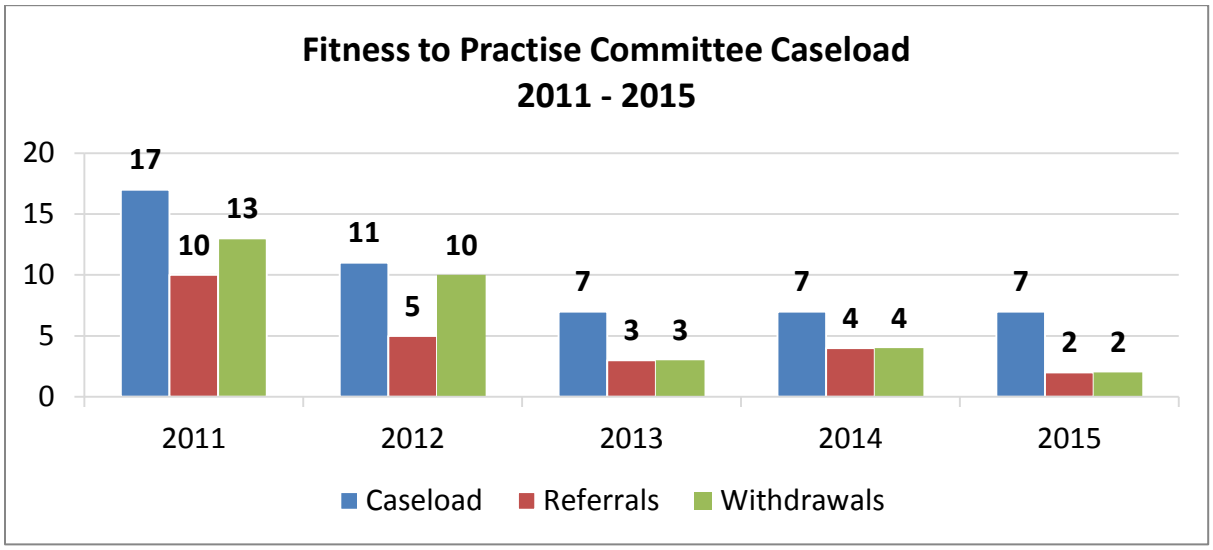
Appeals

In 2015, the Divisional Court dismissed a physician's appeal in a case involving findings of sexual abuse and disgraceful, dishonourable and unprofessional conduct and a physician abandoned his appeal in a case involving findings of sexual abuse, failing to maintain the standard of practice and disgraceful, dishonourable and unprofessional conduct.

Fitness to Practise Committee

The Fitness to Practise Committee rarely hears cases, as matters of incapacity tend to resolve through health monitoring agreements with the Ontario Medical's Association's Physician Health Program.

Caseload



As of December 31st, 2015

The dominant trend is to resolve incapacity matters through monitoring agreements, resulting in withdrawal of the allegation of incapacity before the Committee (two matters were withdrawn in 2015).

The FTP Committee had experienced increased pre-hearing and hearing activity from 2011 to 2013. However, FTP Committee's referrals and caseload, which were on an upward trend, have decreased since 2012. Consequently, pre-hearing and hearing activity have decreased. Since 2011, there have been 2 to 5 PHCs per year

There were two referrals in 2015. There were no hearings in 2014 and 2015.

Compliance Monitoring and Supervision

The College's Monitoring and Supervision Unit monitors all Committee decisions, undertakings and Orders arising from the several College committees, including the Quality Assurance, the Registration, the Inquiries, Complaints, and Reports, the Discipline, the Fitness to Practise, the Premises Inspection and the Methadone Committees.

Compliance Monitoring continues to be challenged by the number of files that remain active compared to a lesser number of files that are closed within a year. The area monitors over 1500 active files.

In 2015 Compliance Monitoring implemented a risk assignment tool, whereby all new and existing files are assigned a risk category. The assignment of a risk category assists Compliance Monitoring with file prioritization, such as when and how often a compliance visit is conducted.

Compliance Monitoring began establishing a training program for Practice Monitors (i.e. chaperones) and physician supervisors. The former is expected to be in operation by the end of 2016. The development and implementation of the latter will carry over into 2017.

Compliance Monitoring will continue in 2016 to work with the Statistician and IT to establish data needs and system requirements for optimum data collection.

A planned initiative for 2016 is to find the most efficient methods of file management to optimize resources. One such initiative is the analysis of Committee decisions that focus primarily on the improvement of Medical Record Keeping (MRK). The intention of the analysis is to create informed and viable options for the Committees to choose from when addressing MRK related concerns. This will help to increase consistency in the decisions related to MRK concerns and decrease the time it takes for a physician to comply with the Committee's decision.

Committee and Staff Education and Training

All committees provided orientation and training to its members

ICR Committee held an education training day for Chairs/Vice Chairs and Alternates was held in February 2015. Topics included key principles of natural justice and their application to ICRC, the decision making framework under transparency and various thresholds and referrals to discipline and settlements.

The ICR Committee incorporated educational sessions into the Committee's semi-annual business meetings. Dr. Scott Woodside, a forensic psychiatrist at the Centre for Addiction and Mental Health, spoke about Risk Assessment in Sexual Misconduct at its spring meeting. Mr. Jeff Hutchinson and Mr. Peter Kennedy, senior program consultants in the Ministry of Health and Long-Term Care negotiations and accountability management division, spoke about OHIP fraud and billing issues at its fall meeting.

Moving forward, on-going ICRC training will be provided to reflect the outcomes of the College's internal review to sexual abuse case managements.

The Discipline Committee provides annual training in orientation, decision writing, chairing pre-hearing conferences and chairing panels. The Discipline Committee utilizes its biannual business meetings to provide education on hearing topics, policies and practices of the Committee and the College and the decisions of other committees, tribunals and courts.

The Fitness to Practise (FTP) Committee provides an annual education program to address the unique requirements of the FTP process so that members are well prepared to conduct a hearing or motion when required. Dr. Sharon Cohen, Behavioural Neurologist and Medical Director, Toronto Memory Program presented an Update on Dementia. FTP members are also members of the Discipline Committee and therefore receive transferable training regarding hearing processes, chairing a panel, chairing a pre-hearing conference, and decision writing.

Department staff attended mutual learning forums and various workshops and presented case debriefs and "lessons learned" to enhance knowledge and skill. Dr. David Tal presented on cognitive impairment. Morgana Kellythorne, Legal Counsel, presented on Administrative Law and thresholds for Discipline referrals.

Staff

I want to thank staff and managers for their outstanding work throughout the year.

Sandy McCulloch

LEGAL OFFICE

2015 ANNUAL REPORT

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2015 ANNUAL REPORT TO THE COUNCIL FROM THE COLLEGE LEGAL OFFICE

Mandate and Objectives

The Legal Office's mandate is to conduct substantially all of the College's litigation[1] and to provide the bulk of the legal advice to the Council, committees and departments.

Core Activities & Statistics

Information about the civil proceedings, discipline prosecutions and appeals is presented, as usual, in separate documents. Other statistical information on discipline hearings is presented in the hearings office report.

Ongoing Activities

Staffing

The Legal Office has increased its complement to thirteen full-time counsel (with one additional position to be filled). One of the lawyers is a corporate lawyer, the others litigators. The office continues to run under the co-director model adopted in January, 2009, with Vicki White and Lisa Brownstone sharing the director duties.

Legislation/ Regulations

2015 saw several by-law changes come into effect. Several by-law amendments were made to further the College's strategic work in transparency.

Litigation

Hearings Office statistics show that 34 discipline cases were concluded in 2015, over a total of 118 hearing days. (In 2014, 27 cases were concluded over 81 hearing days). In addition, there were several appeals from discipline findings, all of which were upheld.

The College also responded to several judicial review proceedings. In *Bernstein*, the Divisional Court upheld the decision of the Inquiries, Complaints and Reports Committee to caution Dr. Bernstein regarding breaches of the advertising and rejected his argument that the regulation violated his *Charter* rights. It also upheld a s. 37 Order suspending Dr. Kunynetz, a physician who was alleged to have breached the terms of an earlier s. 37 Order requiring a chaperone. Further, the Court rejected an application for judicial review from two physicians who were former CPSO members and asked the Court to compel the College to issue certificates of registration to them.

Other Matters of Significance

The Legal Office continues to be involved in many of the College's ongoing initiatives, including providing legal support for the ongoing work on the Quality Management

[1] We are not involved in the College's employment law issues. As well, outside counsel is retained by the insurer when we are sued civilly for claims for which we have insurance coverage.

Partnership with Cancer Care Ontario, participating in the transparency work and data-sharing initiatives, providing legal advice to the College on its sexual abuse initiative and its external reviews, advising on physician-assisted death and other similar endeavours. The Legal Office also continues to support regular College activities, programmes and policies, such as the Premises Inspection Committee, registration initiatives, the QA Committee and the interpretation of the requirement for continuing professional development, the annual renewal process, and governance processes and related by-laws.

Respectfully submitted

Lisa Brownstone
Vicki White

30 April 2016

Policy and Communications

2015 Annual Report

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Policy and Communications
2015 Annual Report

Overview

The Policy and Communications Division provides strategic and operational support in a number of areas including policy development, internal and external communications, public and government relations and governance. The Division coordinates and supports the work of four College committees: Patient Relations, Outreach, Governance and Council Awards. Committee support and coordination also extends to policy-specific working groups.

Major Functions

Policy

- Development and review of policies to provide guidance to physicians about legislative/regulatory requirements and the expectations of the medical profession
- Coordination and management of policy consultations
- Research and analysis of issues related to medical regulation
- Development of submissions to government, agencies and external stakeholders
- Project management and support for corporate initiatives, projects and external reviews

Communications

- Coordination of all media relations activity
- Strategic communications
- Website development and maintenance, management of social media presence
- Publications including *Dialogue, Patient Compass,* specialty newsletters (OHP/IHF, medical students), Annual Report
- Editorial and design support for a range of products
- Coordination of outreach activities
- Public and physician inquiries
- Coordination of Council Award program
- Coordination of all public relations activities

Government Relations

- Management of relationships with government
- Strategic oversight and support for all activities with government
- Monitoring of legislative initiatives of interest to the College
- Coordination of all submissions to government

Governance

- Coordination and support of the Governance Committee including:
  - Coordination and support for all nominations activity
  - Coordination and support for Council, committee and committee chair performance assessment/feedback process
- Strategic support for College leadership
- Development and review of governance policies (together with legal counsel)
- Coordination and support of the district election process

2015 Highlights

1. Policy

Policy review and development are core activities of the Policy Department.

The goal of policy review is to ensure that College policies are evidence-based, fulfill the College's public interest mandate, and provide clear, current and useful guidance to the profession and public. Development of new policies is undertaken in accordance with the direction of the Executive Committee and Council to respond to emerging trends or issues.

In addition to policy review and development, Policy performs a number of other core functions including project support, legislative monitoring and issue support and management. Approximately 50% of the work of the department falls within this category. Highlights from 2015 are described below.

***External Consultation Requests or Initiatives*:** The College's input is sought from a broad range of stakeholders including government, medical regulatory authorities, Ontario health regulatory colleges and health-related organizations. Input is requested on a number of policy, legislation, position statements and other initiatives. Policy develops responses to the majority of the requests that come to the College.

Legislative Monitoring: Legislative monitoring involves regular review of the Ontario Gazette and the Legislative Assembly of Ontario. It also includes review of the Ministry of Health's Regulatory Registry for emerging legislative developments that have relevance to the CPSO and the health regulatory landscape. Legislation is reviewed and analyzed and submissions to government and Standing Committees are developed.

Support of College Projects and Initiatives: Policy provides ongoing support to a broad range of College projects and initiatives. For 2015, Policy has provided this support in relation to the HQO Facilities Regulation Review, the Sexual Abuse Initiative, Physician-Assisted Death and Outreach events.

Committee Support: Support is provided to College Committees, including Registration, Education, Quality Assurance, Methadone, Premises Inspection and Investigations Complaints and Reports Committees.

Patient Relations Program: The department manages and supports the College's Patient Relations Program. This involves managing the ongoing activities related to the Patient Relations Program; and supporting the Patient Relations Committee.

Privacy: The Privacy Officer provides support, assistance, and expertise across the organization on issues related to privacy law requirements, and corporate compliance. The Privacy Officer has been located in the Policy Department since 2005. At the end of 2015, this role was transitioned to Corporate Counsel in the Legal Office.

Professionalism in Undergraduate Medical Education: A new initiative related to the College's broader interest in engaging with medical students was launched in 2013. The 'Professionalism and Practice Program: Undergraduate Medical Education' provides a framework for how the College can collaborate with undergraduate faculties of medicine in the development and delivery of curriculum on core professionalism, ethics and practice issues. Over 2015, educational modules were developed on a range of professionalism topics. Direct support to undergraduate faculties of medicine with respect to curriculum review, case study development and delivery of professionalism content continued to be provided.

2015 Policy Highlights

Five policies were approved in 2015: *Professional Obligations and Human Rights*, *Marijuana for Medical Purposes*, *Consent to Treatment*, *Planning for and Providing Quality End-of-Life Care*, and *Blood Borne Viruses*. Seven policies were in active review, including *Treating Self and Family Members*, *Accepting New Patients*, and *Ending the Physician-Patient Relationship*. The Department was also extensively involved in activities related to Physician-Assisted Death: the analysis of the *Carter* decision, preparation of submissions to government, and the development of the College's *Interim Guidance on Physician-Assisted Death*.


Treating Loved Ones

Physicians' objectivity may be compromised when providing care to those whom they feel an emotional attachment. Tell us what you think.

Does the standard of care suffer when physicians provide care to people for whom they feel a strong emotional attachment? Researchers on the subject would answer with a resounding yes, but historically, the majority of physicians who have participated in our consultations on the subject have argued that it does not.

In previous consultations of draft policies addressing the issue, most physician respondents refuted the notion that their objectivity would be compromised and the standard of care would suffer if they provided care to themselves or their family members.

We understand that physicians wish to be of assistance to those closest to them by providing medical care. However, research into the issue has consistently found that a physician's ability to maintain the necessary amount of emotional and clinical objectivity required for professional judgment can be compromised in this context.

"Although physicians may see themselves as the best advocate for their family, it is easy to lose perspective when one has emotional investment, and informal care may even pose a risk or be detrimental to the patient," wrote Katharine Gold recently in a *New England Journal*

Key Policy Activities – 2015

New Policies/ Statements	**5**	• Professional Obligations and Human Rights: March 2015 • Marijuana for Medical Purposes: March 2015 • Consent to Treatment: May 2015 • Planning for and Providing Quality End-of-Life Care: September 2015 • Blood Borne Viruses : December 2015
Policies under Review	**7**	• Treating Self and Family Members • Physician Behaviour in the Professional Environment • Ending the Physician-Patient Relationship • Accepting New Patients • Block Fees • Change in Scope • Re-entering Practice
Active Policy Working Groups	**7**	• Consent to Medical Treatment • Decision Making for the End of Life • Physicians and the Ontario Human Rights Code • Blood Borne Pathogens • Accepting New Patients • Ending the Physician-Patient Relationship • Physician-Assisted Death
Legislation/ Regulation Development or Response	**3**	• Bill 77, Affirming Sexual Orientation and Gender Identity Act, 2015 • Status Report to Minister of Health on College Sexual Abuse Initiative • Physician-Assisted Death: Submission to the Provincial/Territorial Expert Advisory Group
Consultation Responses to External Stakeholders	**20**	Including: • HPRAC: RN Prescribing, Chiropody/Podiatry • Ministry of Health and Long-Term Care • Ministry of Labour • Health Canada • Transitional Council of the College of Naturopaths of Ontario • College of Nurses of Ontario • College of Occupational Therapists • College of Massage Therapists • Ontario College of Pharmacists • Scarborough Hospital
Support: External Reviews and Projects	**2**	The support provided has included the following: • HQO: Facilities Regulation: Analysis of facilities oversight and the College's concept of the ideal system of regulation; development of formal submission to HQO • Sexual Abuse Initiative: development of formal CPSO correspondence, coordination and development of all supporting briefing materials, and presentations, development of documents related to the Initiative: Sexual Abuse Principles, and What to Expect During Medical Encounters.

Consultation Process Improvements

Policy consultations continue to be a key element of the policy development and review process, and we strive to ensure continuous evaluation and improvement of this process. Improvements to the process to enhance the user-experience over the past few years have yielded greater engagement with the public, profession, and stakeholder organizations. The number of responses to policy consultations increased in 2015.


Have Your Say

Three Open Consultations

The College of Physicians and Surgeons of Ontario values your feedback on policies, regulations, by-laws and other initiatives that are in development, and we invite you to participate in our three open consultations. Materials for each consultation, including instructions on submitting feedback, can be accessed by visiting our website at www.cpso.on.ca under Consultations.

Blood Borne Viruses Draft Policy

We are seeking your input on the Blood Borne Viruses draft policy. The draft policy sets out expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus (Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus), as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, expectations for physicians if they are infected with a blood borne virus.

The deadline to provide feedback is November 20, 2015.

Block Fees and Uninsured Services – Preliminary Consultation

We are inviting comments on the current Block Fees and Uninsured Services policy at this early stage of the review process to help determine what policy changes may be required. Decisions about policy revisions will be made with a view of creating a policy that reflects current practice issues, embodies the values and duties of medical professionalism, and that is consistent with the College's mandate to protect the public.

Later in the review process, once a revised draft policy has been developed, we will hold a second consultation to invite feedback on the draft before it is considered for final approval by College Council.

The deadline to provide feedback is November 20, 2015.

Rights and Responsibilities

The College is seeking feedback on its draft Rights and Responsibilities document that has been developed for patients to use as a resource as part of Council's Sexual Abuse Initiative. The draft document sets out what patients can expect from their physician during medical encounters, what rights they have as a patient, and how the College can help if they have questions or concerns about something their physician said or did.

The deadline to provide feedback is November 20, 2015.

We welcome your comments, and all feedback will be carefully reviewed and used to evaluate each policy/document before being considered for final approval by CPSO Council. In keeping with College's practices, all feedback received will be posted on our website in accordance with our posting guidelines. Your contribution is greatly appreciated.

Through our consultation process, we continue to strive to achieve the twin goals of 1) making our processes more user-friendly, with a view to increasing stakeholder participation, and 2) increasing transparency. The CPSO Consultations newsletter is sent by email directly to all College members, and to the broad range of stakeholders included in our consultation process, including patient and physician organizations.

Improvements have also been made to the look and format of the web pages developed for each policy consultation. All stakeholder feedback continues to be posted online, making the consultation process more transparent, and enabling participants to view the comments of others.

We continue to use on-line surveys as a way for consultation participants to provide feedback. We began this practice in 2011, and it became a standard feature of our consultation process in 2013. Experience indicates surveys provide a number of benefits:

- Participants find them easy to use and many appear to prefer this method of providing feedback, thereby increasing the overall consultation response rate.
- They enable us to ask questions about particular areas of the policy.
- They are used to generate clear and comprehensive reports that can be made available publicly, increasing the transparency of the process.

An overview of the policy consultations undertaken in 2015 together with the response rates are captured below.

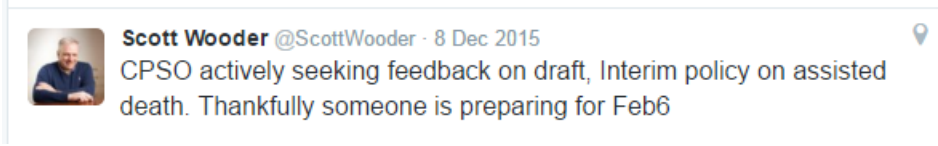
2015 Policy Consultations	Written	Survey	Total
*Professional Obligations and Human Rights	7327	1665	8992
*Planning for and Providing End of Life Care	288	354	642
*Consent to Treatment	30	34	64
Treating Self and Family	38	46	84
Sexual Abuse Principles	18	15	33
Ending the Physician-Patient Relationship	27	33	60
Accepting New Patients	58	47	105
Block Fees and Uninsured Services	44	72	116
*Rights and Responsibilities	95	43	138
*Blood Borne Viruses	13	29	42
*Physician-Assisted Death	116	275	391
*Physician Behaviour in the Professional Environment	10	17	17
TOTALS	8064	2630	10694

* Indicates consultations that carried over between two calendar years. The feedback reported in this table only includes feedback received within the 2015 calendar year.

Public opinion polling is used to inform the policy development and review process. Polling results provide Council with valuable perspective about the views and perspectives of the broader Ontario public.

Top 5 policies visited on website	Avg. visits per month
Medical Records	3514
Confidentiality of Personal Health Information	2356
Prescribing Drugs	2086
Consent to Medical Treatment	1695
Mandatory Reporting	1635

Social media tools (namely, Facebook and Twitter) have been used extensively to promote policy consultations to help us reach a different and broader audience. This practice which began in late 2012 was strengthened and is used to complement the consultation process.



2. Communications

The Communications department develops timely and effective internal and external communications. The department also provides public affairs and media relations advice and support. We continuously develop a broad spectrum of communications products that support College decisions and programs. We work to ensure that stakeholders, members and the public are informed about and engaged in College work.

College Website

CPSO.on.ca is a critical communication vehicle for all aspects of the College's work. From our expanding public register to our dynamic consultation feature, it is how the majority of the profession and the public access information about the College. Improvements are always being made to content and navigation to ensure that information is up-to-date and relevant. In addition, this was a year of long-term strategic planning to improve key components based on the College's strategic priorities and to determine what changes need to be made to support those priorities. Highlights include:

2015 Website Statistics

+ 2.2 million visitors
(2.1 million in 2014)

+ 8.7 million visits
(8 million in 2014)

+ 49.9 million page views
(46.7 million in 2014)

Most visited pages:

1. Public Register/Doc search
2. Homepage
3. Members login dashboard (for annual renewal)
4. Members Info tab
5. About Us

- **Revamp of the Sexual Abuse Complaints section of the website.** As part of our sexual abuse initiatives, a number of enhancements were made to this section of the website. These included:
    - A total rewrite of the information for the public to be more inviting and user-focused for those individuals looking to potentially come forward to make a sexual abuse complaint.
    - Development of additional online documents, including a downloadable brochure translated into 11 languages as well as a "What to Expect during Medical Encounters" document.
    - The scripting of a video introducing the College's patient liaison Pamela Greenberg to potential sexual abuse complainants. (Video to be shot and added to the website in 2016.)

- **The Transparency initiative:** In 2015, a review was conducted with external experts to identify changes and new approaches to the website to better align with the needs of our ongoing transparency initiative. The review included working with public focus groups to identify areas for improvement to make it easier for the public to find what they need. Also included in this review was making significant improvements to the public register that effectively incorporate all the new information that is now available about physicians. Some of the key changes that will be made in 2016 include:
    - Improvements to "Doc Search" to make it easier for the public to find the information they are looking for
    - A revamp of the Public Register landing page to make it more user-friendly and provide better information on how the register works.
    - New labels, tabs and organizational approach to physician profiles in the public register to help members of the public make decisions about their health care.
    - A revamp of the main Complaints page to make it easier to understand including the addition of a helpful video.
    - A revamp of the website homepage, with improved emphasis on information for the public.

Dialogue and Annual Report

The College's quarterly magazine Dialogue is our most important communications product. It conveys the work of the College and includes College expectations for the profession. In addition, every issue of Dialogue includes summaries of the College's discipline decisions to ensure the profession is aware of the outcome, the rationale and the expectations of the profession. Dialogue is sent to the entire profession and many key stakeholders including MPPs, many law firms, and various associations. In addition to regular columns and features, we highlighted, over the previous year, such policies as Professional Obligations and Human Rights, and Planning for and Providing Quality End-of-Life Care. With each article, we emphasize the importance of feedback from the profession to our policy consultation process and direct readers to the website to share their thoughts and opinions.

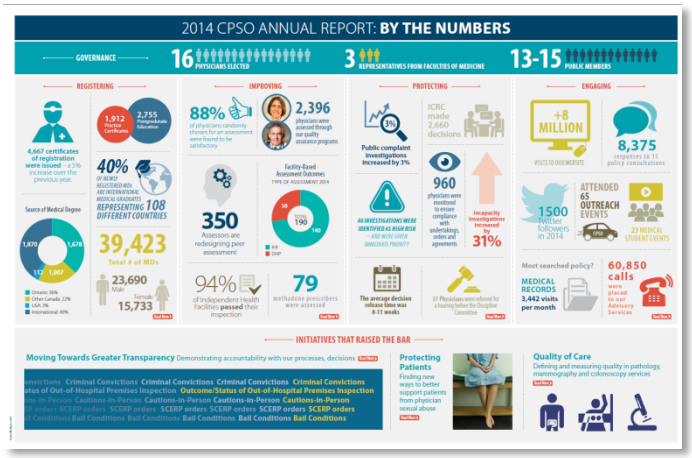
In 2015, the magazine included in-depth articles on all the College's high priority-initiatives, such as the Transparency Initiative and the Sexual Abuse Review. As part of the College's Sexual Abuse initiative, Council directed the development of an educational framework to provide opportunities for enhanced education and training of physicians and medical

trainees. To further that goal, we produced an informative article on the importance of maintaining boundaries with patients

We also continued our efforts to address best practices for infection prevention and control, with an article on a different aspect of infection prevention in almost all of last year's issues. As part of this series, we included a list of the top 10 infection control breaches that College investigators see as part of their work.

We also produced a cover article on child maltreatment entitled "A Duty to Report, a Chance to Protect." The article stemmed from recommendations made in the Jeffrey Baldwin coroner inquest and served to remind the profession that suspicions of child abuse or neglect must trigger a fundamental professional obligation.

With our social media properties now well established, we also use Dialogue to consistently drive the conversation online as often as possible, whether it pertains to the development of a policy or an important undertaking, such as the transparency Initiative.



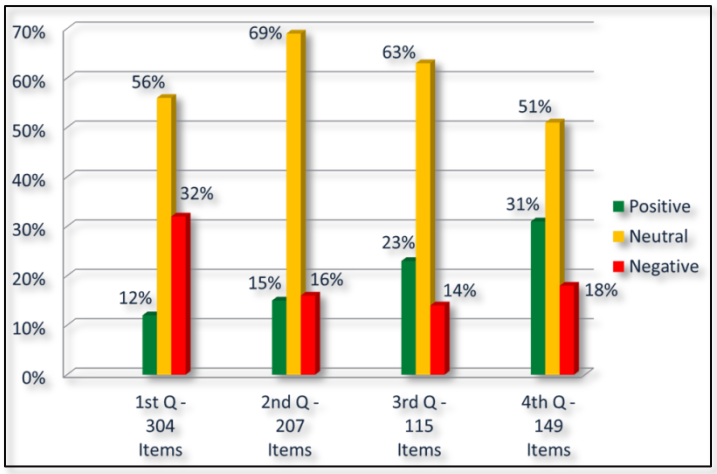
To augment our 2014 annual report, we used an eye-catching "by the numbers" infographic to highlight a busy and productive year. These graphics helped communicate key points of the report and the use of clickable "read more" icons brought the reader into the relevant section of the online annual report. We also continued to produce a small run of a print version of our annual report.

Media Relations

The work of the College is closely followed and scrutinized by the media and the communication staff works to provide and disseminate timely information to the media. The team also develops and coordinates responses to daily requests for information on a variety of issues and topics.

We actively reach out to media on a range of issues, and respond quickly to requests for information or interviews. We strive to provide information in a clear and complete manner and, in the case of College policies for example, the rationale behind changes, reviews and updates.

The team works to support action the College has taken on a number of high profile important issues including our initiatives to prevent and improve the way that we deal with sexual abuse of patients, transparency of physician-specific information; our policies on end-of-life care and human rights. We always look for opportunities to generate accurate and balanced coverage of these initiatives and College policies and programming.

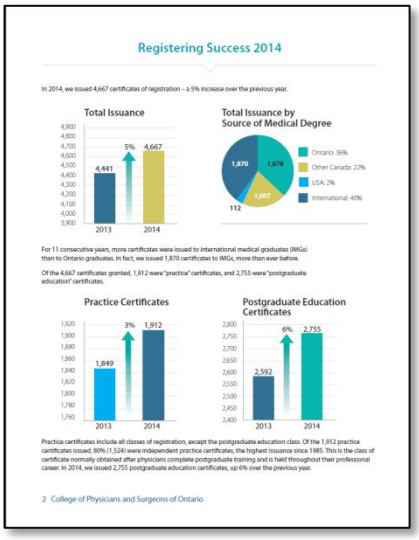


Looking at the volume of coverage in 2015, it was a busy year. There was sustained interest from media on discipline cases, investigations, and CPSO policies and programs, with more than two news items about the College on average per day in 2015. The College was also the subject of focused attention from faith-based media on policies that set requirements for conscientious objectors Overall, **18%** (139 news items) were positive; **59%** (461 news items) were neutral; and **23%** (176 news items) were negative in tone.

While the number and percentage of news items with a negative tone in the first quarter resulted in a higher percentage overall of **23%** for the year, in the next three quarters we either met or were very close to meeting our dashboard target in terms of positive and neutral coverage.

Media relations will continue to be an area of focus for the Division in 2016, which has begun with great interest from media in Ontario and across the country in our Interim Guidance on Physician-Assisted Death.

Registration Report



Our *Registering Success 2014* report provided information about the total number of certificates issued by registration class and source of medical degree. The 2014 registration results (which were released in 2015) showed a continuing upward trend in the number of certificates issued to practice medicine. The report is useful in demonstrating our ongoing commitment to licensing qualified physicians, and statistics from the report are cited by the media and public officials throughout the year.

The report highlighted that we had another record-breaking year in terms of the issuance of certificates of registration; it showed that more certificates were issued to international medical graduates (IMGs) than to Ontario grads; illustrated some of the reasons why issuance to IMGs continues to increase, and showed the top countries from which IMGs obtained their medical degree. It also provided demographical information about the CPSO's membership, including the gender and age of the profession, and a breakdown by the source of their medical degree.

Social Media

We use our social media tools to provide help in real time to doctors, members of the public, and organizations who are looking for information or assistance.

We also use social media to promote a wide variety of College publications, announcements, career opportunities, media releases, and more. In addition, we live tweet each Council meeting and we have seen some real interest from a broad audience of media and health care stakeholders who have shared the outcome of significant discussions and decisions at Council.

Outreach Program

The College's Outreach Program reaches out to members and the public on key College issues, targets specific areas of the province with organized events and participates in a variety of medical student and resident events.

In 2015, the Outreach Program focused on building relationships with stakeholders, educating physicians and the public on the role of the College and encouraging participation in medical regulation. Continued efforts were made to improve the CPSO's engagement with public audiences.

Highlights

- **Hosted the 5th annual *Future Leaders' Day* November 20st 2015**
  - 25 participants representing various specialties from across the province engaged in program that incorporated practical applications and illustrative case studies.
- **Hosted 2 international health regulatory delegations:**
  - Medical & Dental Council of Nigeria
  - Medical Board of Australia

- **Produced 2 issues of *Medical Student Update*: e-newsletter**
    - Each issue contained critical information about self-regulation, professionalism and ethics geared towards medical students.
- **Sponsored and attended *Canadian Federation of Medical Students AGM (CFMS) & Ontario Medical Student Weekend (OMSW)***
    - 600+ Ontario medical students in attendance at OMSW hosted by Queens University.
    - 100+ students in medical leadership roles including student reps from each Ontario medical school in attendance at CFMS annual general meeting hosted by Western University (Windsor).
    - Students had an opportunity to ask questions at an interactive CPSO booth

- **Continued regular engagement at medical school milestones**
    - Registrar, President, Academic Council Representatives and Medical Advisors gave welcome and congratulatory remarks at medical class orientation sessions and convocation ceremonies across the province.

Outreach By the Numbers	
31	Member outreach meetings with the profession: Academies of Medicine, medical staff associations, hospital rounds
5	Public education meetings including: University of Toronto Alumni Association, Health Care Social Media Canada, CARP (Ajax/ Pickering Chapter), Ontario Patient Relations Association
8	Education sessions with postgraduates on: Relationship with Industry, Professionalism, Consent
17	Medical student engagements including convocation addresses, orientation week sessions on professionalism
8	Medical leadership, health regulators and health administration
69	**Total outreach meetings with key CPSO target audiences**

3. Government Relations

The role of the College, as well as our authority and powers, are set out in provincial legislation. The same is true for some College program areas including the Out of Hospital Premises Program as well as the College role and authority in relation to the Independent Health Facilities Program. The government has entrusted the regulatory function of regulating the medical profession in the public interest to the College. Given the scope and nature of College work we are regularly called upon by government decision-makers to inform policy development and potential legislative changes. We work to contribute to the public discourse in areas that touch on medical regulation and matters of patient safety. We also respond to legislation that has implications for medical regulation and patient protection, develop and maintain productive relationship with government decision makers and MPPs from all three parties, and are active participants in the legislative process.

The following outlines some of the main initiatives underway in 2015.

Legislative work

Although 2015 was a relatively quiet year for legislation introduced that had an impact on the College, a number of legislative initiatives were closely followed. Of continued interest to the College is *Bill 33, Safeguarding our Communities Act (Patch for Patch Return Policy), 2015*. The College has a longstanding interest and concern with opioid prescribing related issues. 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 and contains regulation making authority that among other provisions, could allow for exceptions to be put in place. Although the Bill passed third reading and received Royal Assent on December 10, 2015, the date of when the Bill will come into force is not yet known. The College is working closely with the government to provide input on the regulations and the roll-out of this new initiative.

The College also made a submission on *Bill 77, Affirming Sexual Orientation and Gender Identity Act, 2015*. This Bill sought to prohibit payment for services broadly referred to as conversion or reparative therapy, whose intent is to seek to change or direct the sexual orientation or gender identity of a patient. The Bill made it an offence to provide these services to patients under the age of 18. In addition to this communication to government, the expectation that these services are outside the bounds of acceptable professional practice was communicated to the profession through an article in *Dialogue.* This Bill passed third reading and also received Royal Assent on June 4, 2015.

GR Outreach

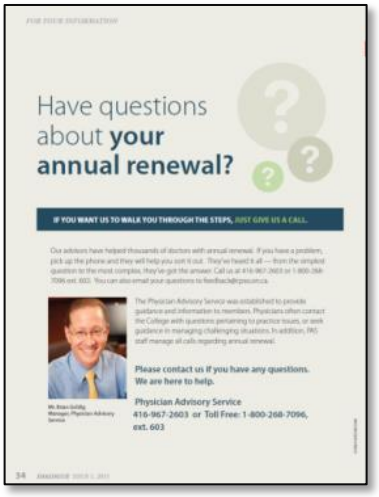
The College reaches out to elected officials of all political parties and their staff. The primary purpose of College interaction with elected officials is to build awareness of the College role and to support public access to information about College processes. The College works to develop and maintain constructive and effective relationships with government to help facilitate and support regulation in the public interest. We also routinely reach out to elected officials and their staff to ensure they are aware of and have the opportunity to respond and participate in the Colleges public consultation processes. In 2015 we worked particularly closely with government on areas of shared focus including physician assisted dying, prevention of sexual abuse, transparency, government support for public members of the College Council, and assisted reproduction.

4. Public and Physician Advisory Services

The Public and Physician Advisory Services area is the initial contact for members of the public and the profession. Advisors provide information about CPSO policies and assist with a wide variety of questions about physician practice. Advisory staff are the initial contact for complaints and resolve issues when possible and appropriate. They also assist physicians will all aspects of the annual renewal process. They respond to thousands of inquiries annually, via phone, e-mail, and correspondence.

General Overview

In 2015, a total of 55,647 calls were placed to our frontline areas- Public Advisory and Physician Advisory Service (PPAS), reflecting a 9% decrease from 2014. The decrease in call volume is partially attributed to the increased success of the annual renewal process. Physicians are now more familiar with the online process and require less assistance. Technical problems experienced in the past couple of years have been resolved, resulting in fewer technical inquiries. 90% percent of incoming calls were answered live in 2015 reflecting a 6% increase from 2014, and represents the department's highest achievement to date in this area.



Live call rates and abandoned call rates are part of the College's strategic dashboard under operational excellence. Our live answer target in 2015 was 80% and our call abandonment target was 15%. These targets were achieved in all four quarters of 2015. As a result, the targets for 2016 have been changed to 85% and 10% respectively.

The Advisors continue to serve as the primary contact for all annual renewal related inquiries, and in 2015, they assumed responsibility for all Post Graduate Education renewal inquiries as well since the questions in both surveys are similar.

As per the agreement with the Investigations and Resolutions Department in 2014, PPAS assumed management of all clinical related inquiries and subsequent follow up starting in January 2015. Approximately 30% of calls from members of the public are clinical in nature.

2015 Annual Call Volumes (All Queues)

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned
2015	55,647	50,230 (90%)	1,751 (3%)	3,666 (7%)
2014	60,850	51,247 (84%)	3,019 (5%)	6,584 (11%)
2013	66,671	46,841 (70%)	9,003 (14%)	10,823 (16%)
2012	63,851	53,503 (84%)	3,991 (6%)	6,357 (10%)
2011	61,107	52,101 (85%)	4,812 (8%)	4,194 (7%)

Public Advisory Service

We are in the process of merging the telephone queues so that there is one contact number for both the public and physicians. As a result, more physicians are calling the number that was previously designated solely for members of the public. The total incoming call volume for 2015 decreased by 9% from 2014, which primarily reflects the lower call volume from members during the annual renewal process. The increased live call response rate also reduces the amount of people abandoning the call and calling back at a later time.

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned
2015	**51,815**	**46,724 (90%)**	**1,593 (3%)**	**3,498 (7%)**
2014	56,419	47,537 (84%)	2,636 (5%)	6,246 (11%)
2013	59,615	41,958 (70%)	7,844 (13%)	9,811 (16%)
2012	57,648	48,640 (84%)	3,291 (6%)	5,717 (10%)
2011	54,742	46,841 (86%)	4,112 (8%)	3,789 (7%)

Physician Advisory Service

The total incoming call volume for 2015 decreased by 14% compared to 2014. The decrease in volume is attributed the fact that the public advisory extension continues to be published as the primary contact for both public and physician inquiries, and we expect this trend to continue. The 91% live call response rate is the highest achieved by the department to date.

Year	Calls Incoming	Answered Live	To Voicemail	Abandoned
2015	**3,832**	**3,506 (91%)**	**158 (4%)**	**168 (4%)**
2014	4,431	3,710 (84%)	383 (9%)	338 (8%)
2013	7,056	4,883 (69%)	1,159 (16%)	1,012 (14%)
2012	6,203	4,863 (78%)	700 (11%)	640 (10%)
2011	6,365	5,260 (83%)	700 (11%)	405 (6%)

Emails

- PPAS reviews and either replies to or forwards all emails sent to Feedback, the College's main address on its website for general inquiries.
- 5,821 e-mails were received in 2015, representing a 12% decrease over 2014.
- Advisory Services responded to 65% of these e-mails. Thirty-six percent were directed to other departments.
- 32% percent of the e-mails received related to the annual renewal process.

QUALITY MANAGEMENT DIVISION

2015 ANNUAL REPORT

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Quality Management Division (QMD) has four operational units:

- Applications and Credentials
- Membership, Corporations and Physician Register
- Practice Assessment and Enhancement
- Quality Management Partnership

Activities, achievements and outcomes for 2015 within these four areas are summarized below.

APPLICATIONS AND CREDENTIALS

(Processes activities for individuals who want to become members)

MAJOR FUNCTIONS:

- Assess applications for a certificate of registration for all physicians in Ontario
- Issue, renew or terminate certificates of registration
- Provide guidance for applicants through the assessment, training and examination systems in Ontario and Canada
- Provide guidance for applicants for all CPSO registration policies and pathways
- Direct compliance and supervision for restricted certificates of registration, such as supervision and assessment
- Facilitate the Changing Scope of Practice and Re-entry into practice for all registrants and members
- Facilitate and implement initiatives and policies that increase access to CPSO registration for qualified candidates
- Support Registration Committee to fulfill their decision making authority
- Fulfill the reporting mandate to the Office of the Fairness Commissioner

ACHIEVEMENTS:

- For the 17th successive year there has been an increase in the number of certificates issued
- In 2015 there was a 7% increase in the total number of new issuance of certificates
- 98% of certificates in all classes were issued well within the benchmark service standard of 4 to 5 weeks
- Amendments to restricted certificates decreased by 223 applications due in part to the new implementation of the amendment fee
- HPARB appeals have decreased for 4 consecutive years
- Inquiries achieved an 86% live call answer rate, surpassing the service target of 80%
- For the 13th consecutive year more certificates were issued to IMGs than to Ontario graduates
- The scope of a project to automate the Registration Application for Independent Practice was completed

- Scoping of the Practice Ready Assessments in Family medicine was initiated to allow for a 2017 pilot, driven by the Office of the Fairness Commissioner and Ministry of Health
- Work continues with stakeholder engagement at the Post Graduate offices, Ministry of Health, CaRM's symposium, Touchstone Institute, Office of the Fairness Commissioner

OUTCOMES AND DATA HIGHLIGHTS:

Registration Committee Decisions

Applications Considered	2013	2014	**2015**
Total applications approved	1,187	1446	**1,247**
Total applications refused	11	6	**12**
Total applications deferred	16	12	**16**
Total applications withdrawn	2	6	**5**
Total Applications Considered	1,216	1470	**1275**

HPARB Activity

Status of Appeals to HPARB	2013	2014	**2015**
HPARB confirmed the Reg Comm. Decision	4	2	**0**
HPARB returned the case to the Reg Comm. for reconsideration	0	0	**0**
Appeals withdrawn	1	3	**2**
Appeals outstanding	4	3	**4**

Inquiries of Applicants Serviced	2013	2014	**2015**
Calls Received	38,199	34,846	**30,127**
Calls Answered	29,925	29,172	**26,005**
Service Standard	78%	84%	**86%**
Written Correspondence	4,606	4,946	**6261**
Customized application packages	1,886	2,230	**2508**
Letters of Eligibility	1,886	1,411	**1306**

Certificates of Registration Issued	2013	2014	**2015**
Independent Practice	1,430	1,524	**1,624**
Postgraduate Ed.	2,566	2,755	**2,794**
Restricted	434	364	**551**
All Other	43	24	**24**
Total Applications Processed	4,473	4,667	**4,993**

MEMBERSHIP SERVICES, CORPORATIONS AND PHYSICIAN REGISTER

(Processes a variety of activities for existing members)

MAJOR FUNCTIONS:

- Maintain the College Register
- Assess applications from medicine corporations and issue, renew or terminate certificates of authorization
- Issue Certificates of Professional conduct
- Ensure the annual renewal of general membership by collecting annual fees and by facilitating completion of the mandatory annual renewal form
- Ensure the most effective and efficient administrative processes to successfully renew approximately 33,000 physicians
- Ensure adequate follow-up by specific departments related to individual physician responses to the annual survey
- Coordinate annual renewal of over 4,000 Ontario postgraduate trainee certificates

ACHIEVEMENTS:

- Certificates of Professional Conduct: Achieved record-high issuance of 8,445 certificates. Over 90% issued within defined service level of 5 days or less
- Introduced a new online application form for the Postgraduate Annual Renewal Process which asked similar questions to the general membership form. Despite the new form, the PGE renewal process was completed faster than in any previous year. For example, only 47 renewals were not yet completed by July 1 in 2015 versus 62 not completed by July 1 in 2014
- Online annual renewal for General Membership: The process of renewing nearly 33,000 members was carried out on schedule, with no major issues or obstacles
- Non-Renewals: Conducted successful follow-up of the 1612 members who missed the June 1 due date, resulting in only 47 suspensions for non-renewal
- Certificates of Authorization: Processed record high 17,529 renewals of certificates held by medicine corporations. Processed 1643 new issuances
- Physician Register Activities: Continued to process significant volumes of activity related to member resignations, undertakings, Registrar's notices, discipline entries, name changes, address changes
- Online Member Portal: Introduced online membership renewal cards. Also, an increasing number of members used the self-serve address change option. Over 18,000 online address and email updates were made by members in 2015
- The College's Transparency Initiative in 2015 resulted in new entries of information in the public register, e.g. criminal charges, SCERPS, cautions-in-person, discipline findings in other jurisdictions

OUTCOMES AND DATA HIGHLIGHTS:

Certificates of Authorization

Medicine Professional Corporations	2013	2014	**2015**
New Issuances of Certificates of Authorization	1,638	1,546	**1,643**
Renewals Certificates of Authorization	14,827	16,536	**17,529**

Certificates of Professional Conduct

	2013	2014	**2015**
CPCs Issued	6,800	8,220	**8443**

Renewals and Extensions of Postgraduate Education Certificates

	2013	2014	**2015**
Postgraduate Renewals and Extensions	4,811	4,926	**5,362**

Physician Register

Total Membership	2013	2014	**2015**
All Registration Classes	38,503	39,423	**40,243**
Independent Practice Class	30,666	31,313	**31,803**

Total Physicians in Active Practice in Ontario (excluding trainees, retired, out-of-province, etc.)	2013	2014	**2015**
	27,124	27,800	**28,400** (estimated)

Physician Register – Related Activities

Physician Register – Related Activities	2013	2014	**2015**
Address Changes Entered by Staff (new & edits)	28,248	28,914	**25,707**
Address Changes –Entered Online by Members	10,494	10,710	**16,518**
Email Address Changes – Entered by Staff	--	896	**1659**
Email Changes – Entered Online by Members	_	2012	**2147**
Resignations from Membership	847	780	**965**
Legal Name Changes	75	68	**60**
Foreign Embassy Letters[1]	544	578	**640**
Registrar's Notices	104	153	**236**

[1] Foreign Embassy letters are a service for persons travelling abroad with medical forms requiring certification that the physician who prepared the form is registered with the College

PRACTICE ASSESSMENT AND ENHANCEMENT

(Coordinates all assessments in the Quality Management Division)

MAJOR FUNCTIONS:

- Conduct Peer Assessments generally comprised of an onsite records review and an interview with feedback to the physician
- Conduct Change of Scope and Re-entry Assessments of physicians changing their scope of practice, re-entering practice, and multi-day re-assessments that also encompass observation and interviews with colleagues and co-workers
- Conduct Pathways Assessments which include multi service feedback
- Conduct Out-of-Hospital Assessments of new premises as they notify to become operational, as well as existing premises on a 5-year cycle
- Conduct Assessments of Physicians wishing to obtain and maintain an exemption from Heath Canada to prescribe methadone
- Conduct Methadone Delegation exemption assessments. The federal delegation exemption allows the administration of methadone from community clinics for which the College, in conjunction with Ontario College of Pharmacists (OCP), conducts clinic inspections for new applications and existing clinics on a 5 year basis to ensure they meet the federal requirements for the secure transfer and administration of doses
- Conduct Independent Health Facilities (IHF) assessments as requested by the Director of IHF. IHFs are assessed on a 5 year cycle
- Update Clinical Practice Parameter (CPP) documents on a 5 year cycle
- Conduct Registration Assessments on behalf of the Registration Committee to determine if a physician should obtain an independent practice certificate
- Conduct Assessments of CPSO members providing anesthesia procedures in dental clinics. These assessments are conducted in collaboration with the Royal College of Dental Surgeons of Ontario
- Coordinate the Assessor Network, providing support through administration of the Assessor Governance Framework, ensuring a consistent approach to recruitment, orientation and training of Assessors for QMD

ACHIEVEMENTS:

- Ongoing implementation of recommendations from a process review of existing peer assessment process; review identified gaps in data reporting requirements and proposed solutions to streamline work
- Convened Quality Assurance Committee Working Group to develop expertise in opining on Pathways Assessments and the Peer Redesign assessments being piloted in 2016 and workshop ideas for presentation to Quality Assurance Committee
- Continued collaboration on the development of the Peer Redesign project in preparation for launch of pilot protocols Spring 2016:
    - Completed external stakeholder consultation stage for 4 groups and 6 more to be engaged in 2016

    - 14 groups currently developing handbooks
    - First assessments scheduled for May 2016
- Revisions to Peer Assessment physician questionnaire – data collection underway in support of Physician Factors project
- Completed the CPD reporting project resulting in 99% compliance. Transitioned this process into ongoing Annual Renewal process
- Committee Education – PA&E Committees continued to participate in planning/education sessions
- Launched Assessor Governance Framework
- Hosted the annual Methadone Prescribers Conference attended by over 300 participants
- Methadone Patient Registry discontinued as of July 2015
- Undertook a review process for development of IHF Clinical Practice Parameter documents for MRI/CT and Sleep Medicine
- Initiated second five year cycle of OHPIP inspections
- Launched capacity for OHPIP online reporting via the CPSO members portal including adverse events, new clinics, and physician notifications
- Convened a working group to provide recommendations related to performing Interventional Pain Management procedures – Output will be the provision of key recommendations to College Committees for feedback and approval
- Worked with MOHLTC on establishing a process to ensure quality oversight of IVF Services in 2016
- Convened OHPIP Standards update to review scope and accountability of the role of Medical Director in OHPs – to deliver in 2016
- Working on OHPIP/IHF Legislation changes with MOHLTC related to HQO recommendations to the out of hospital environment
- Increased collaboration with Regional Pubic Health Units related to infection control practices in clinical offices
- Engaged in several Infection Prevention and Control Initiatives in collaboration with Public Health Ontario:
    - Implemented a new infection control assessment tool as part of OHP inspections
    - Public Health Ontario led a one day educational workshop to OHP/IHF assessors
    - Development of a reprocessing and sterilization course for OHP nurse assessors
    - Collaborating on the development of a physician self-assessment survey for consideration to be implemented into the Peer Assessment process
    - Provided guidance to Premises Inspection Committee articulating acceptable standards and qualifications for reprocessing and sterilization in community settings

OUTCOMES AND DATA HIGHLIGHTS:

Type of Physician Assessment	2013	2014	2015
QA Peer Assessments*	1,306	1,145	1048
Change in Scope of Practice Assessments**	25	21	32
Re-entry to Practice Assessments (through QAC)**	2	6	3
Peer & Practice Reassessment (Comprehensive)	9	3	
Methadone Assessments**	113	79	87
IHF Physicians Assessed**	223	311	298
OHP Physicians Assessed**	59	50	111
Assessments for Registration Decisions **	155	150	193
Pathways Assessments*	592	631	612
TOTAL	2,487	**2,396**	**2,384**

(*) Assessments completed with Committee Review, or in progress
(**) Assessments completed with Committee or IHF Director Review

Peer Assessment Outcomes

	Satisfactory Assessment			Re-Assessment			Interview		
	2013	2014	**2015**	2013	2014	**2015**	2013	2014	**2015**
Overall	83%	81%	80%	9%	11%	14%	6.5%	7%	6%
Random	91%	88%	87%	7%	8%	7%	2%	4%	6%
Age 70	81%	79%	76%	12%	12%	15%	6%	8%	9%
Age 70+	79%	76%	75%	11%	13%	14%	10%	11%	11%

(*) Exempted Assessments – assessments initiated but upon completion of physician questionnaire it was determined the physician had already retired or did not have a practice that could be assessed: 152 Reports exempted

Pathway Assessment Outcomes

	Satisfactory Assessment			Re-Assessment			Interview		
	2013	**2014**	**2015**	**2013**	**2014**	**2015**	**2013**	**2014**	**2015**
Overall	86%	89%	87%	6%	6%	9%	8%	5%	4%

Note: Number of exempted Pathway assessment - 94

Methadone Assessment Outcomes

	Satisfactory Assessment			Re-Assessment or Interview		
	2013	2014	**2015**	2013	2014	**2015**
1st Year Assessment	56%	74%	60%	44%	26%	40%
3rd Year Assessment	75%	75%	76%	25%	25%	24%
5th Year Assessments	76%	87%	75%	24%	13%	25%
Re-assessments	50%	80%	79%	50%	20%	21%

Facility Based Assessment Outcomes

Type of Assessment	2013	2014	2015
IHF	231	140	199
OHP	79	50	67
TOTAL	**310**	**190**	**266**

*In the fiscal year 2013/2014 there was an increase in the sale and return of IHF licenses which resulted in a lower number of facilities available for assessment.

Independent Health Facilities Outcomes

	Satisfactory Assessment			Licensing Action Required by MOHLTC		
	2013	2014	2015	2013	2014	2015
All IHFs	95%	94%	97 %	5%	6%	3%

Out of Hospital Assessment Outcomes

	Pass			Pass with Conditions			Fail		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
All OHPs	63%	40%	34%	27%	38%	39%	1.2%	2%	3%

Note**:** In addition to Pass/Pass with Conditions/or Fail – 24 % of 2015 total Assessments were categorized as: Deferred or Not Rated. A decline was noted in the amount of pass outcomes in 2015 as the majority of inspections conducted were due to following up on clinic concerns and/or changes requested by the Facility.

QUALITY MANAGEMENT PARTNERSHIP

(Formal partnership, created by the Ministry of Health, between Cancer Care Ontario (CCO) and the CPSO to develop provincial quality management programs for pathology, mammography and colonoscopy)

MAJOR FUNCTIONS:

- Develop, implement and operationalize quality management programs for colonoscopy, mammography and pathology services
- Increase the consistency in quality of care in facilities performing these services through the development of facility standards and guidelines
- Identify needs and training opportunities for clinical leadership in the three services that will foster a culture of continuous quality improvement
- Monitor and evaluate Partnership programs to make improvements and identify outcomes
- Link to health system stakeholders to leverage opportunities for implementing and championing the Partnership programs
- Link the Partnership program to CPSO programs as needed
- Monitor needs and represent the interests of the CPSO as the regulator within the Partnership
- Determine legislative and/or regulatory supports and strategies to support the Partnership programs

ACHIEVEMENTS:

- Established the three Provincial Leads for colonoscopy, mammography, and pathology
- Established Regional Leads for colonoscopy, mammography, and pathology
- Released a report on the quality of the health service areas
- Finalized the measurement and facility and physician reporting plan
- Prioritized facility standards and recommendations and completed approach for implementing them

- Researched changes to legislative, regulatory and/or other levers to enable implementation of the quality management programs
- Designed approach to facilitating the adoption of standards into key system stakeholders
- Lead the development of four Early Quality Initiatives for colonoscopy and produce quality improvement tools and guidelines
- Evaluated the quality improvement resources produced for the colonoscopy Early Quality Initiatives
- Conducted environmental scan for Pathology Early Quality Initiative on tissue release and exemption
- Development of Partnership governance model
- Liaised with MOHLTC staff for regular updates
- Supported meetings of the Healthcare System Reference Group which consists of senior leaders from system stakeholder organizations including Health Quality Ontario (HQO), Ontario Medical Association (OMA), Ontario Hospital Association (OHA), College of Nurses of Ontario (CNO) and academic, quality management representatives

OUTCOMES AND HIGHLIGHTS:

- Staff team was hired and each of their work streams is now scoped and work plans are in place
- Collaborated to develop and maintain administrative documents, MOU, Funding Agreement, and Data Sharing Agreement) for the Partnership
- Ongoing management of the program budget and reporting to CCO in collaboration with Finance
- Contributed to 22 external presentations to organizations including provincial associations, pertinent OMA sections, the OMA, OHA, HQO:
    - Mammography (2)
    - Colonoscopy (4)
    - Pathology (8)
    - Health system (8)
- Evaluated four colonoscopy quality improvement resources:
    - Bowel preparation selection best practice guidelines
    - Standardized endoscopy reporting guidelines
    - Standardized patient discharge guidelines for endoscopy facilities, and
    - Pre and post procedure guidelines and checklists for endoscopy facilities
    - Held bi-monthly CPSO staff reference group meetings to assist with change management and communications

Research and Evaluation Department 2015 Annual Report

The Research and Evaluation Department (RED) provides services to all College departments to assist them in using evidence and data-driven decision-making to fulfill their mandates.

Major Functions

- Support physician assessment programs by developing and continuously improving rigorous, valid and useful assessment tools and processes
- Promote, facilitate and support program evaluation initiatives for continuous improvement in College programs
- Provide support to the foundational College activity of requiring all Ontario physicians to participate in continuing professional development (CPD) including tying relevant CPSO programs and initiatives to CPD opportunities
- Provide conceptual and evidence-based thinking to College activity pertaining to applying educational interventions to meet identified physician learning needs
- Facilitate a College-wide focus on outcomes measurement in physician improvement initiatives, including educational and quality improvement initiatives, remediation interventions and practice supervision
- Provide a range of services in survey methods, data collection and analysis
- Collaborate with external research partners to promote College research interests
- Develop and continuously improve mechanisms to collect physician factor information such as practice description/scope to ensure the College has relevant and current information about Ontario physicians and their practices
- Contribute to developing capability to continuously generate unique "College-knowledge" from College data; analyze and produce reports from College data to assist staff and program areas across the College
- Foster a culture of data-driven and evidence-informed decision making at the College

RED Achievements for 2015

A. Research and Data Analysis:

1. Analyzing the Post-Assessment Questionnaire (PAQ) and Assessor Feedback Form (AFF)

Background and context:

- The PAQ and AFF collect important information from assessed physicians and assessors
- Based on assessor feedback about the usefulness of the information, the Quality Assurance Committee and staff launched a review of the forms

Goals and objectives:

- Analyze several years' worth of data from the PAQ and AFF
- Report on the results of those analyses to QAC and staff
- Work with the QAC to improve these forms

Achievements for 2015:

- In consultation with PA&E staff, analyzed results for hundreds of PAQs and AFFs
    - Results from analysis of the PAQ highlighted areas where CPSO is doing well, such as assessors being seen as knowledgeable and calming, and areas for improvement, such as CPSO alleviating subject physicians' anxiety
    - Results from analysis of the AFF suggest that a rethink of the tool is appropriate given that all items were positively endorsed in $\geq$ 90% of cases
- With QAC Working Group, revisions of AFF have been drafted, approved and will be implemented in 2016

2. Physician Practice Taxonomy

Background and context:

- Project originally started with aim to update 'practice codes' (ie. Descriptor statements about clinical practice) used on Annual Renewal and other College questionnaires (e.g., Physician Questionnaire)
    - Some changes to the Annual Renewal had already taken place, namely revising the questions around practice settings
- Practice activity data gathered on the Annual Renewal is used by numerous stakeholders both internally and externally (e.g., data that is shared with the Ontario Physician Human Resources Data Centre for provincial planning purposes)

Goals and objectives:

- Create a cross-College system for describing physician practice activity
    - Link this work to other College projects (e.g., update to change of scope policy, peer redesign) and national initiatives (e.g., Physician Factors project)
- This update is centered around making the data collected:
    - Accurate
    - Meaningful and useful to the College and its partners
    - User-friendly for physicians to complete
    - Based on language that is intuitive and understandable for physicians
    - Appropriately detailed

Achievements for 2015:

- Cross-College Scope of Practice Working group formed
- Worked with staff, Medical Advisors, assessors and external researchers to refine lists of practice areas and draft new physician questionnaire
- Liaised with CFPC and RCPSC to get feedback on project

- Connected CPSO initiative to pan-Canadian initiative on Physician Factors (see section E)

3. CPD Non Reporter Initiative

Background and context:

- RED provided analysis, design and planning support to the Practice Assessment and Enhancement (PA&E) Department in tracking, analysing and proposing an approach for 1985 physician members who self-identified on the 2014 Annual Survey that they were not tracking CPD with one of three approved CPD tracking organizations (CPD Non Reporters)
    1. Royal College of Physicians and Surgeons of Canada (RCPSC)
    2. College of Family Physicians of Canada (CFPC), OR
    3. General Practice Psychotherapy Association (GPPA)

Goals and objectives:

- To track and provide descriptive analyses of CPD Non Reporter cohorts in 2013, 2014 and 2015
- To develop and support implementation of phase one to ensuring members are fully compliant with the CPD Regulatory Requirement (ie. registered with an approved CPD tracking organization)

Achievements for 2015:

- With PA&E, RED co-led development of an alternative strategy to assessing non-Compliant members including:
    - Administrative suspension of certificate of practice for members who failed to submit the appropriate documentation proving they are signed up with a CPD tracking organization
    - accepting undertakings not to practice from eligible members (physicians who are fully retired (not engaged in any kind of work that requires their certificate of practice), members who are sick or on disability, or members who are in practice outside of Ontario)
- Supported PA&E in follow up communications with CPD Non Reporters, and approved CPD tracking organizations
- Hosted meetings with each national education College (CFPC and RCPSC) to discuss how to ensure full compliance with the CPD regulatory requirement (including data sharing, strategies for supporting physician members etc.)
- Invited the GPPA to meet with the Education Committee to discuss compliance of GPPA members
- Began discussions for phase two including:
    - ensuring the CPD regulatory requirement is integrated across all relevant College departments and programming
    - ensuring all members are not just signed up with a CPD tracking organization but are meeting the minimum annual requirements for CPD
        - this is a multi-year initiative that will require national work with FMRAC and the national education Colleges (e.g., around data sharing)

B. Supporting College Programs with Survey Design and Analysis

Background and Context

- RED provides assistance to various departments and their staff in survey design, data collection and results analysis
- RED liaises with external research teams requesting data to better determine the team's needs and evaluate whether CPSO can provide the data requested

Goals and Objectives

- Develop College survey processes to standardize survey construction, testing, deployment, analysis, technical reports and data display and assist College programs and departments to meet their survey needs
- Build capacity in other departments to promote best practices in survey design and analysis
- Ensure that needs of other departments are met in a timely manner

Achievements for 2015:

- Developed, administered surveys and/or completed data analysis to assist projects including the Education Strategic Initiative
- Liaised with several external researchers (e.g., ICES, Western University) regarding their data requests and, following consultation with and approval from the Data Sharing Working Group, provided the requested data
- As part of CPSO and Cancer Care Ontario's Quality Management Partnership (QMP), there were several achievements:
    - Completed analysis and report of stakeholder engagement survey started in late 2014
    - With CCO, provided and verified data for interim QMP report that described volume and location of physicians working in the three areas of interest (colonoscopy, mammography, pathology)
    - Developed and analyzed several surveys including the evaluation of the implementation of a QMP-designed bowel preparation regimen tool for colonoscopists
- Continued support of PA&E's work identifying, understanding and contacting physicians who do not report their CPD to one of the three approved tracking organizations
    - Work done understanding CPD non-reporters contributed to improved questions on Annual Renewal about meeting and reporting CPD

C. Assessment Re-visioning – Peer Assessment Re-design

Background and Context

- Assessment Re-visioning is a multi-year, cross-College project to create a common assessment model and continuous quality improvement strategy for all College physician assessment.
- The model clearly defines the purposes of each of three distinct types of College assessments and sets a quality standard and a process for continuous improvement to ensure all College assessments consistently meet the standard.
- The re-visioning project currently focuses on improving peer assessment.

Goals and Objectives

- Create more emphasis on activity happening before and after the assessment visit
- Follow-up with all assessed physicians to determine the peer assessment impact, i.e. quality improvement
- Make assessors central to creating new assessment processes, tools and reporting formats, including working with assessors to develop discipline-specific quality indicators
- Design mechanisms to capture data at multiple points to allow continuous evaluation and improvement of the peer assessment program
- Train assessors to develop skills in facilitation, feedback, CPD coaching and quality improvement processes and techniques
- Integrate the CanMEDS framework to describe practice and group quality indicators and outcome measures
- There are 5 key goals: To redesign the peer assessment to be: **Discipline-specific**; **Purpose-driven,** i.e. align the program with its purpose to promote continuous quality improvement; **Consistent**, i.e. ensure consistency in assessor decision-making; **Transparent** so any physician can readily see how the peer assessment program defines and evaluates "quality" and **Relevant,** i.e. linked to other quality initiatives

2015 Achievements

- Each of the 14 discipline groups engaged in peer redesign are progressing through five developmental milestones leading to implementing new assessment tools and procedures:
    - **Milestone 1**: form a working group and create a first draft of an assessor handbook (Discipline Groups: Anesthesiology, Rheumatology, Hematology-Oncology, Radiology, Pathology)
    - **Milestone 2**: orient all assessors in the network group to the handbook; update the handbook following all assessor content review
      (Discipline Groups: Cardiology, Endocrinology)
    - **Milestone 3**: Group training in use of the "scoring rubrics" and measuring/building consensus on evaluation criteria using a modified Delphi technique
      (Discipline Groups: Family Medicine, Emergency Medicine, Psychiatry)
    - **Milestone 4**: internal and external review and handbook modification as required
      (Disciplines Groups: Walk-In Clinic, Hospitalist, GP-Psychotherapy, Dermatology)

    - **Milestone 5**: controlled live assessments initiated with collection of feedback to refine tools and processes
- There is close collaboration with peer assessors to develop and refine "peer assessment handbooks"; each handbook is "discipline-specific" and includes content tailored to the discipline, for example, the handbooks define elements of quality and evaluation criteria for each of 8 assessment domains, i.e. history, examination, investigation, diagnosis, management plan, medication, follow-up and monitoring, documentation for continuity of care
- Planning continues for gradual implementation of the tools in live assessments. Feedback on these pilot cases will be sought from assessors, assessed physicians, and members of the Quality Assurance Committee
- An evaluation of the impact of implementation on other program areas and departments commenced in the 3rd quarter of 2015 as part of an internal review of new peer assessment tools and procedures.
- An external consultation commenced to elicit feedback from physicians and physician organizations on newly developed assessment tools and procedures.
- A modified approach to peer assessment in pathology is under review (assessing the effective engagement of the pathologist team within local quality management systems).
- An evaluation plan is being drafted to support monitoring and continuous improvement of the program in addition to measuring assessment impact. One facet of the evaluation will focus on usage of resources created to promote assessor consistency and support physician education, referred to as Quality Improvement Resources (QIRs). The evaluation outcomes of QIRs will be used to inform decision-making regarding their continued development and maintenance.
- Research Presentations:
    - The developmental approach to peer redesign was presented at the Canadian Conference on Medical Education in April
    - A presentation on the challenges related to establishing assessor consistency in decision-making was presented at the Coalition for Physician Enhancement in May

D. Pathways Evaluation

Background and context:

- The project to evaluate registration pathways and policies is consistent with Council's strategic priority to "Optimize the Registration System."
- The purpose of the project is to design and implement a program evaluation to understand the effectiveness of registration pathways and policies.
- Over the past decade, the College has developed numerous alternative pathways to physician registration aimed at facilitating the entry of qualified and competent practitioners into Ontario without compromising quality of care or patient safety.

- Since 2004, the number of IMGs obtaining a license to practice has been steadily increasing. The current evaluation of registration pathways and policies strives to determine if there is a relationship between registration by alternative pathways and physician performance within a patient safety and quality of care framework.
- In order to investigate potential performance differences in practice, the following data sources will be included in the analysis, resulting in a comprehensive picture of practice:
    - Peer assessment results based on patient record review and physician interview
    - Communication, collaboration, and manager roles (multi-source feedback or MSF data)
    - Complaints and investigations (practice and conduct data)
    - Quality indicators in family practice (through the Institute for Clinical Evaluative Sciences - ICES).

Goals and objectives:

- The evaluation will focus on learning what, if any, differences exist between practicing physicians who achieved registration through alternative and traditional routes to registration. The objectives of the project are as follows:
    - Contribute to the validation of alternative routes to ensure that pathways and policies are meeting their intended purpose;
    - Gain insight into the ways in which alternative route process changes may be useful, and
    - Better understand the educational needs of different physician subgroups to enable the development of appropriate quality improvement and support activities.
- Conduct assessments will form part of the QAC's annual allocation of peer assessments.
- Physicians registered through alternative pathways and policies will be matched to physicians who have been registered through traditional routes to registration. Matching will be based on gender, medical specialty, practice experience and practice location. Up to 2000 physicians will be included in the evaluation and will be assessed between 2013 and 2016.
- Information learned from the evaluation will contribute to understanding multi-source feedback in order to make future program decisions about the use of MSF. The project will also contribute to the Quality Assurance Committee and Council's understanding of the pros and cons of focused selections for peer assessment (i.e. selections that are not random but based on studied indicators that are associated with performance).

Achievements for 2015:

- The collaboration with the Institute for Clinical Evaluative Sciences (ICES) was fully developed including the finalization of a data sharing agreement and the design of the study. Data analysis will be completed in 2016.
- In 2015, 567 Pathway Assessments were completed. This brings the total number of completed assessments to 1267, or approximately 70% of the estimated total of 1800. The remaining assessments (estimated at 533) will be completed in 2016, bringing an end to the data collection phase of the evaluation.
- The nature of the study was presented at research conferences in 2015:

    - Globalization Symposium hosted by The Hospital for Sick Children and the Wilson Centre
    - Canadian Conference for Medical Education and the Canadian Evaluation Society.
- Project updates and preliminary findings were presented to the Quality Assurance Committee and Registration Committee on a regular basis.
- In 2015, a subset of the Quality Assurance Committee was formed to review pathways cases where the peer assessment was supplemented with MSF. The group was formed to enhance consistency in the use of new assessment tools (e.g. MSF) and to work closely with staff on the development of new assessment processes and tools.
- The complaints component of the project will be initiated in 2016.

E. Supporting Physician Education and CPD

The Education Liaison works across the College towards two broad goals:

- To liaise with internal (College) and external stakeholders to provide leadership and share information related to continuing professional development (CPD) and physician education
- To develop and integrate College activities, processes and systems in CPD and physician education, with a focus on supporting committee educational decision making, identifying and tracking physician learning needs, advocating for these needs to be met and measuring educational outcomes

1. Follow up on Recommendations from 2014 IEP Analysis

Background and context:

- In 2013-2014, a RED led cross-College working group conducted a retrospective analysis of Individualized Education Plans produced between 2010 and 2012 (IEP Analysis). The goals of this project were:
    - to obtain aggregate information on physician learning needs, interventions and outcomes (where possible) across College Committees; and
    - to make recommendations for improving and streamlining future IEP data collection, and educational processes across relevant College Committees
- The report included 29 recommendations, for which progress was made against 13 in 2015

Achievements for 2015:

Progress against key recommendations included:

- Council officially adopted CanMEDS as the CPSO's organizing framework for physician assessment and education
- A new CPD/Practice Improvement site on the CPSO website was created that consolidates all CPD information in one location, and provides resource links to CPD and practice improvement opportunities for members

- RED participated in a cross College working group that developed a business case and job description for a new full time position in the Compliance and Monitoring Department dedicated to working with Supervisors and Practice Monitors (for hire in 2016)
- In partnership with Manager, Applications and Credentials, RED co-led a review of education decision-making by the Registration Committee, including the following activities/suggestions:
  - mapped all types of education decisions currently made by Registration Committee and applied lessons learned from IEP Analysis
  - revised the approach for Committee referrals to the Registrar for pilot in 2016
  - added CPD regulatory information to the application process
  - developed a study plan template for applicants who have failed credentialing or certification exams
  - developed a way of tracking Committee decisions with education for pilot in 2016

2. Education Committee

- Education Liaison continued to provide strategic leadership for the Education Committee including developing agendas and ensuring Education Committee has input into CPSO activity pertaining to CPD and physician education (including undergraduate and postgraduate medical education)

3. Sexual Abuse Initiative – Education and Training Plan

Background and context:
As part of the College-wide Sexual Abuse Initiative (SAI) that began in December 2014, the Education Liaison led a cross-College working group in scoping and beginning work on four broad, inter-related areas of activity related to education and training (see Figure 1 for key deliverables)

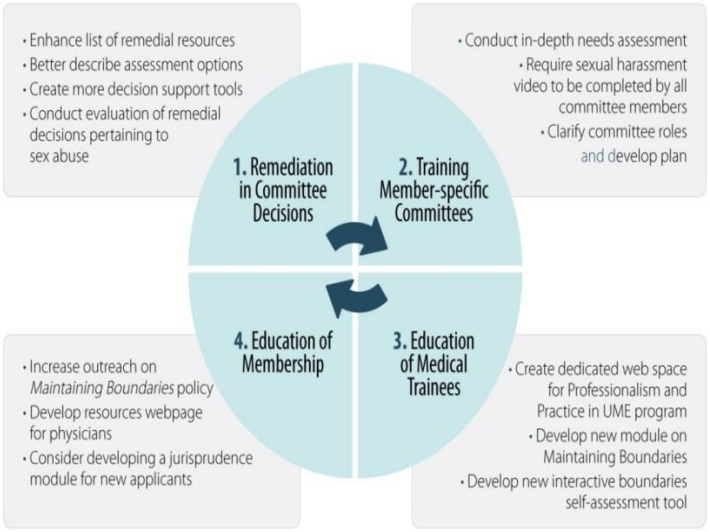


Figure 1: Key Deliverables in SAI Education and Training Project Plan

Achievements for 2015:

- Coordinated 3 rapid external studies to support planning: 1) an environmental scan on what other medical regulatory authorities and health regulators are doing in mandatory education; 2) an external scan on North American educational/remedial resources for healthcare professionals related to inappropriate communication, professionalism and maintaining boundaries to prevent sexual abuse; and 3) a literature review on physicians and eLearning
- Conducted a feasibility study on mandating member education around preventing sexual abuse or any another topic (that included an eLearning readiness assessment) that was presented to SMT, Executive Committee and Council with several recommendations, including:
    - Further scoping mandatory jurisprudence education as a credentialing requirement for new members and a CPD opportunity for all members (for final decision in 2016)
- Conducted a committee training needs survey for all member specific (MS) committees, the results of which were presented at the November 19th meeting of Joint Chairs
- Developed a draft decision framework for committees when remediation related to sexually inappropriate communication, professionalism and/or boundaries is required

4. Other

- On behalf of the Federation of Medical Regulatory Authorities of Canada (FRMAC), conducted data collection, analysis and wrote final proceedings for the International Association of Medical Regulatory Authority's (IAMRA) 3rd International Revalidation Symposium in October 2015
- Ongoing liaising with:

- MS committees, committee support staff, Medical Advisors and senior management
- three education consultants who provide individualized coaching and instruction in physicians referred for communication and professionalism issues
- Ontario CPD offices
- Other external stakeholders (e.g., CPD-Ontario, CPD-COFM, CFPC, RCPSC, OCFP etc.)

F. Physician Factors

Background and context:

- Colleges across Canada face a similar challenge to assure and enhance physician competence on a regular basis
- The CPSO has a significant assessment program with a large number of annual assessments, and resources for the continual evaluation of the quality and effectiveness of the assessments to achieve their desired purpose.
- A pan-Canadian regulatory Steering Committee was formed to provide oversight on (1) identifying, understanding and using empirically defined factors of practice that support physician performance or that suggest a risk of poor performance; (2) developing and implementing alternative interactions between the College and physicians that serve to "provide feedback to physicians to validate appropriate care and show opportunities for practice improvement"; and, (3) alignment with, and greater physician participation in, local systems and supports that enhance their performance for safe and quality patient care.

Achievements for 2015:

- The project is led by the Colleges in Ontario and Alberta, with participation of BC, Manitoba, Quebec and Nova Scotia, FMRAC, external researchers, and several observing national bodies (eg. CFPC, RCPSC).
- The Steering Committee has made significant progress in identifying an evidence-base for risk and support factors to guide College assessment programs. The following projects are contributing to the Steering Committee's goals, and the CPSO is leading or contributing to all of them:
    - Understanding and testing an existing risk framework: Several regulators are using the CMQ's risk framework to further test and validate the performance risk factors against existing assessment program outcomes (e.g. Peer assessment, multisource feedback). CPSO is leading this initiative.
    - Understanding risk and support factors beyond the published evidence: A qualitative research project has been initiated to identify and understand factors that are based on the experience of assessors, committees, and MRA staff members. CPSA is leading the project, with two RED staff members co-leading the Ontario component of the study.
    - Factors related to aging, wellness and physician health are being reviewed in more detail. FMRAC is leading this initiative, and the RED team has been working closely

with an external researcher on defining the scoping review, to help shape the deliverables so the information is optimally useful for MRAs.

- Defining a common national framework for physician scope of practice (the actual practice activity and context at a given point in time) will lead to standardization and data quality for the purpose of identifying factors in individual physicians' practices. CPSO is leading this initiative. This project will deliver a consistent approach to defining scope and effective methods to capture information from individual doctors. This work is also important to national partners in considering data needs for robust health human resource planning.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: Opioid Update

1. **Ministry of Health:**
    a. **Narcotics Monitoring System**
    b. **Comprehensive Drug Profile Repository Development**
2. **Safeguarding our Communities Act (Patch for Patch Return Policy) – Regulation Development**
3. **Centres for Disease Control (CDC) Guidelines**

FOR INFORMATION

ISSUE

There has been significant media attention to opioid prescribing over the past few months, with the most recent focus on fentanyl. This briefing note summarizes the current status of on-going work at the CPSO related to opioids.

BACKGROUND

1. Ministry of Health:

a. Narcotics Monitoring System (NMS)

The NMS is a database which includes all monitored drugs. It has been in place since 2012. The database is not accessible to physicians or pharmacists. Pharmacists receive alerts in limited circumstances[1].

The *Narcotics Safety and Awareness Act* (NSAA) enables the MOH to send information to the CPSO. The CPSO has been working with the MOH to set out thresholds for referring information to the CPSO.

Generally speaking, the goal has been to focus on the highest risk prescribing first. Highest risk matters have generally been defined as circumstances in which individual patients have received high volumes of opioids in a single dispense or are receiving daily morphine equivalents that greatly exceed the recommended watchful dose of 200 OME[2].

Work continues to establish the most effective mechanism to ensure safe prescribing, via education for lower risk matters and regulatory response for higher risk matters.

[1] 1) double-doctoring: 3 or more prescribers within past 28 days, 2) polypharmacy: 3 or more pharmacies in past 28 days, 3) refill too soon, 4) fill/refill too late and 5) duplicate drug other pharmacy.
[2] See information below about current dosing guidelines.

b. Comprehensive Drug Profile Repository (CDPR) Development

The CPSO's position has been that in order to facilitate safe prescribing, physicians need access to a patient's medication profile prior to writing a prescription. This is particularly important for patients on opioids.

Currently, some physicians have access to the medication profiles of Ontario Drug Benefit patients only via the Drug Profile Viewer that is available in emergency departments and some community health centres.

Physicians do not have access to medication profiles for non-ODB patients.

The MOH is currently moving forward with a Comprehensive Drug Profile Strategy which includes the following:

- Replacing the existing Drug Profile Viewer with a Comprehensive Drug Profile Repository (CDPR) that has greater data capacity and will be able to integrate with the electronic health record.
- Creating the capacity to include narcotics data from the NMS in the CDPR.
- Once ODB and NMS data is integrated into the CDPR, there will be ~30% of prescription data still remaining (non-ODB patients, non-narcotics) in order to create a comprehensive 'all drugs, all people' database.

Currently, the CPSO is a member of the Comprehensive Drug Profile Strategy Stakeholder Panel.

Further information about the strategy and repository will be provided as part of a presentation from the MOH.

2. Safeguarding our Communities Act (Patch for Patch Return Policy) – Regulation Development

- There has been significant media attention to the issue of fentanyl over the past month. Multiple communities have been struggling with fentanyl overdoses from both prescribed and illicit sources.

- In 2015, the *Safeguarding our Communities Act* was passed. It requires the return of used fentanyl patches before further patches can be dispensed, in an effort to reduce the misuse of fentanyl.

- The CPSO had previously supported pilot Patch for Patch programs in various communities. Patch for patch programs are highly supported by police forces, which see this as a way to control fentanyl abuse in communities.

- The Act includes the following:

  - Prescribers must record the name/location of the pharmacy where the patient intends to fill the prescription, and notify the pharmacy about the prescription.
  - Dispensers may only dispense a fentanyl patch if they have been previously notified by the prescriber and the patient returns a used patch.

- The Ministry is now developing regulations, and has consulted with various stakeholders, including the CPSO and Ontario College of Pharmacists (OCP).

- The draft regulations will focus primarily on exemptions to the patch for patch requirement:
  - First prescriptions, that is, prescriptions for which a patient will not be required to return patches in order to have the prescription filled. The draft regulations will require physicians to write 'first prescription' on the fentanyl prescription.
  - Settings in which patch for patch may not be required because systems already exist to manage narcotics ie. hospitals or residential care facilities.

- As noted, above, the NMS is not accessible to prescribers or dispensers, and there is no system alert relating to fentanyl. As a result, there is no way to definitively identify first prescriptions of fentanyl. Physicians who write 'first prescription' will only be able to attest that this is the first fentanyl prescription they have written for the patient, not that this is the patient's first fentanyl prescription.

- The CPSO and OCP will be communicating the requirements of the Act and regulations to physicians and pharmacists, and will provide guidance on general issues relating to fentanyl prescribing and dispensing. For example, it will be important for prescribers to explain the patch for patch requirements to patients before they take their prescription to the pharmacy. As well, physicians will be reminded about current best practice for fentanyl prescribing.

- Draft regulations will likely be circulated for consultation over the summer and become effective in the fall.

- Ultimately, the College's Prescribing Drugs policy will need to be updated to reflect these requirements.

- Work will continue with the Ministry and OCP on this issue and Council will be updated at its September meeting.

3. Centers for Disease Control (CDC) Guidelines

- In April, the CDC released a new guideline for prescribing opioids for chronic pain. An overview is attached at Appendix A.

- The guideline sets out multiple recommendations with respect to prescribing, with the following information about dosing:

- *When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to* ***≥50*** *morphine milligram equivalents (MME)/day, and should avoid increasing dosage to* ***≥90*** *MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.*

- In comparison, the 2010 Canadian Guideline[3] says the following:

  - *Chronic non-cancer pain can be managed effectively in most patients with dosages at or below* ***200 mg/day*** *of morphine or equivalent. Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes.*

- The Canadian Guideline is currently under review and it is anticipated that it will also reduce the 'watchful dose'. However, it is not yet clear how this will compare with the CDC guidelines. Revision of the Canadian Guidelines is anticipated to be concluded in early 2017.

- Several other medical regulatory authorities in Canada (including BC and NS) have endorsed the CDC Guidelines. Due to the changing nature of clinical guidelines, the CPSO includes references to clinical guidelines, but does not endorse them. The CPSO's Prescribing Drugs policy sets out expectations for ensuring safe prescribing and includes a specific section on narcotics that indicates physicians should carefully consider the benefits and risks prior to prescribing. The policy and associated guidelines currently include references to the Canadian Guidelines.

- However, in the next issue of Dialogue, there will be an article about the CDC Guidelines and an update on the status of the review of the Canadian Guideline.

DECISIONS FOR COUNCIL:

For Information

CONTACT: Maureen Boon, Extension 276

DATE: May 16, 2016

Appendix A: CDC Guidelines

[3]Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Canada: National Opioid Use Guideline Group (NOUGG); 2010

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outwei risks. Clinicians should continue opioid therapy only if there clinically meaningful improvement in pain and function tha outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinic should discuss with patients known risks and realistic bene of opioid therapy and patient and clinician responsibilities f managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

COUNCIL PRESENTATION

Karen McKibbin
Director
Ontario Public Health Integrated Solutions (OPHIS)

Status Update: Comprehensive Drug Profile Strategy, Digital Health Drug Repository

Comprehensive Drug Profile Strategy and Digital Health Drug Repository Project

Overview

Briefing to Council for
College of Physicians and Surgeons of Ontario (CPSO)
May 31, 2016

Ontario

CDPS Vision

- The Comprehensive Drug Profile Strategy (CDPS) plans to improve the health and wellness of Ontarians and the quality of care received from health care providers through integrated access to patient medication information for all Ontarians, enabling the Best Possible Medication History.

- The CDPS' vision of 'All Drugs, All People' contributes to the foundation of a connected health system for the province. The Ministry continues to work with its partners to expand access to provincial assets to support the delivery of care throughout the health care system.

- The CDPS will leverage, where possible and taking into consideration time to market, existing assets to maximize the current investments and successes in Ontario. The CDPS will apply a flexible, incremental approach to deliver clinical value to patients and health care providers where benefits will start to accrue in a shorter term.

- The CDPS supports *Patients First: Ontario's Action Plan for Health Care* which reflects the government's commitment to transform the health care system into one that puts the needs of patients at its centre.

Comprehensive Drug Profile Strategy

To improve the health and wellness of Ontarians and the quality of care received from health care providers through integrated access to patient medication information, enabling the Best Possible Medication History.

The CDPS vision of 'All Drugs, All People' contributes to the foundation of a connected health system for the province.

Access	Connect	Inform	Protect
Improve Access:	**Connect Services:**	**Support People and Patients:**	**Protect Our Universal Health Care System:**
Providing all health care providers with timely and integrated access to patient medication information through a Drug Profile in Ontario for 'All Drugs, All People' .	Enhancing delivery of coordinated care in the community through sharing of patient medication information across local and regional clinical information systems.	Enabling the Best Possible Medication History to facilitate informed clinical decision making at the point of care to improve the patient's experience with the health care system and to improve patient safety through the identification of possible adverse drug events.	Leveraging new and existing technologies to enhance providers' knowledge of their patients' medication information to improve overall patient care and to help identify trends and potential cost drivers for health system planners.

Patients First: Ontario's Action Plan for Health Care

- Improve Access
- Connect Services
- Inform by Providing Education, Information and Transparency
- Protect the Universal Public Health Care System

Comprehensive Drug Profile Strategy (CDPS) Vision

To improve the health and wellness of Ontarians and the quality of care received from health care providers through integrated access to patient medication information, enabling the Best Possible Medication History

Stream 1

Concept 1:

Drug Profile Viewer (DPV) and Ontario Drug Benefit (ODB) Portlet:

1. DPV access to Ontario hospitals and 20 Community Health Centre sites
2. ODB Portlet to The Ottawa Hospital DPV users
3. Assessment of the Health Network System (HNS) for extended services and recommendations

Concept 2:

Design and build capacity to accommodate a Digital Health Drug Repository (DHDR) with web services and enable health care providers to view dispensed ODB and NMS data through Clinical Viewers:

Information from the HNS, including ODB and Narcotics Monitoring System (NMS):

- Additional information related to medication management
- Additional information related to historical Drug Utilization Review (DUR)
- Additional information related to professional services such as MedsCheck and Smoking Cessation Programs

Concept 3:

Enable incremental access to the DHDR data through the Connected Backbone at point of service. Include additional dispensed data sources and tools:

- Point of service (POS) systems:
  - a) Clinical Viewers
  - b) Pharmacy Management Systems (PMS)
  - c) Electronic Medical Records (EMR)
  - d) Hospital Information Systems (HIS)
  - e) Others
- Additional data attributes available in POS
- Health analytics tools

Stream 2

Concept 1:

ePrescribing (Under Review):

Jurisdictions recognize that a Pan-Canadian approach is appropriate for ePrescribing. This will be facilitated by financial support recently announced by the Federal government.

- Ontario continues to participate in discussions with Canada Health Infoway to move forward with this important initiative

Enablers

Policy

- Supporting legislation and regulations (e.g. HIPA)
- Data sharing and user access agreements
- Consent directive requirements
- Federated identity management

Infrastructure

- Connected Backbone provincial and regional integration services
- Provincial registries/functionality (i.e. Provider, Client, Consent, Audit)
- Security assessments

Engagement

- Communication and stakeholder management
- Partnerships for ongoing service delivery and operations management

Delivery Partner

Ontario eHO

LHINs, CPSO, OCP, CNO, NPAC, CHI, OMA, OPA, RNAO, OntarioMD

Key Stakeholders

Physicians / Nurse Practitioners

Pharmacists

Specialists

HealthLink

Community Health Providers

- Community Health Centres
- Primary Care Providers
- Family Health Teams
- Nurse Practitioner-Led Clinics

Outcome

- A coordinated, incremental access to patient medication information in Ontario supporting the vision of 'All Drugs, All People'
- Improved patient outcomes and experience with health care system
- Improved clinical decision making based on best possible medication history

CDPS Benefits

Value for the Public

- Enhanced patient experience with the health care system when care is provided by better informed health care providers
- Contribution towards improved patient-centered care based on secure electronic access to patient clinical data
- Contribution towards improved patient outcomes and a decreased risk of adverse drug events.

Value for Providers

- Clinically relevant data for providers to access quickly, securely, and efficiently, at the point of care and via existing Electronic Medical Record (EMR) access such as clinical viewers
- Enhanced patient safety and continuity of care and the ability of a provider to provide the best possible treatment options for a patient
- Improved collaboration between health care providers through the sharing of patient clinical data

Value for Government

- Work will support government's **Patients First: Ontario's Action Plan for Health Care** which reflects the government's commitment to transform the health care system into one that puts the needs of patients at its centre.

Value for Industry

- A drug system that is more cost effective by decreasing costly health care system utilization to treat adverse drug events
- Access to enriched evidence to support population-based quality improvement initiatives

DHDR Initial Scope

- The Digital Health Drug Repository (DHDR) project represents the first foundational component of the Ministry's CDPS. A repository will be established to facilitate expanded access to Ministry drug data holdings in the Health Network System (HNS) (e.g. initially Ontario Drug Benefit (ODB) claims data followed by Narcotics Management Systems (NMS) data) with access through the Clinical Viewers.

- The DHDR supports the long-term CDPS vision of 'All Drugs, All People' and contribute to the foundation of a connected health system for the province.

- In accordance with the CDPS Placemat and the Roadmap, the DHDR will be designed and developed to house additional data sources and attributes that are clinically valuable.

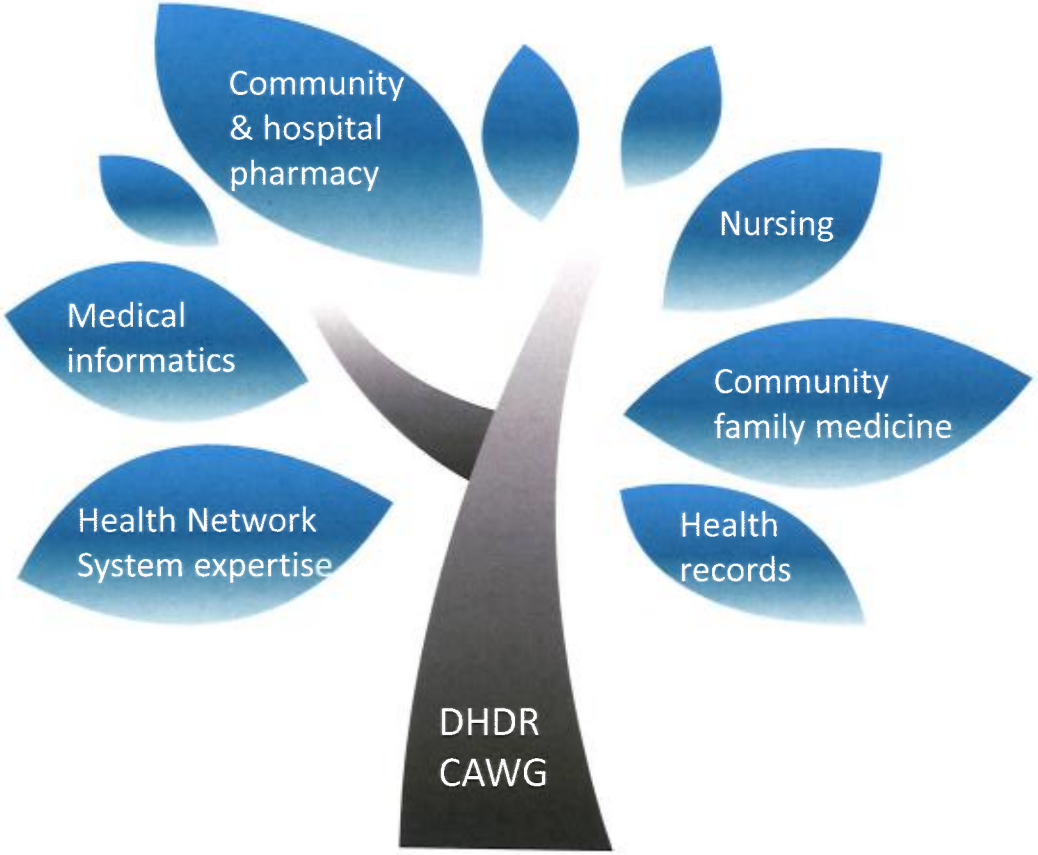
- The DHDR will deliver clinical value to patients and health care providers through an incremental approach, where benefits will start to accrue in the shorter term.

- Initially, the DHDR will be populated with dispensed drug history events from the Ministry's Health Network System (HNS) ODB asset.
  - In parallel, options to include data from the Narcotics Monitoring System (NMS) as part of the early release of DHDR are being investigated.

- The path to enabling the Best Possible Medication History will develop as more data sources (such as narcotics and non-publicly funded drugs) are incorporated, more clinical data elements are available and integration to other Point of Service systems such as EMRs, Hospital Information Systems and Pharmacy Management Systems has been provisioned for prescribed data, drug utilization and medication reconciliation.

DHDR Clinical Advisory Working Group (CAWG)

- A Clinical Advisory Working Group was established in February 2016.
- Chaired by Dr. Robin Williams, Special Advisor to the Ministry and an Order of Canada recipient.



Clinical areas represented by the Clinical Advisory Working Group (CAWG)

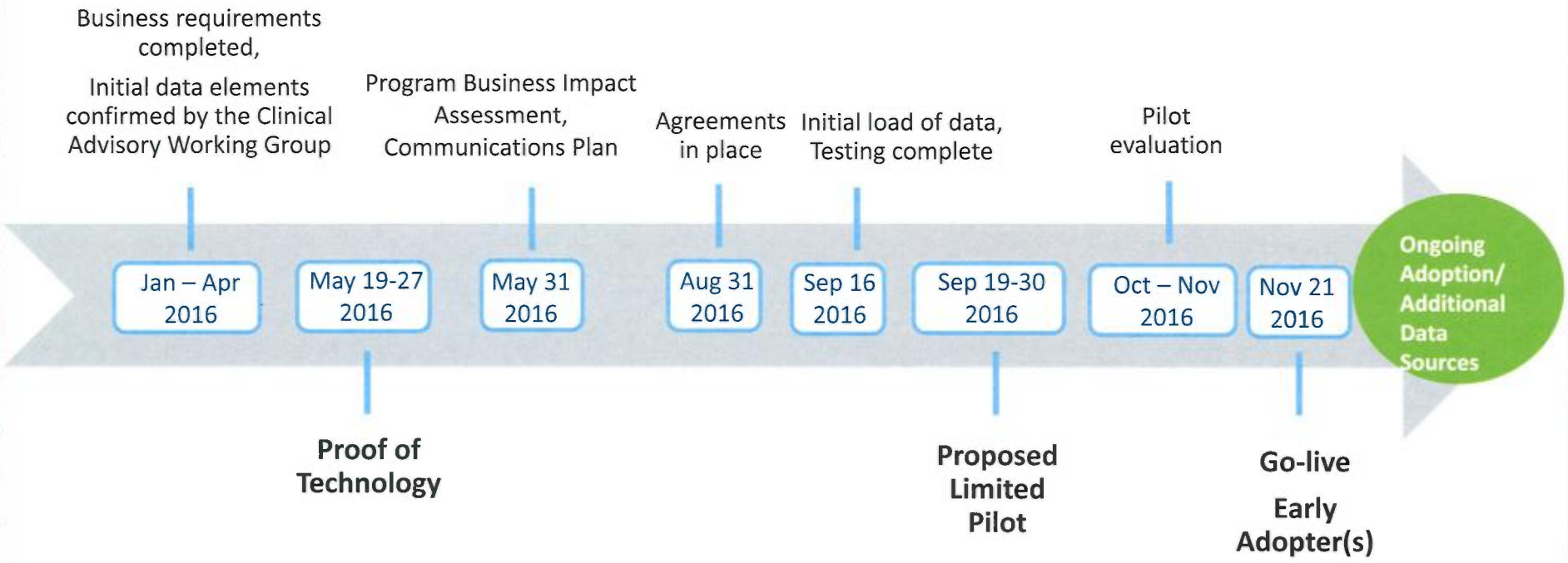
CAWG will be key to ensuring that health care providers' access to a patient's dispensed drug history positively contributes to better informed clinical decisions and reduced adverse drug events

Key Roles:

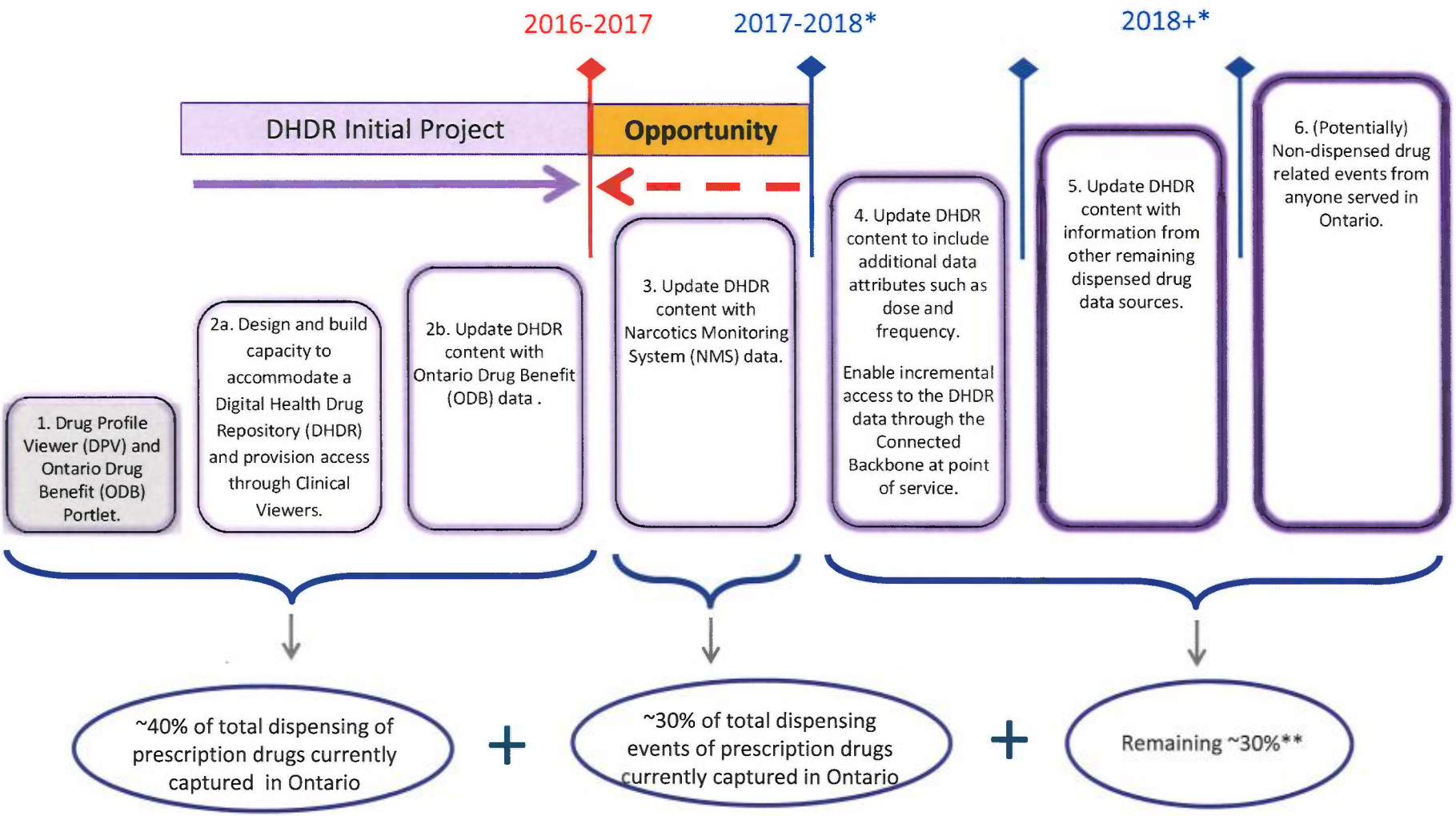
- Represent the views of key clinical stakeholders
- Provide advice to ensure clinical relevance and optimal data quality of information to be contained in the DHDR
- Provide direction and best practices for implementation, change management, and ongoing system use

DHDR Major Milestones (based on initial scope)

Timeline for Proof of Technology, Limited Pilot & Go Live



Roadmap to All Drugs All People

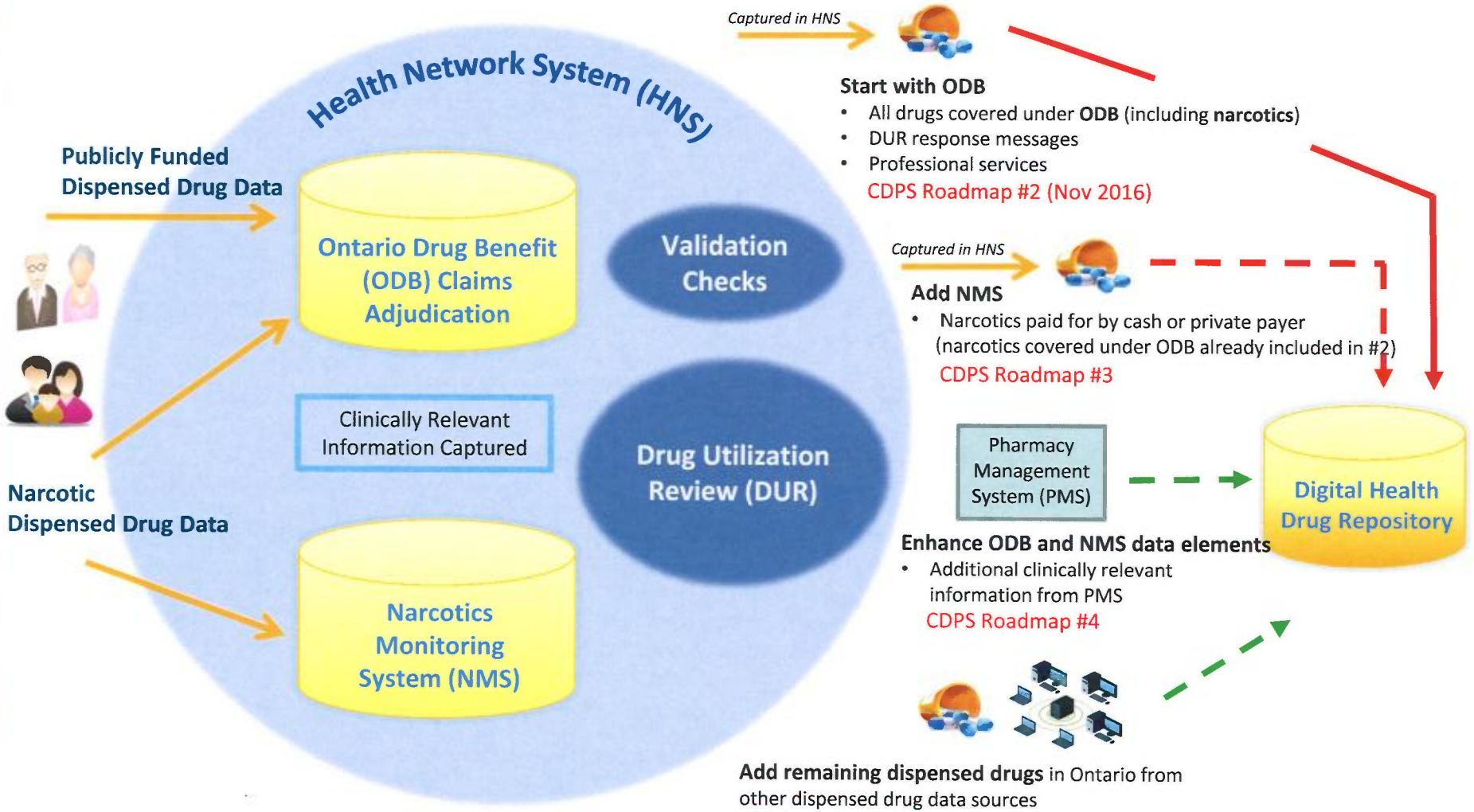


Note: Consideration for incorporating prescribed events is part of the Roadmap but pending review of options.

* This approach may change as technical, policy and business requirements evolve over time. The timeline will also depend on policy decisions to support the 'All Drugs, All People' vision.

** This represents 30% of dispensed drugs in Ontario as well as non-dispensed drugs.

Overview – Building Dispensed Events in DHDR



THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

COUNCIL BRIEFING NOTE

TOPIC: **2015 AUDITED FINANCIAL STATEMENTS & APPOINTMENT OF THE AUDITOR FOR 2016**

FOR DISCUSSION / DECISION

ISSUE: Annual audit and audited financial statements for 2015

BACKGROUND:

- The spring meeting of Council is the Annual Financial Meeting for the College. At this meeting the auditors present the audit report along with the audited financial statements.
- As well, at this meeting, Council appoints the external auditors for the next year.

Mr. Dale Tinkham, of Tinkham and Associates LLP, reviewed the audited financial statements for the year ended December 31, 2015 comparing the actual expenditures to those of the previous year.

The auditor reported that the financial statements are represented fairly and in accordance with Canadian accounting standards for not-for-profit organizations.

The report states:
"In our opinion, these financial statements present fairly, in all material respects, the financial position of The College of Physicians and Surgeons of Ontario as at December 31, 2015, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations."

The Finance Committee made the following motion:

The Finance Committee recommends to Council that the Audited Financial Statements for the year ended December 31, 2015, as presented by Tinkham and Associates LLP, be accepted.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Finance Committee also recommends to Council the following motion:

The Finance Committee recommends to Council that the firm of Tinkham and Associates LLP, Chartered Accountants be appointed as the College's auditors for the year 2016.

INTERNAL CONTROLS

Each year, the Finance Department completes a document that details the College's internal controls in the following areas: General Business Environment; Information Technology; Financial Statement Presentation; Purchases, Payables and Payments Transaction Stream; Payroll Transaction Stream; Revenues, Receivables and Receipts Transaction Stream and Assets. The College's auditor uses this document to assist in determining the strength of the College's internal controls annually. The auditor supported the current controls and had no recommendations.

DECISION FOR COUNCIL:

The Finance Committee recommends approval of the audited financial statements for 2015 and further recommends the firm of Tinkham and Associates LLP, be reappointed as the College's auditors for the year 2016.

CONTACT: Mr. Pierre Giroux, Chair of the Finance Committee
Mr. Douglas Anderson, Corporate Services Officer, ext 607
Ms. Leslee Frampton, Manager, Finance & Business Services, ext 311

DATE: May 9, 2016

Financial statements of

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 31, 2015

Tinkham & Associates LLP
CHARTERED ACCOUNTANTS

D C Tinkham, FCPA, FCA, LPA, CMC
Associates
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INDEPENDENT AUDITOR'S REPORT

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

We have audited the accompanying financial statements of The College of Physicians and Surgeons of Ontario, which comprise the statement of financial position as at December 31, 2015 and the statements of operations and changes in net assets, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of The College of Physicians and Surgeons of Ontario as at December 31, 2015 and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

TORONTO, Ontario
May 31, 2016

Licensed Public Accountants

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Financial Position

As at December 31	2015	2014 (note 14)
Assets		
Current		
Cash and cash equivalents (note 3)	**$ 28,097,450**	$ 31,757,246
Accounts receivable (note 4)	**1,011,408**	1,115,085
Prepaids	**403,845**	411,362
	29,512,703	33,283,693
Investments (note 5)	**50,085,129**	40,948,839
Capital assets (note 6)	**10,726,155**	10,894,465
	$ 90,323,987	$ 85,126,997
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 5,917,333**	$ 4,931,710
Due to Ministry of Health and Long Term Care (note 8)	**1,288,849**	1,288,849
Administered programme (note 8)	**152,978**	233,642
Current portion of obligations under capital leases (note 10)	**295,510**	404,704
	7,654,670	6,858,905
Deferred revenue (note 7)	**26,501,566**	25,508,688
	34,156,236	32,367,593
Accrued pension cost (note 9)	**5,445,028**	5,496,911
Obligations under capital leases (note 10)	**211,518**	341,293
	39,812,782	38,205,797
Net assets (note 11)		
Invested in capital assets	**10,219,127**	10,148,468
Building fund	**40,292,078**	36,772,732
Unrestricted	**197,648**	164,356
Pension remeasurements (note 9)	**(197,648)**	(164,356)
	50,511,205	46,921,200
	$ 90,323,987	$ 85,126,997

Commitments and Contingencies (notes 12 and 13)

Approved on behalf of the Council

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See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Operations and Changes in Net Assets

Year ended December 31	**2015**	2014 (note 14)
Revenue		
Membership fees		
General (note 7)	**$ 52,722,529**	$ 51,244,782
Educational (note 7)	**2,023,054**	1,937,250
Penalty fee	**371,501**	395,001
Credit card service charges	**(1,204,105)**	(1,183,030)
	53,912,979	52,394,003
Application fees	**5,276,453**	5,074,837
OHPIP annual and assessment fees (note 7)	**995,830**	737,455
IHF annual and assessment fees (note 7)	**1,140,568**	716,341
OHPIP, IHF application fees and penalties	**78,619**	134,193
Cost recoveries and other income	**2,179,027**	1,996,136
Investment income	**1,428,933**	2,023,576
	65,012,409	63,076,541
Expenses		
Committee costs (schedule I)	**14,657,126**	13,156,346
Staffing costs (schedule II)	**39,655,511**	36,642,007
Department costs (schedule III)	**4,244,471**	3,709,303
Depreciation of capital assets	**1,289,327**	1,419,696
Occupancy (schedule IV)	**1,542,677**	1,497,164
	61,389,112	56,424,516
Excess of revenue over expenses before unrealized gains	**3,623,297**	6,652,025
Add: unrealized gain on investments	**-**	2,222,342
Excess of revenue over expenses for the year	**3,623,297**	8,874,367
Net assets, beginning of year	**46,921,200**	38,397,690
Actuarial remeasurement for pension (note 9)	**(33,292)**	(350,857)
Net assets, end of year	**$ 50,511,205**	$ 46,921,200

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Statement of Cash Flows

Year ended December 31	2015	2014
Cash flows from operating activities:		
Excess of revenue over expenses for the year	**$ 3,623,297**	$ 8,874,367
Unrealized gain on investments	**-**	(2,222,342)
	3,623,297	6,652,025
Depreciation of capital assets	**1,289,327**	1,419,696
	4,912,624	8,071,721
Net change in non-cash working capital items:		
Accounts receivable	**103,677**	(16,592)
Prepaids	**7,517**	(97,409)
Accounts payable and accrued liabilities	**985,623**	(445,699)
Administered programme	**(80,664)**	(302,315)
Deferred revenue	**992,878**	1,871,955
Pension cost	**(85,175)**	(51,918)
Cash provided by operating activities	**6,836,480**	9,029,743
Cash flows from investing activities:		
Purchase of capital assets	**(896,953)**	(769,347)
Purchase of investments (net)	**(9,136,291)**	(1,529,575)
Cash used by investing activities	**(10,033,244)**	(2,298,922)
Cash flows from financing activities:		
Payment of capital lease obligations	**(463,032)**	(445,003)
Net increase (decrease) in cash and cash equivalents	**(3,659,796)**	6,285,818
Cash and cash equivalents, beginning of year	**31,757,246**	25,471,428
Cash and cash equivalents, end of year	**$ 28,097,450**	$ 31,757,246

See accompanying notes to the financial statements.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Notes to the Financial Statements
December 31, 2015

1 Organization

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

The College is exempt from income taxes provided certain criteria are met.

2 Significant accounting policies

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

a) Cash and cash equivalents

Cash and cash equivalents includes cash deposits held in a major financial institution.

b) Investments

Guaranteed investment certificates are subsequently valued at amortized cost. The College had elected to value all investments at fair value, which was based on quoted market values. Investment management fees were expensed as incurred.

c) Capital assets

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

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. An impairment loss is recognized in the statement of operations when the carrying amount of the asset exceeds the sum of the undiscounted cash flows resulting from its use and eventual disposition. The impairment loss is measured as the amount by which the carrying amount of the capital asset exceeds its fair value. An impairment loss is not reversed if the fair value of the capital asset subsequently increases. As at December 31, 2015, no such impairment exists.

Amortization is provided for on a straight-line basis over their estimated lives as follows:

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

d) Pension plans

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

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

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

2 Significant accounting policies continued

e) Revenue recognition

i) Members' fees and application fees

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

ii) Independent health facility (IHF) and Out of Hospital Premises Inspection Program (OHPIP) fees

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

iii) Investment income

Investment income is comprised of interest from cash and cash equivalents, and guaranteed investment certificates, distributions from mutual funds, and realized gains and losses on the sale of investments. Unrealized gains and losses resulting of changes in the fair value of mutual fund investments held is recognized separately in the statement of operations. Interest and dividends are recognized when earned.

f) Financial instruments

i) Measurement

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

The College subsequently measures its financial assets and liabilities at amortized cost, except for marketable securities that are quoted in an active market which are measured at fair value based on quoted market prices. Changes in fair value are recognized in income in the period incurred.

Transaction costs are recognized in income in the period incurred, except for financial instruments subsequently measured at amortized cost. Transaction costs associated with the mutual fund investments are expensed as incurred.

Financial assets subsequently measured at amortized cost include guaranteed investment certificates and receivables. Financial liabilities subsequently measured at amortized cost include accounts payable and accrued liabilities, Due to Ministry of Health and Long Term Care, and obligations under capital leases.

The fair values of the mutual fund investments are determined by reference to the latest closing net asset value of each respective fund.

ii) Impairment

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

g) Management estimates

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

h) Net assets invested in capital assets

Net assets invested in capital assets comprises the net book value of the capital assets less the related obligations under capital leases.

3 Cash and cash equivalents

As at December 31	**2015**	2014
Cash on deposit	**$ 28,097,450**	$ 30,963,116
Short term investment	**-**	794,130
Cash and cash equivalents	**$ 28,097,450**	$ 31,757,246

Cash is held in an operating bank account at a major Canadian financial institution and earned an average yield of 1.2% (2014 - 1.4%).

Short term investment was comprised of an investment in units of a fund consisting of a selection of high quality Canadian dollar denominated money market instruments, issued or guaranteed by, the Government of Canada. This investment was recorded at market value based on year-end quoted market price.

4 Cancer Care Ontario Quality Management Partnership

The College and Cancer Care Ontario (CCO), are jointly developing a provincial quality management program in three areas: mammography, colonoscopy and pathology. The College has incurred expenses totaling $604,071 (2014 - $307,393) which are not included in these financial statements as they are fully funded by Cancer Care Ontario. As at December 31, 2015 there is $456,931 receivable from CCO which is included in accounts receivable (2014 - $177,393). CCO has the right to audit the expenses charged to the program.

5 Investments

As at December 31	**2015**		2014
	Amortized Cost	Cost	Market Value
Guaranteed Investment Certificates (GIC)			
Bank of Montreal, 1.76%, due November 14, 2016	**$ 10,000,000**	**$ -**	**$ -**
Manulife Bank, 1.70%, due November 14, 2017	**10,000,000**	**-**	**-**
Manulife Bank, 1.95%, due November 13, 2018	**10,000,000**	**-**	**-**
CIBC, guaranteed growth, minimum 0.50% annual return, due November 13, 2019	**10,000,000**	**-**	**-**
CIBC, guaranteed growth, minimum 0.60% annual return, due November 13, 2020	**10,000,000**	**-**	**-**
Accrued interest to December 31	**85,129**	**-**	**-**
Mutual Funds			
Cash and equivalents	**-**	1,414,898	1,400,307
Fixed income	**-**	29,878,373	31,294,051
Equities - Canadian	**-**	3,377,880	3,926,349
Equities - US	**-**	2,716,293	4,328,132
	$ 50,085,129	$ 37,387,444	$ 40,948,839

The College revised its investment strategy in 2015, moving the short term investment of $794,130 and mutual fund investments into a laddered GIC structure. The GIC investments are measured at amortized cost. Interest on the guaranteed growth investments held at CIBC will be determined at maturity based on the percentage change in price of an equally weighted portfolio of five Canadian bank's shares. Interest has been accrued at the minimum guaranteed rates. In 2014 and prior years, the College held a managed portfolio of mutual funds. The investments were recorded at fair value based on year-end quoted market prices.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Notes to the Financial Statements
December 31, 2015

6 Capital assets

As at December 31	2015		2014	
	Cost	**Accumulated Amortization**	Cost	Accumulated Amortization
Land	**$ 2,142,903**	**$ -**	$ 2,142,903	$ -
Building and building improvements	**20,482,488**	**13,634,713**	19,952,310	13,152,884
Furniture and fixtures	**4,151,119**	**3,186,793**	3,836,017	3,003,660
Computer and other equipment	**1,261,867**	**1,206,894**	1,245,016	1,148,966
Computer equipment under capital lease	**1,249,542**	**748,944**	1,519,042	780,932
Leasehold improvements	**396,339**	**198,169**	396,339	118,902
Website	**856,086**	**838,676**	821,266	813,084
	$ 30,540,344	**$ 19,814,189**	$ 29,912,893	$ 19,018,428
Net book value		**$ 10,726,155**		$ 10,894,465

7 Deferred revenue

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

	Membership Fees	**IHF**	**OHPIP**	**2015 Total**	2014 Total
Balance, beginning of year	**$ 23,198,029**	**$ 1,281,985**	**$ 1,028,674**	**$ 25,508,688**	$ 23,636,733
Amounts billed during the year	**55,217,175**	**1,449,706**	**1,207,979**	**57,874,860**	56,507,783
Less: Recognized as revenue	**(54,745,584)**	**(1,140,568)**	**(995,830)**	**(56,881,982)**	(54,635,828)
Balance, end of year	**$ 23,669,620**	**$ 1,591,123**	**$ 1,240,823**	**$ 26,501,566**	$ 25,508,688

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

8 Administered programme

The College administers the Methadone programme on behalf of the Ministry of Health and Long Term Care (MOHLTC). The revenues and expenses incurred for the programme are not included in the statement of operations of the College as they are the responsibility of the MOHLTC.

	2015	2014
Balance, opening	**$ 233,642**	$ 535,957
MOHLTC	**342,473**	139,878
Expenditures	**(423,137)**	(442,193)
Balance, closing	**$ 152,978**	$ 233,642

The College previously administered two additional programs: Independent Health Facilities and Registration Practice Assessment. These programmes were both completed in 2013. Funds due back to the MOHLTC are recorded on the Statement of Financial Position and total $1,288,849.

All amounts owing for these programs have been repaid in full subsequent to December 31, 2015.

9 Pension Plans

i) Plan description

The College maintains a defined contribution pension plan for the benefit of substantially all of its employees. The College also sponsors a supplementary defined contribution retirement plan for employees of the College in order to supplement the pension benefits payable to employees which are subject to the maximum contribution limitations under the Canadian Income Tax Act.

In addition, the College maintains a closed defined benefit pension plan for certain designated former employees. The retirement benefits of these designated employees are provided firstly through a funded plan and secondly through an unfunded supplementary plan.

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2015 Total**	2014 Total
Plan assets at fair value	**$ 3,243,210**	**$ -**	**$ 3,243,210**	$ 3,441,318
Accrued pension obligations	**(4,150,083)**	**(4,538,155)**	**(8,688,238)**	(8,938,229)
Funded status - deficit	**$ (906,873)**	**$ (4,538,155)**	**$ (5,445,028)**	$ (5,496,911)

iii) Plan assets

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2015 Total**	2014 Total
Fair value, beginning of year	**$ 3,441,318**	**$ -**	**$ 3,441,318**	$ 3,435,749
Interest income	**129,049**	**-**	**129,049**	156,326
Return on plan assets (excluding interest)	**(5,314)**	**-**	**(5,314)**	167,982
Employer contributions	**-**	**291,311**	**291,311**	288,426
Benefits paid	**(321,843)**	**(291,311)**	**(613,154)**	(607,165)
Fair value, end of year	**$ 3,243,210**	**$ -**	**$ 3,243,210**	$ 3,441,318

9 Pension plans continued

iv) Accrued pension obligations

Defined Benefit Plan	Funded Plan	Unfunded Plan	2015 Total	2014 Total
Balance, beginning of year	**$ 4,282,845**	**$ 4,655,384**	**$ 8,938,229**	$ 8,633,721
Interest cost on accrued pension obligations	**160,608**	**174,577**	**335,185**	392,834
Benefits paid	**(321,843)**	**(291,311)**	**(613,154)**	(607,165)
Actuarial (gains) losses	**28,473**	**(495)**	**27,978**	518,839
	$ 4,150,083	**$ 4,538,155**	**$ 8,688,238**	$ 8,938,229

The most recent actuarial valuation of the pension plan for funding and accounting purposes was made effective December 31, 2012. In accordance with that valuation, no payments have been made or are required under the funded plan. The next required actuarial valuation for funding purposes must be as of a date no later than December 31, 2015.

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

	2015	2014
Funded defined benefit plan	**$ 31,558**	$ 33,173
Unfunded supplementary defined benefit plan	**174,577**	203,335
Defined contribution plan	**2,540,336**	2,379,507
Supplementary defined contribution plan	**187,321**	177,592
	$ 2,933,792	$ 2,793,607

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

Defined Benefit Plan	Funded Plan	Unfunded Plan	2015 Total	2014 Total
Interest cost on accrued pension obligations	**$ 160,607**	**$ 174,577**	**$ 335,184**	$ 392,834
Interest income on pension assets	**(129,049)**	**-**	**(129,049)**	(156,326)
Pension expense (recovery) recognized	**$ 31,558**	**$ 174,577**	**$ 206,135**	$ 236,508

9 Pension plans continued

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

Defined Benefit Plan	**Funded Plan**	**Unfunded Plan**	**2015 Total**	2014 Total
Actuarial (gain) losses	**$ 28,473**	**$ (495)**	**$ 27,978**	$ 518,839
Return on plan assets (excluding interest)	**5,314**	**-**	**5,314**	(167,982)
Charge (credit) to net assets	**$ 33,787**	**$ (495)**	**$ 33,292**	$ 350,857

viii) Actuarial assumptions

The significant actuarial assumptions adopted in measuring the accrued pension obligations as at December 31 and the pension expense for the years then ended are as follows:

	2015		2014	
	Accrued pension obligations	**Pension expense**	Accrued pension obligations	Pension expense
Discount rate	**3.75 %**	**4.55 %**	3.75 %	4.55 %
Rate of compensation increase	**N/A**	**N/A**	N/A	N/A

10 Obligations under capital leases

The College has entered into several capital leases for computer equipment. The following is a schedule of the future minimum lease payments of the obligations under these leases, at an effective average rate of 2.19% interest, expiring on various dates to October 2018:

2016	$ 304,055
2017	178,267
2018	35,607
Total minimum payments	517,929
Less: amount representing interest	10,901
	507,028
Less: current portion	295,510
	$ 211,518

11 Net assets

2015	Invested in Capital Assets	Building Fund	Unrestricted	Pension Re-measurement	Total
Balance, January 1	**$10,148,468**	**$36,772,732**	**$ 164,356**	**$ (164,356)**	**$46,921,200**
Excess of revenue over expenses for the year	**70,659**	**-**	**3,552,638**	**-**	**3,623,297**
Actuarial remeasurement for pensions	**-**	**-**	**-**	**(33,292)**	**(33,292)**
Transfers	**-**	**3,519,346**	**(3,519,346)**	**-**	**-**
Balance, December 31	**$10,219,127**	**$40,292,078**	**$ 197,648**	**$ (197,648)**	**$50,511,205**

2014	Invested in Capital Assets	Building Fund	Unrestricted Net Assets	Pension Re-measurement	Total
Balance, January 1	$10,353,814	$28,043,876	$ (186,501)	$ 186,501	$38,397,690
Excess of revenue over expenses for the year	(205,346)	-	9,079,713	-	8,874,367
Actuarial remeasurement for pensions	-	-	-	(350,857)	(350,857)
Transfers	-	8,728,856	(8,728,856)	-	-
Balance, December 31	$10,148,468	$36,772,732	$ 164,356	$ (164,356)	$46,921,200

The College has transferred unrestricted net assets in the amount of $3,519,346 (2014 - $8,728,856) to a building fund.

Net assets invested in capital assets is calculated as follows:

As at December 31	2015	2014
Net book value of capital assets	**$ 10,726,155**	$ 10,894,465
Less: obligations under capital leases	**(507,028)**	(745,997)
	$ 10,219,127	$ 10,148,468

12 Commitments

The College has entered into a lease for additional office space extending to June 30, 2018. Minimum payments in aggregate and for each of the next three years are estimated as follows:

2016	$ 369,891
2017	374,647
2018	187,323
Total	$ 931,861

13 Contingencies

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

The College acknowledges that it has an obligation to provide funding to patients who are approved by the Patient Relations Committee.

14 Comparative figures

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

15 Financial instruments

General objectives, policies and processes

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

Credit risk

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

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

Credit risk associated with cash and cash equivalents and investments is minimized by ensuring that these assets are invested in financial obligations of major financial institutions, instruments issued or guaranteed by the Government of Canada, and/or other credit-worthy parties, including AAA-rated funds. The College has formal policies and procedures that establish target asset mix for investments. The College's policies also require diversification of investments within categories, and set limits on exposure to individual investments. Credit risk has decreased this year due to the College moving the investments to guaranteed investment certificates, even though the amount invested exceeds maximum insurance coverage.

Liquidity risk

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

Market risk

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

Currency risk

Currency risk reflects the risk that the College's earnings will vary due to the fluctuations in foreign currency exchange rates. The College manages this risk through controls to monitor and limit concentration levels.

The value of financial instruments denominated in a currency other than the Canadian dollar will be affected by changes in the value of the Canadian dollar in relation to the value of the currency in which the instrument is denominated.

15 Financial instruments continued

Currency risk continued

Included in cash is US currency of $14,833 (2014 - $68,307) expressed in Canadian dollars. Included in investments are US equity investments with a fair value of $Nil (2014 - $4,328,132) expressed in Canadian dollars.

Interest rate risk

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

Equity risk

Equity risk is the uncertainty associated with the valuation of assets arising from changes in equity markets. The College was exposed to this risk through equity holdings (note 5). The College manages equity risk by maintaining a well-diversified investment asset mix.

Other price risk

Other price risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate because of changes in market prices (other than those arising from currency risk or interest rate risk), whether those changes are caused by factors specific to the individual instrument or its issuer or factors affecting all similar instruments in the market.

Changes in risk

The College's credit risk and market risk have decreased this year due to the change in investments held. There have been no other significant changes in risk exposures from the prior year.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule I
Committee Costs

Year ended December 31	**2015**	2014
Attendance	**$ 3,685,883**	$ 3,139,762
Preparation time	**2,732,775**	2,420,455
Decision writing	**905,294**	936,164
Expert opinions	**1,577,743**	1,366,483
Assessors	**368,994**	322,302
Travel time	**1,681,383**	1,742,448
HST on per diems	**486,260**	385,940
Consultant fees	**394,933**	608,667
Legal costs	**1,397,637**	707,669
Audit fees	**35,719**	62,506
Sustenance	**235,803**	256,590
Meals and accommodations	**333,657**	352,416
Travel expenses	**765,245**	794,523
Witness expenses	**55,800**	60,421
	$ 14,657,126	$ 13,156,346

Schedule II
Staffing Costs

Year ended December 31	**2015**	2014
Salaries	**$ 31,410,406**	$ 29,094,961
Employee benefits	**3,874,236**	3,558,556
IT consulting and web support	**546,303**	433,781
Pension (note 9)	**2,933,792**	2,793,607
Training and employee engagement	**560,936**	589,790
Personnel, placement and pension consultants	**329,838**	171,312
	$ 39,655,511	$ 36,642,007

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
Schedule III
Department Costs

Year ended December 31	**2015**	2014
Software	**$ 162,792**	$ 154,051
Equipment leasing	**71,554**	98,960
Equipment maintenance	**104,295**	98,226
Miscellaneous	**531,796**	218,635
Photocopying	**416,680**	472,429
Printing	**52,637**	58,917
Postage	**301,713**	304,138
Members dialogue	**399,265**	260,264
Courier	**118,876**	115,722
Telephone	**269,683**	302,783
Office supplies	**347,284**	259,051
Reporting and transcripts	**255,864**	182,629
Professional fees - staff	**92,178**	80,843
FMRAC Membership fee	**469,860**	458,280
Publications and subscriptions	**200,710**	159,395
Travel, conferences, workshops and seminars	**375,284**	345,480
Grants	**74,000**	139,500
	$ 4,244,471	$ 3,709,303

Schedule IV
Occupancy

Year ended December 31	**2015**	2014
Building maintenance and repairs	**$ 426,221**	$ 407,198
Insurance	**449,721**	453,559
Realty taxes	**78,486**	78,624
Utilities	**216,332**	199,233
Rent	**371,917**	358,550
	$ 1,542,677	$ 1,497,164

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

COUNCIL BRIEFING NOTE

TOPIC: **REPORT OF THE FINANCE COMMITTEE**

FOR INFORMATION

ISSUE: **Activities of the Finance Committee since the last meeting of Council**

BACKGROUND:

- The Finance Committee has met twice in 2016 and attached is a Report of the Finance Committee detailing the issues discussed at the meetings.

CONTACT: Mr. Pierre Giroux, Chair of the Finance Committee
Mr. Douglas Anderson, Corporate Services Officer, ext 607
Ms. Leslee Frampton, Manager, Finance & Business Services, ext 311

DATE: May 9, 2016

May 2016

REPORT OF THE FINANCE COMMITTEE

DEFINED BENEFIT PENSION PLAN – ASSET MIX

The Committee reviewed the options for the Defined Benefit Pension Plan asset mix as presented by the College's investment consultant. As this is a mature plan and there are no more active members, Mercer recommended modifying the asset mix (which is aggressive due to exposure in equity) to a more conservative mix of 45% equity and 55% fixed income. The Committee agreed with Mercer's recommendation and directed staff to make the change.

PENSION PLANS – STATEMENT OF INVESTMENT POLICIES AND PROCEDURES

The Financial Services Commission of Ontario (FSCO) implemented a new requirement, effective January 1, 2016, that requires organizations that sponsor pension plans to file a Statement of Investment Policies and Procedures no later than 60 days after the end of the fiscal period for the pension. The documents for both of the College's pension plans were filed on time.

AMENDMENT AND RESTATEMENT OF THE DEFINED CONTRIBUTION PENSION PLAN

The Finance Committee recommended to the Executive Committee the following amendments and restatement of the plan text for the Defined Contribution Pension Plan:

1. Comply with changes made to the Ontario *Pension Benefits Act* effective July 1, 2012 which deal with immediate vesting of members contributions;
2. Establish new member and College contributions in respect of employees hired by the College on or after January 1, 2016; and
3. Change the name of the Plan to the Employees' Retirement Savings Plan for The College of Physicians and Surgeons of Ontario effective January 1, 2016

Restatement of the Plan will incorporate these amendments and prior amendments made to the Plan in 2008. The Executive Committee (at its April meeting), approved the Resolution for the amendments and restatement of the plan.

HIROC

The Committee reviewed the College's reciprocal insurance coverage with HIROC (Healthcare Insurance Reciprocal of Canada). This has afforded the College decreased premiums and increased coverage (when compared to traditional insurance). As well, when the reciprocal makes a surplus, the College may share in any disbursement. The insurance covers CPSO, employees, councillors, officers, committee members, summer students and peer assessors. In addition to various coverages for liability there is traditional coverage for crime and property damages as well as Errors and Omissions and Directors and Officers. HIROC further reviewed the College's new coverage for cyber-crime.

FIRMS (FMRAC's Integrated Risk Management System)

All subscribers to the College's insurer are required to participate in a risk management self-appraisal of their programs and premises in an effort to proactively control risk. The completion of these modules leads to reductions in insurance premiums. The College self-assesses Governance, Operations, Registrations and Licensure, Complaints and Resolutions, Quality Assurance of Medical Practice and Facility Accreditation/Quality Review programs. This provides continuing analysis of the risks and mitigation strategies for the College to scrutinize.

FINANCIAL STATEMENTS AND VARIANCES

Financial statements and variances were reviewed at each meeting of the Committee.

FM GLOBAL RISK REPORT

In a recent report, FM Global (contracted by the College's insurer) completed the triennial audit of the College's premises confirmed that the building scored a 96% effective risk review. The College is at the top of 249 sites audited by FM Global, achieving the highest score possible. This is due to diligence from the Facilities and Operations department.

BUDGET OBJECTIVES FOR 2017

The Committee discussed the historical increases for membership fees as well as the pressures to handle current commitments and how that may affect the 2017 budget.

BUSINESS CONTINUITY

Business Continuity Plan development continues to proceed in consultation with all divisions.

PCI COMPLIANCE

The Payment Card Industry Data Security Standard ("PCI DSS") is a contractual standard for the protection of data regarding payment cards issued by the major card brands, including VISA, MasterCard and American Express which encompasses the cards that the College uses. Organizations that accept payment card transactions or store, process of transmit payment card data are contractually obligated to comply with PCI DSS. The College is currently working to ensure that compliance is achieved by the end of this calendar year.

FACILITIES/FACILITIES

The Committee reviewed the status of current construction work and future needs for space to accommodate growth.

2016 GOALS OF THE FINANCE COMMITTEE

Goal: a financially stable organization with control processes in place to appropriately manage all relevant College matters.

	Objective is complete		Work in Progress and on schedule		Work in Progress but may not meet the target date		Work on Hold, will not meet target.

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
Ensure College Meets Operating Goals						
Oversee the development and approval of the 2017 budget	Discuss with Management the parameters for the 2017 budget	At the spring meeting, the Finance Committee will provide guidelines and direction for Management to follow in preparing 2017 budget.	Spring	April 5		At the spring meeting, the committee reviews the budget process. The budget is divided into two stages: 1) the base budget and 2) the business cases for new projects, staffing, etc.
	Review and comment on proposed budget	At the fall meeting, the proposed budget is submitted to the Committee for discussion and feedback on the appropriateness of the budget and implication to the fees required to fund the operation	Fall	Oct 11		Finance Committee is given the budget detail at the fall meeting. At that meeting the Finance Committee will review base budgets and assumptions and meet with department heads requesting new projects, staffing and capital projects
	Present Budget to Council for approval	Once the Committee has reviewed and makes any changes to the budget it will recommend to Council that the budget be approved.	Fall	Dec 1/2		Finance Committee will be recommending to Council the acceptance of the budget
Ensure all Council decisions are fully reflected in financial projections	Review all major College initiatives	Each initiative recommended to Council by the Finance Committee shall be accompanied by a Financial Impact Analysis and Business Case.	On-going	April 5 Oct 11		At each meeting of the Finance Committee any new initiatives with budget implications will be presented for review.
Ensure plans are in place to provide adequate space for College operations	Continually monitor real estate market for long-term permanent solutions for future expansion	Keep the committee up to date regarding potential opportunities for space	On-going		 	Funds have been directed to the College's building reserve to assist in savings for future building needs. The Committee agreed to transfer any surplus funds to the building reserve. Staff are continually reviewing

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
						options with regards to acquiring space.
On-going review of the financial statements	The Committee will be provided the latest financial statements at spring & fall meetings. The Committee will receive Financial Statements and a variance report in the summer and winter so that the Committee will have quarterly financial information	A variance analysis will be provided explaining the large variances between the actual expenditures versus the budget allocation.	Spring & Fall	April 5 Oct 11		
Ensure the College continuously improves business processes and achieves cost savings.	Review management report on College process improvements annually	Feedback provided to Management on continuous improvement program	On-going	Work in Progress		The IT Steering Committee regularly reviews the IT priorities at the College. When a project is undertaken part of the development of the new system or a change to an existing system is to complete a process review to ensure the changes contribute to continuous program improvement and efficiencies
Financial Indicators and Ratios						
	Working Capital	Ensure the College has enough money to cover its current obligations	1:0	0.9		This ratio measures the ability of an organization to pay its current obligations. The major contributing factor to the decrease of 0.2 is that during the month of November, $10M was transferred from our bank account, which is consider a Current Asset, was placed in a Long Term Investment. The transfer of this money provides for a higher rate or interest than we were earning in our current account.
	Operating Expense Ratio	In a not for profit organization expenses should match revenue	91.2%	95.2%		This ratio is an indication of the percentage of operating revenue which is being absorbed by operating expenses. While 100% is ideal in the Not-for-Profit sector, the 4.0% increase over the year is a concern.

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
	Days in Accounts Receivable (A/R only)	Ensure the College is collecting outstanding receivables in a timely fashion	6.09 business days	4.11		Compares days in accounts receivable to terms of payment. The 1.98 decrease in days shows that we have been more efficient in collecting payment than we were at this time last year.
	Days in Accounts Payable (A/P only)	Ensure the College is paying its bills in a timely fashion	7 – 10 business days	10.43		Compares the days in accounts payable to terms of payment. Accounts Payable have increase over 8% from 2014 which is a contributing factor to the time it takes us to pay our bills.
Ensure that Risk Management Processes are in Place						
Monitor development of a formal risk management program at the College	Submit RMSAM modules for 4-year review as required for regular cycle	The HIROC risk management program ensures that the College has a risk assessment program in place	2014/15			The RMSAM program is evolving to FMRAC Integrated Risk Management Systems (FIRMS). This new program is designed specifically for the Medical Regulatory Authorities (MRAs) and will be implemented in the future. To date, we have received a 5% discount applied to our insurance premiums.
Ensure College's short term investments are managed appropriately	Review recommendations from Management regarding the investment of the short term funds.	Invest College's short-term funds prudently and ensure the best rate of return at the lowest risk.	Spring Fall	April 5 Oct 11		This is revenue from the annual membership fees. Currently, it resides in the College's current account; however, it also may be in Government of Canada Treasury bonds (depending on the highest net interest rate). We have been able to negotiate an increase from 1.1% to 1.25% in our current account.
Ensure College's long term investments are managed appropriately	Review recommendations from Management and 3rd party consultants regarding the asset mix of the longer term investments.	To position the portfolio in a manner that could be utilized to fund any capital projects such as a new building and to protect our capital	Spring	Nov 2015		The Finance Committee recommended to and Council approved the transfer of longer term investments from the current asset mix to a 5 year ladder GIC - including a GIC for one, two and three years and a 4 and 5 year market linked GIC.
Ensure College's maintain its fiduciary responsibility to the Defined Benefit Pension Plan and the Defined Contribution	Chair of the Finance Committee sits on the Pension Committee and is kept apprised of the issues	To ensure that the pension plans are administered in compliance with the Pension Benefits Act and Financial Services Commission of Ontario requirements	On-going			Council delegated the oversight of the College's pension plans to the Executive Committee, who in turn delegated to the Finance Committee. The Finance Committee has direct oversight of the Defined Benefit Pension Plan. The Defined Benefit Plan is review every three years to determine the financial status of the plan. It should be noted that the Defined Benefit Plan is closed. There are

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
Pension Plan						12 retired members and 1 inactive member. The Finance Committee has delegated the administration of the College's Defined Contribution Pension Plan to the Pension Committee. There is Finance Committee, management representation on this committee and staff representatives who are elected by their peers.
Risk Management for Not –for –Profit Organizations	Review questions developed by the Canadian Institute of Chartered Accountants	To ensure the College has an effective Risk Management program	On-going			The Canadian Institute of Chartered Accountants has developed a list of 20 questions that directors of boards should be asking about risk at the organization. The Finance Committee was provided a copy of this document in the Orientation Package.
Business Continuity Plan	Work continues in updating the current Business Continuity Plan to current best practices.	A business continuity document that is comprehensive but easy to use and implement	On-going			In 2011 the College developed a business continuity plan. The plan needs to be updated to reflect current best practices. The College engaged the services Marsh Risk Consulting to assist in this process. It is anticipated that this will be completed by the end of 2016. Once the plan has been drafted the Finance Committee will review
Ensure Proper Financial Safe-Guards in Place						
Ensure College operates in compliance with generally accepted accounting principles and not for profit rules	Review and comment on the results of the annual external audit. Meet in camera with External Auditors to discuss the results of the audit.	Comments provided to auditor.	Spring	April 5		The College's audit firm, Tinkham & Associates will review the audited financial statements for the year ended December 31, 2015 comparing the actual expenditures to those of the previous year. The Committee will hold an in camera meeting with the Auditor at the Spring meeting.
	Arrange for auditor to present results of audit to Council.	Audit report presented to Council	Spring	May 30/31 Council		College's external auditor to present 2014 audited financial statements to Council
Internal Control Questionnaire	Each year staff in conjunctions with the external auditor, will update an	Confirms the strength of the internal controls at the College	Spring	April 5		The Finance Committee is responsible for maintaining oversight for management's efforts to create a strong control environment. Best practices dictates that the Finance Committee's review should

Objective	Work Plans	Outcome	Target	Actual	Status	Notes
	internal control questionnaire that assesses the strength of the internal controls at the College					include an evaluation of management's risk assessments and processes for identifying and addressing business and fraud risks.
Conflict of Interest and Code of Conduct for individuals sitting on Finance Committee	Ensure at each meeting that Committee members declare any potential conflicts of interest	Declaration to be noted in the minutes.	Each meeting	Each meeting		Any conflicts of interest would be noted in the minutes
Ensure Adequate Orientation/Education for Members						
Ensure all Committee members are adequately trained and have appropriate tools to fulfill their Committee responsibilities.	Prepare a detailed orientation/ education document	Members receive education as needed	On-going	Jan 18, April 5, Oct		Continuous education throughout the year from various consultants and investment managers.
	Develop a glossary of financial terms	Glossary provided to Committee members		Complete		The glossary is updated on an on-going basis.
	Hold an annual formal orientation session for members	The objective is to brief new members regarding the financial matters of the College, and bring them up to date with the existing members of the Committee.	Jan 18	Jan 18		An orientation/education session is scheduled for January 18, 2016
	Role/Mandate of Committee	Ensure that the Committee members understand the role and mandate of the Committee	On-going	Each meeting		The Chair of the Committee ensures that the members of the Committee understand the role and mandate of the Committee and address any educational needs
	Timely distribution of materials	Ensure materials are distributed to the Committee in a timely manner	Each meeting	Each meeting		
	Development and strengths	Receive feedback from Committee regarding any development or educational needs.	Each meeting	Each meeting		

May 2016

COUNCIL BRIEFING NOTE

TOPIC: ***Government Sexual Violence and Harassment Initiatives***

FOR INFORMATION

ISSUE:

- Since the fall of 2014 there has been increased attention on the underlying causes and occurrences of sexual violence and harassment in Ontario and beyond.

- The recent attention to these issues has broadly impacted organizations across Ontario including many workplaces, educational institutions, and bodies like the College.

- As part of this focus, the issue of sexual abuse of patients by physicians and the College's role in investigating and prosecuting sexual abuse complaints received renewed attention in 2014 with the Minister of Health initiating the Sexual Abuse Task Force.

- As the report of Marilou McPhedran's Sexual Abuse Task Force is expected to be released in the coming months, Council is provided with a contextual overview of the current environment and recent history of these issues and government action in Ontario.

CONTEXT:

Re-framing the Problem of Sexual Violence

- Over the last number of years, increased attention has been paid to issues of sexual violence and harassment. Although the goal of eradicating these abuses is not new, the explanation for the continued pervasiveness and the work needed to end it has undergone significant change as of late.

- In *It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment*, a multi-faceted plan authored by the provincial government; the Premier in her opening remarks notes that "Above all, we want to challenge and change the deep-rooted attitudes and behaviours that contribute to sexual violence and harassment."

- The action plan goes on to say that an end to rape culture meaning "a culture in which dominant ideas, social practices, media images and societal institutions implicitly or explicitly condone sexual assault by normalizing or trivializing male sexual violence and by blaming survivors for their own abuse"[1] is the key to stopping sexual violence and harassment.

- This shift in understanding the root cause of sexual violence is relevant not only in explaining why the government has taken such broad action over the past year and a half but also in anticipating the changes that may occur in the future, some likely of specific relevance to the College.

Recent Events

- In the fall of 2014, a series of events brought a heightened focus to these issues, a growing pressure to take action, and significant changes to the way government and the media discussed issues of sexual violence and harassment.

- In October 2014, CBC Q radio host, Jian Ghomeshi was fired from the CBC and subsequently charged with seven counts of sexual assault. The accusations and ensuing trial against Ghomeshi raised questions about our culture's complacency when faced with sexual violence, the treatment of survivors, and how we can move to end rape culture.

- The impact of the Jian Ghomeshi story was sweeping and immediate. In an expression of solidarity with the women who came forward with their stories of being assaulted by Ghomeshi, Toronto Star reporter Antonia Zerbisias started the hashtag "BeenRapedNeverReported". The hashtag went viral and within days it had been viewed by eight million people and a national conversation about sexual violence, the criminal justice system, and the treatment of survivors had begun.

- These conversations have continued and were once again centre stage when a not guilty verdict in Ghomeshi's trial was delivered in March 2016. This verdict and the judge's comments on the honesty and credibility of the complainants brought renewed calls for the government to consider justice reforms that would bring greater compassion, support, and sensitivity to survivors navigating the criminal justice system.

- In November 2014 the first of what would end up being dozens of women came forward with allegations of sexual assault by Bill Cosby – yet again bringing issues of complacency towards sexual violence and the experiences of survivors to the forefront.

[1] It's Never Okay, page 9.

- Also in 2014, questions again arose about the College's use of gender based restrictions for physicians with a finding of professional misconduct related to the sexual abuse of patients and whether there is truly a culture of "zero tolerance" across regulatory colleges.

- Following and concurrent with these events, the provincial government started rolling out a series of announcements and new initiatives in late 2014.

CURRENT STATUS:

Government Initiatives

- In October 2014, the Minister of Health, Dr. Eric Hoskins, announced a review of the *Regulated Health Professions Act* with a focus on its sexual abuse provisions.

- On December 4, 2014 the Premier announced a package of initiatives to raise awareness of sexual violence and harassment, enhance prevention initiatives, and improve supports for victims. Included in this announcement was a commitment to bring forward an action plan to enhance support for victims of sexual violence.

- On December 11, 2014, a Select Committee on Sexual Violence and Harassment was struck at Queen's Park following PC MPP Laurie Scott's Motion to establish the Committee. The final report was delivered a year later.

- On December 16, 2014, Minister Hoskins followed through on his October commitment and announced a task force to review and modernize laws that deal with the sexual abuse of patient by health professionals. Marilou McPhedran and former Ontario chief justice Roy McMurtry (who later resigns) are appointed as co-chairs and Registered Nurse Sheila Macdonald is also appointed to the committee.

- On March 8, 2015 the government released *It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment*. The plan is aimed at taking concrete steps to help change attitudes, provide more supports for survivors, and make workplaces and campuses safer and more responsive to complaints about sexual violence and harassment. The government also commits to increased funding of $41 million over three years to support the plan's implementation.

- It's Never Okay included thirteen commitments, most notably:

    - a multi-media public education campaign to help change behaviours when witnessing sexual violence or harassment;

- introduction of legislation to strengthen provisions related to sexual violence and harassment in the workplace, on campus, in housing, and through the civil claim process;

- strengthen supports provided by hospital-based Sexual and Domestic Violence Treatment Centres;

- develop tools and identify best practices to support a compassionate and sensitive response from law enforcement to encourage more survivors to report sexual assaults; and

- creation of a permanent Roundtable on Violence Against Women with representatives from more than 20 organizations to provide ongoing advice to the government.

- In October 2015, the government introduced *Bill 132: Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment)*, as promised in *It's Never Okay.*

- Bill 132 establishes substantial new obligations on employers, educational institutions, and landlords and increases support available to victims of sexual assault. Specifically, it requires post-secondary institutions to develop a stand-alone sexual violence policy. It also creates specific duties for all employers to develop policies and procedures to prevent sexual harassment in the workplace and includes a duty to investigate incidents and complaints. Bill 132 received Royal Assent on March 8, 2016.

- On the same day that the government passed the *Sexual Violence and Harassment Action Plan* Act, they also released the 2015-16 Progress Report on *It's Never Okay.* The Report outlines the steps the government had taken in the past year to deliver on the promises outlined in the initial report.

- On February 23, 2016, the government released *Walking Together: Ontario's Long-Term Strategy to End Violence Against Indigenous Women*. Ontario will spend $100 million over the next three years on initiative outlined in the strategy. The majority of the funding ($80 million) will be directed at programs to support indigenous families in crisis and help communities deal with the effects of inter-generational violence and trauma.

College Sexual Abuse Initiative

- In December 2014, the College Council launched an initiative to ensure that we are doing all that we can to support and protect patients from sexual abuse by physicians.

- In this initiative, the College has looked carefully at what we as an organization can do to enhance and improve our legislative framework and our processes to protect and support patients.

- Highlights of the College's work include the development and adoption of Sexual Abuse Principles that serve as the foundation for the College's approach to physician sexual abuse and patient protection; a request for legislative change; the assessment of a range of activities including use of gender-based restrictions and information sharing with the police; enhancements to patient support and access including an educational brochure and *What to Expect During Medical Encounters;* and the development of a framework and plan for education and training opportunities related to sexual abuse and maintaining boundaries for physicians, medical trainees, College Council, Committees, and staff.

- As part of this work, the College asked government whether their pilot program designed to provide free independent legal advice to sexual assault survivors whose cases are proceeding toward a criminal trial includes victims of sexual assault who may be testifying in our processes. The College continues to explore the issue.

- The College's work on our sexual abuse initiative has been broadly communicated to the government, opposition parties, the public and media.

NEXT STEPS:

- Staff will continue to monitor developments in this area, both broadly speaking, as well as specifically in relation to the Sexual Abuse Task Force's report. Council will be kept apprised of this activity.

CONTACT: Louise Verity, ext. 466
Miriam Barna, ext. 557

DATE: May 12, 2016

Grey Areas
SML Steinecke Maciura LeBlanc Barristers & Solicitors
A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

"Oops, did I just hit 'Reply All'?" - Electronic Communications by Board / Council Members

by Richard Steinecke
April 2016 - No. 205

Almost every regulator uses electronic communications to conduct business. It is common for secure portals on the regulator's website to be used for sensitive information and for "regular" email to be used for less sensitive matters.

It is tempting for Board or Council and Committee members to communicate electronically as well (typically, but not exclusively by email). These communications can be formal (e.g., sending a draft of a document to all participants to send comments to a specified staff person) or informal (e.g., two participants texting each other with respect to voting on an upcoming motion). While the convenience of such electronic communications is undisputable, there are a number of potential pitfalls that need to be taken into account by regulators.

Public Meetings: Many Boards and Councils are required by law to debate matters transparently at an open, public meeting. To the extent that substantive discussion occurs by private electronic communications, this value is undermined and the legal requirement for public debate could be breached.

Including Everyone: Often electronic communications exclude certain Board or Council members. Emails and text messages are often sent to only one or two colleagues. In fact, the purpose of many such communications is to conduct a private conversation. Even if fellow Board or Council members are not omitted, such electronic communications can be used to exclude regulatory staff from the exchange.

Coordinated Agenda: Most Boards and Councils have a formal process for prioritizing agenda items. This ability to rank items and focus on important matters is undermined if an individual Board or Council member can initiate a discussion on matters of personal interest. In fact, some would call this action "hijacking" the agenda.

Ensuring Considered Discussions: Significant policy issues require considerable research and analysis of need, mandate, information, options and application of decision criteria (i.e., public interest, right touch regulation, risk management, etc.) by Committees and staff. This necessary study is often lost in private electronic communications. Impulsive, unconsidered and poor decision-making can result.

Decorum: Where electronic communications take place during actual meetings (or even when they are simply referred to at meetings) an appearance of disrespect of other Board or Council members (or of staff and observers) is created.

Confidentiality: Confidentiality is difficult to maintain when private electronic communications are used. It is easy for the wrong person to be copied or for a third party (e.g., a family member, co-worker, hacker) to gain access to the device or record. In addition, the safeguards implemented to prevent the interception of electronic information by a regulator are often absent from personal devices used by Board or Council members.

FOR MORE INFORMATION
This newsletter is published by Steinecke Maciura LeBlanc, a law firm practising in the field of professional regulation. If you are not receiving a copy and would like one, please contact: Richard Steinecke, Steinecke Maciura LeBlanc, 401 Bay Street, Suite 2308, P.O. Box 23, Toronto, ON M5H 2Y4, Telephone: 416-626-6897 Facsimile: 416-593-7867, E-Mail: rsteinecke@sml-law.com

Grey Areas
A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION
SML Steinecke Maciura LeBlanc Barristers & Solicitors

Documentation: Rarely is there is a central record of private electronic communications. Such a record, kept by regulatory staff, is important to explain the rationale for decisions when they are challenged (see: *Sobeys West Inc. v. College of Pharmacists of British Columbia, 2016 BCCA 41*). In addition, there are times when the regulator is legally required to provide disclosure all of its documents on an issue (e.g., in litigation) which is not possible when there are private electronic communications that are not copied to staff.

Inappropriate Comments: There is something about the impersonal, immediate nature of electronic communications that fosters flippant, ill-considered and downright inappropriate comments. Such comments can come back to haunt its maker and the affiliated regulator.

That said, electronic communications are commonly used. Regulators should undertake a candid risk assessment of their current circumstances to assess whether these concerns can be avoided entirely. It may be unrealistic to think that some regulators can prohibit all electronic communications by its Board or Council members. So it may be more effective to negotiate a mutually agreeable set of protocols within the Board or Council than to ban it, with the result that it is simply driven underground. At least then the communications are more likely to be thoughtful, inclusive, confidential and documented.

For example, protocols could be developed to cover the following topics:

1. Electronic communications should not be used to advocate for a position on a matter that is to be discussed at a public meeting.
2. All members of the group should be copied on all electronic communications relating to decisions to be made by that group.
3. Electronic communications should not be used to introduce a new topic to a group (except through official channels requesting to have the topic added to the agenda).
4. Electronic communications should supplement, but not replace, the usual policy development process for the group.
5. Electronic communications cannot be used during a meeting.
6. No confidential information should be mentioned in an insecure form of electronic communication and no secure information should be accessed on a shared or unprotected device. In the alternative, the regulator could provide secure devices that are to be used solely and exclusively for electronic communications by Board and Council members for regulatory business.
7. A designated staff person should be copied on all electronic communications so that it can be stored in the regulator's system.
8. All participants should be reminded frequently of the need for professionalism in electronic communications. If it would not be said at the meeting, it should not be included in the communication.

It is important to consciously address this issue so that an informed and shared approach can be adopted by the regulator.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: Policy Report

ITEMS FOR INFORMATION

External Consultation Responses:

1. College of Optometrists of Ontario: Proposed Amendments to the *Optometry Act, 1991,* Designated Drugs and Standards of Practice Regulation under the *Optometry Act, 1991,* and Controlled Acts Regulation under the *Regulated Health Professions Act, 1991*

2. Ministry of Health and Long-Term Care, Public Consultation Paper: *Strengthening Ontario's Smoking and Vaping Laws*

Updates:

3. Marijuana for Medical Purposes – Legislative Update

4. Laboratory Services Expert Panel Final Report

5. Patient Care Groups: A New Model of Patient-Based Primary Health Care for Ontario

6. Patient's Frist: A Proposal to Strengthen Patient-Centred Care in Ontario (Ministry of Health and Long-Term Care)

7. Minister's Roundtable on Pan-Canadian Pharmacare

8. Scope of Practice Consultation

9. Policy Status Table

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1. College of Optometrists of Ontario: Proposed Amendments to the *Optometry Act, 1991,* Designated Drugs and Standards of Practice Regulation under the *Optometry Act, 1991,* and Controlled Acts Regulation under the *Regulated Health Professions Act, 1991.*

- Since 2011, Ontario optometrists have been authorized to prescribe drugs for the treatment of conditions of the eye and vision system. The Drugs and Standards

of Practice Regulation (Schedule 1) under the *Optometry Act, 1991* lists the drugs optometrists can currently prescribe.

- The College of Optometrists of Ontario (COO) proposed amendments to the regulations that would abandon the list of drugs and replace it with the authority to prescribe *all* topical and oral drugs that have been approved by Health Canada within the scope of practice of optometry. The COO states that this change would bring Ontario in line with recent changes in Alberta and Saskatchewan, and the majority of US states.

- In addition, the COO is proposing other amendments that, if approved, would:

    - Allow optometrists to dispense drugs for the sole purpose of trial/sample therapy;
    - Allow optometrists to remove superficial foreign bodies from the cornea; and
    - Specify that optometrists can use diagnostic ultrasound as a prescribed form of energy for the performance of corneal pachymetry or A/B scan ocular ultrasonography.

- The COO held a consultation on these proposed amendments between February and March, 2016.

- A response was drafted with the assistance of Drs. Jim Wilson and Nathan Roth (Medical Advisors) and Dr. Edward Margolin, Ophthalmologist (ICRC Member).

- The draft response was reviewed by the Executive Committee, and the final response was submitted to the COO on March 29th, 2016 (the final response is attached as **Appendix A**).

- In summary, the response states that the CPSO is generally supportive of most of the proposed amendments, but articulates key concerns raised by some provisions with respect to patient safety.

2. Ministry of Health and Long-Term Care, Public Consultation Paper: *Strengthening Ontario's Smoking and Vaping Laws.*

- The Ministry of Health and Long-Term Care (MOHLTC) is proposing changes to the regulations made under the *Smoke-Free Ontario Act, 1994*, and the *Electronic Cigarettes Act, 2015*, that would restrict the public consumption of medical marijuana, as well as sale and display of e-cigarettes.

- To support these changes, the MOHLTC released a public consultation paper, articulating key issues and proposed direction that will be incorporated into the ultimate regulations.

- These proposed changes seek to recognize the potentially harmful and psychoactive properties of second hand marijuana smoke and vapour.

- More specifically, the MOHLTC is proposing to:

    - Expand the *Smoke-Free Ontario Act's* "no smoking rules" to apply to medical marijuana;
    - Prohibit the use of e-cigarettes (including the use of vaporizers to consume medical marijuana) in all enclosed public places;
    - Permit parents, guardians, and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
    - Expand the definition of "e-cigarette" to include "e-substance";
    - Expand the list of places where e-cigarettes (including vaporizers) are prohibited for sale; and
    - Establish rules for the display and promotion of e-cigarettes at places where they are sold.

- The College was invited to provide comments on the public consultation paper. It is anticipated that the College will also have an opportunity to provide comments on any regulation amendments the MOHLTC develops in accordance with the consultation paper.

- In order to accommodate the MOHLTC's short timelines, the College's feedback was finalized with Dr. Joel Kirsh. The College's response was submitted to the Ministry on April 26, 2016 (the response is attached as **Appendix B**).

- In summary, the College's response expressed general support for restricting the public consumption of medical marijuana in places where others may be exposed to second-and smoke or vapor; however, it was also noted that any restrictions must be balanced against the fact that courts have upheld the right of patients to access and consume marijuana for medicinal purposes.

3. Marijuana for Medical Purposes – Legislative Update.

- The federal *Marijuana for Medical Purposes Regulations (MMPR)* establish the legal framework that permits patients to obtain a legal supply of marijuana for medical purposes in Canada.

- The College's current Marijuana for Medical Purposes policy reflects the requirements set out in the MMPR.

- Since the policy was approved, there have been significant developments in the regulatory landscape which have implications for the policy and raised questions about the future of the MMPR:

1. Regulations now permit the sale of cannabis oil and fresh buds and leaves in addition to dried marijuana.

    - Under the original MMPR, licensed producers were only permitted to sell marijuana in a dried form.
    - In response to legal challenges, this restriction was struck down by the Supreme Court of Canada, and an exemption was issued which permits licensed producers to sell cannabis oil and fresh marijuana buds and leaves.
    - Because the current policy reflects the original language of the MMPR, it does not set out guidance or acknowledge the possibility of prescribing marijuana in a non-dried form.

2. Courts have struck down the ban prohibiting patients from growing their own supply of medical marijuana.

    - Under the MMPR, patients are only permitted to obtain medical marijuana directly from a licensed producer (i.e. they are specifically prohibited from growing their own).
    - This restriction was recently struck down in a Federal Court decision which effectively declared the entire MMPR invalid. This decision ultimately gave the federal government 6 months to develop a new, Charter-compliant regulatory structure.
    - At this point, it is unclear how the government will respond. While they may appeal the decision, it is possible that they will seek to introduce new regulations that will significantly alter the medical marijuana framework.
    - Any significant changes to the current regulations would also require revisions to the College's policy.

- These developments and their implications for the College have been discussed with Dr. Marc Gabel and Carolyn Silver, both of whom were involved in the initial policy development process.

- The Executive Committee was provided with this information at their April, 2016 meeting and provided with the proposal that policy revisions be postponed until after the Federal government responds to the Federal Court decision. The rationale is that should new regulations be introduced, these may require further and more substantial policy changes.

- Should questions arise in the interim regarding fresh marijuana and cannabis oil, existing expectations in the policy will be used to guide physician conduct.

- Staff will continue to monitor these developments to determine whether further consideration or action is needed, and all new developments will be communicated to Council at future meetings.

4. Laboratory Services Expert Panel Final Report.

- The Laboratory Services Expert Panel was convened in 2015 to conduct a review of Ontario's community laboratory sector, and to provide recommendations to the Minister of Health and Long-Term Care to improve and modernize laboratory sector funding and services.

- The Panel released their final report on November 12th, 2015 and concluded that there are a number of opportunities to improve the accountability, transparency, effectiveness and value of the supply of laboratory services. The Panel also noted there are opportunities to better manage the demand for laboratory services, particularly with respect to appropriate physician utilization of laboratory services.

- A total of 15 recommendations were made by the Panel that fall into one of 4 categories: funding model, funding model supports, broader community lab supports, and the broader Ontario laboratory sector.

- The Panel's recommendations are currently not binding, and it is unclear whether the Minister intends to implement any of the recommendations made.

- Some of the recommendations, if implemented by government in their current form, would have implications for the CPSO. Two such recommendations are highlighted for Council's information.

- Recommendation #11, if implemented, could result in the CPSO being asked to assume responsibility for the accreditation of laboratories in Ontario, though the language used by the Panel is unclear. As noted, this recommendation focuses on establishing independence of the IQMH from the OMA. The Panel sets out two potential options for the IQMH going forward: one is to establish the IQMH as a stand-alone entity; the second is for IQMH to be placed in corporate alignment with the CPSO.

- The extent to which the CPSO would be involved depends on how the Panel's term 'corporate alignment' is interpreted.

- Recommendation #15E, if implemented, could result in the CPSO being asked to assume responsibility to provide oversight for the quality of in-office testing conducted by physicians at the point-of-care.

- The Panel has recommended a 3 year implementation timeline of 2015- 2018 for reform if the Minister moves forward on implementing any recommendations.

- The Government's response to the Final Report will be monitored for any movements toward implementation. Council will be kept apprised of any developments.

5. Patient Care Groups: A New Model of Patient-Based Primary Health Care for Ontario.

- The Ministry of Health and Long-Term Care has struck a Primary Health Care Expert Advisory Committee as part of its work on primary care reform. The Expert Advisory Committee has released a report, *Patient Care Groups: A new model of population based primary health care for Ontario* (better known as the Price Report).

- The principal recommendation in the Report is to improve Ontario's primary care system through the creation of sub-LHIN boards called Patient Care Groups (PCGs).

- The proposed PCGs would be structured around geographic zones, similar to school districts. Patients within each zone would be assigned a primary care provider, either a physician or a nurse practitioner. Patients could move from one PCG to another through transfer payment agreements.

- The PCGs would be managed by fund-holding boards with community and physician representation. Each PCG would hold an accountability agreement with their LHIN and manage and commission primary care services within their zone. Primary care providers would be under contract to their PCG, who would commission and pay the primary care providers for their services.

- Adopting the reforms proposed in the Price Report would have an overall positive effect on the patient experience. However, reactions to the report among members of the profession and professional organizations have been negative or moderate due to concerns regarding perceived inefficiencies arising from an additional layer of bureaucracy and fears of increased physician workload. The Ministry's *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario,* a summary of which follows, is a much "softer" approach than was recommended by the Price Report, but was clearly informed by it.

- The Price Report will be considered in the context of the proposed work relating to Continuity of Care.

- Council will be kept apprised of any further developments relating to the Price Report and the government's efforts in relation to primary care reform.

6. Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario (Ministry of Health and Long-Term Care).

- The Ministry of Health and Long-Term Care has released a discussion paper *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

which identifies gaps and shortcomings with the health care system and proposes significant structural solutions in response.

- The discussion paper was released in December 2015 and continues to build on earlier commitments spelled out in the *Patients First: Action Plan for Health Care* and *Ontario's Action Plan for Health Care* reports, which are all part of the Ministry's broader primary care reform efforts. It also followed the release of an earlier report by the Ministry's Primary Health Care Expert Advisory Committee titled *Patient Care Groups: A new model of population based primary health care for Ontario*. (summarized directly above)

- The discussion paper recommends increasing the oversight and authority of the Local Health Integration Networks (LHINs) in order to: more effectively integrate services and ensure greater equity by bringing all health service planning and performance monitoring, including primary care, under one authority; improve access to timely primary care and improve links between primary care and other health care services; increase consistency and accessibility with respect to home and community care; and, strengthen links between public health units and the LHINs to better integrate population and public health with other health services.

- While concrete implications to the public, our members, or to the College are difficult to offer without more detail, if adopted it is likely that there will be significant changes to the coordination and integration of primary care with the broader health care system and that there will be improvements in the delivery of integrated and patient-centred care that may improve the continuity of care across the system. However, these changes also have the potential to impact physician hours and work-load.

- As this discussion and the changes that may flow from it are relevant to the College's own work relating to the development of a new Continuity of Care policy (an update and proposal relating to this work is provided under a separate briefing note), staff will continue to watch for any decision or developments that may impact this work.

7. Minister's Roundtable on Pan-Canadian Pharmacare.

- The *Ministers' Roundtable on Pan-Canadian Pharmacare, Summary Report Prepared by Health Quality Ontario*, was released in July 2015.

- The roundtable was conducted in June 2015 and involved Ministers of Health from six other provinces and the Northwest Territories.

- The Ministers discussed solutions to dealing with problems in the existing system. These problems include the low numbers of Canadians who have pharmacare coverage through insurance and the rising cost of pharmaceuticals.

- The Ministers found that there was broad consensus on a number of points. They accepted that there are too many Canadians with insufficient coverage, Canadians could spend less on prescription drugs and get better care, and that the present situation could get worse without reform.

- Other points were more contentious. For instance, the Ministers were unsure if reform should be incremental or dramatic; if public pharmacare should be "first dollar" (no deductible) or if there should there should be some private contribution; what role, if any, private actors should be called upon for consultation in pursuing the reform; or what the reaction from the public or employers might be to any such reform.

- Implications to the College and its members are unclear at this time. The Roundtable was merely a discussion and did not lead to an action plan for reform or any policy statements. Staff will continue to watch for any developments that may impact the College's activities.

8. Scope of Practice Consultation.

- The College is currently holding a consultation on physician scope of practice. As part of this consultation, the concept of scope of practice is being looked at broadly and the College's *Changing Scope of Practice* policy is also being reviewed.

- The goal of the broader review is to support a pan-Canadian Working Group, representing Medical Regulatory Authorities, CPD professionals, researchers and national organizations, that has formed to focus on understanding and using scope of practice as an important contributor to effective medical regulation, patient safety and physician performance. Feedback provided on the broader topic of scope will be provided to the national Working Group in aggregate form to inform the national project.

- The goal of the policy review is to update the College's *Changing Scope of Practice* policy. The policy sets out expectations for physicians who have changed or intend to change their scope of practice and the requirements of physicians in demonstrating their competence in the new area of practice.

- The consultation is taking place from April 4 to June 2, 2016 and has been coordinated to coincide with the national work.

- As of the Council submission deadline (May 12, 2016), the College received a total of 147 responses to this consultation. These include 34 comments on the

College's online discussion page (28 physicians and 6 anonymous), and 113 online surveys[1] (All of these respondents were physicians)[2].

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website shortly after the close of the consultation.

- Survey respondents provided a variety of feedback on a range of topics related to scope of practice. A few of the key themes that have emerged throughout the consultation are described below:

Feedback on the College's *Changing Scope of Practice* Policy

- Broadly speaking, stakeholders expressed support for the current policy. In particular, the majority of online survey respondents felt that the current policy was clearly written, easy to understand, and well organized.

- The majority of physician respondents indicated that it is clear from the current policy that a physician must meet certain expectations before they can practise in a new area.

- Physicians also provided feedback indicating that they know when they would be changing their scope of practice significantly.

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

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

- A number of physician respondents also suggested that the following elements should also be considered when defining a physician's scope of practice:

    - Values including beliefs, religion, interests, goals, lifestyle, and remuneration;
    - Personal characteristics such as age, health, physical ability, ethnicity, languages spoken, and family; and
    - Resources such as access to specialists, supports, and other health care professionals.

[1] 130 respondents started the survey, but of these, 17 did not complete any substantive questions – leaving 113 for analysis.
[2] The other Canadian Medical Regulatory Authorities were invited to provide their members with a link to this consultation but the majority of the feedback has come from stakeholders within Ontario.

National work around scope of practice

- When asked about support for a single mechanism to collect information related to scope of practice and manage its use, with full consideration of confidentiality and privacy, the majority of survey respondents expressed their support.

- About two thirds of survey respondents also indicated that they think a national database containing aggregate information about physicians' scopes of practice would be valuable.

- Of those that did not support this initiative, a few expressed concerns about how the data would be used as well as concern that different organizations would be interested/ find value in different types of data related to scope of practice and thus data collection should be specific to the needs of each organization.

General Feedback

- Many physicians suggested that the College should strengthen the requirements in order for a physician to change their scope of practice in certain areas of medicine, including:

    - Family physicians practising psychotherapy;
    - Family physicians practising in dermatology or cosmetic medicine;
    - Physicians working in addictions and prescribing methadone;
    - Physicians practising in chronic pain management and interventional pain management;
    - Physicians practising reproductive endocrinology and infertility.

- All feedback received will be carefully reviewed and used to evaluate and revise the current policy as well as contribute to work happening at the national level.

- Once a draft revised policy has been developed, it will be presented to the Executive Committee and Council for consideration.

9. 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 C**. 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.

CONTACTS: Andréa Foti, ext. 387

DATE: May 12, 2016

Appendices:

Appendix A: Response to the College of Optometrists.

Appendix B: Response to the Ministry of Health and Long-Term Care.

Appendix C: Policy Status Table.

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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(800) 268-7096

March 29, 2016

Dr. Paula Garshowitz
Registrar
College of Optometrists of Ontario
65 St. Clair Ave. E., Suite 900
Toronto, ON M4T 2Y3

Dear Dr. Garshowitz:

Thank you for requesting the College of Physicians and Surgeons of Ontario's (CPSO) feedback on the College of Optometrists of Ontario's (COO) proposed amendments to the *Optometry Act, 1991*, Designated Drugs and Standards of Practice Regulation under the *Optometry Act, 1991*, and Controlled Acts Regulation under the *Regulated Health Professions Act, 1991*. The CPSO appreciates the invitation to participate in the COO's consultation.

The CPSO values initiatives that ensure that every health care professional can work to their full scope of practice and that encourage the inter-professional and collaborative delivery of health care. The CPSO is generally supportive of most of the proposed amendments, but is concerned that some may exceed the scope of practice for optometrists, putting patients at risk. Bearing in mind that patient safety is of the utmost importance, the CPSO offers the following comments regarding each of the proposed amendments.

Proposed Amendments re: Prescribing and Dispensing Drugs

The CPSO has considered the amendment to the *Optometry Act, 1991* that authorizes the prescribing or dispensing of a drug to be administered or taken topically or orally (instead of prescribing from a drug list) and appreciates that limiting the prescribing of drugs to those on a list can be problematic given that it would prevent the prescribing of the newest drugs that may become the standard of care because the list would be difficult to amend and keep up-to-date. However, the CPSO is concerned with broadening the scope of drugs that can be prescribed to *all* topical and oral drugs that have been approved by Health Canada within the scope of practice of optometry. Given the broad spectrum of drugs this could include, not *all* of the drugs may be directly relevant to the day-to-day practise of optometry. As such, optometrists may be authorized to prescribe drugs, particularly new drugs, they have never prescribed before and do not have the knowledge, skill and judgment to prescribe, putting patients at risk. Instead, the CPSO suggests that the COO consider permitting categories of drugs that can be prescribed, such as: anti-infective agents, anti-inflammatory agents, mydriatics, anti-allergic agents, etc. and restricting optometrists from prescribing specific types of drugs such as oral steroids and oral immunosuppressants. This approach would be less

prescriptive than the current drug list, as the COO would not be specifying the individual drugs that could be prescribed within each category, and would help ensure the drugs optometrists are authorized to prescribe would be directly relevant to the practice of optometry. This may help mitigate the problems associated with the current drug list, while ensuring patient safety is not compromised.

Patient safety considerations are paramount when any regulated health care professional has the authority to prescribe and dispense drugs. Appropriate education and training is particularly important given the potential risks to patient safety that are inherent in prescribing and dispensing drugs. The CPSO's support for optometrists prescribing specified categories of drugs and dispensing drugs for trial/sample therapy would be contingent on optometrists having the appropriate education and training in pharmacology to do so in an a safe and effective manner. The CPSO notes that education and training in pharmacology 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. The CPSO notes that if optometrists are now permitted to prescribe a broader range of drugs (e.g. specified categories of drugs instead of prescribing from a drug list) and to dispense drugs, they may require some additional education and training in pharmacology in order to do so safely and effectively. In particular, appropriate education, training and clinical judgment would be required to ensure optometrists are able to determine which specific drug(s) from a category should be prescribed.

The CPSO's Prescribing Drugs policy sets out expectations for physicians who prescribe drugs and the CPSO's Dispensing Drugs policy sets out expectations for physicians who dispense drugs. The policies contain a number of requirements physicians are expected to comply with in order to prescribe and dispense in a safe and effective manner. To ensure patient safety is maintained, any health care professional who prescribes and dispenses drugs should do so in a manner that is consistent with the CPSO's expectations for physicians. The CPSO's support for optometrists prescribing specified categories of drugs and dispensing drugs for trial/sample therapy would be contingent on this.

The CPSO notes that the proposed amendments to the Designated Drugs and Standards of Practice Regulation under the *Optometry Act, 1991* include stating the common requirements for prescribing. These requirements are generally consistent with the expectations set out in the CPSO's Prescribing Drugs policy, however, the COO may also want to consider including the following in regulation or policy:

- Requirements regarding consent to treatment and their applicability to prescribing.
- Clarifying what information must be included on a prescription.
- Clarifying the different ways in which a prescription can be authorized (e.g. verbal, signature, electronic).

- Stating that patients must receive 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.
- Stating expectations regarding prescription refills.

The CPSO also notes that the proposed amendments to the Designated Drugs and Standards of Practice Regulation under the *Optometry Act, 1991* include stating the common and specific requirements for dispensing. The requirements are generally consistent with the expectations set out in the CPSO's Dispensing Drugs policy, however, the COO may also want to consider including the following in regulation or policy:

- Clarifying that optometrists must use proper methods of procurement in order to be assured of the origin and chain of custody of drugs being dispensed.
- Clarifying that drugs must be stored securely and appropriately to prevent spoilage (e.g. temperature control where necessary).
- Requiring that optometrists have an audit system in place in order to identify possible drug loss.
- Requiring that appropriate packaging be provided.
- Requiring that optometrists dispose of drugs that are unfit to be dispensed (expired or damaged) safely and securely and in accordance with any environmental requirements.

The CPSO understands that the sale of drugs will remain prohibited and supports this position, given that sales can give rise to conflicts of interest. The COO may wish to explicitly state this prohibition in regulation.

The CPSO is supportive of the prohibition on prescribing/dispensing controlled substances as this is extremely complex, especially given the associated significant patient and public safety risks. Access to prescribing/dispensing controlled substances should not be provided to additional health care professions until prescribers/dispensers are able to get real-time access to patient medication histories.

The CPSO is supportive of the proposed amendments to the Designated Drugs and Standards of Practice Regulation under the *Optometry Act, 1991* that restrict when oral secretagogues and oral carbonic anhydrase inhibitors (CAIs) or steroids can be prescribed.

Proposed Amendments re: Removing Superficial Foreign Bodies from Cornea

The CPSO is generally supportive of the proposed amendment to the *Optometry Act, 1991* that authorizes optometrists to remove *superficial* foreign bodies from the *surface* of the cornea based on the understanding that needles and bores will not be involved and irrigation will be used. However, it may be difficult for optometrists to know where the foreign body is located in the cornea and whether the foreign body would go beneath the corneal layer. If there are

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

surface of the cornea, as these would be more complex and require surgical training, which optometrists do not have.

Proposed Amendments re: Application of Soundwaves for Diagnostic Ultrasound

The CPSO is supportive of the proposed amendments to the Controlled Acts Regulation under the *Regulated Health Professions Act, 1991* that authorize optometrists to apply soundwaves for diagnostic ultrasound in order to perform corneal pachymetry or A/B scan ocular ultrasonography. The CPSO's support for optometrists performing these forms of diagnostic ultrasonography would be contingent on optometrists having the appropriate education and training to do so in a safe and effective manner.

In conclusion, the CPSO is generally supportive of most of the proposed amendments, but is concerned that some may exceed the scope of practice for optometrists, putting patients at risk. More specifically, the CPSO is supportive of the proposed amendments regarding prescribing and dispensing provided that prescribing is limited to specified categories of drugs, optometrists have any additional education and training in pharmacology that may be required in order to prescribe a broader range of drugs (e.g. specified categories of drugs instead of prescribing from a drug list) and to dispense drugs in a safe and effective manner, and prescribing and dispensing is done in a manner that is consistent with the CPSO's expectations for physicians. The CPSO is generally supportive of the proposed amendments regarding removing *superficial* foreign bodies from the *surface* of the cornea provided that they are irrigated, but believes that patients would be put at risk if optometrists were authorized to remove foreign bodies from *in or below the surface* of the cornea as surgical training would be required. Finally, the CPSO is supportive of the proposed amendments regarding soundwaves for diagnostic ultrasound.

Should you require any further input or wish to discuss the above further, please do not hesitate to contact me. Thank you again for the opportunity to participate in your consultation.

Yours very truly,

Rocco Gerace MD
Registrar

Appendix B

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Rocco Gerace MD
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April 26, 2016

Population and Public Health Division
Ministry of Health and Long-Term Care
777 Bay Street, Suite 1903, 19th Floor
Toronto, ON M7A 1S5

Re: Public Consultation Paper: *Strengthening Ontario's Smoking and Vaping Laws*

The College of Physicians and Surgeons of Ontario (the College) appreciates the opportunity to comment on the Ministry of Health and Long Term Care's (MOHLTC) proposal to strengthen Ontario's smoking and e-cigarette (vaping) laws with respect to medical marijuana.

The College is strongly supportive of the MOHLTC's efforts to protect Ontarians from the harmful effects of second-hand smoke and vapour, and recognizes the need for clear rules around the consumption of medical marijuana in public places.

In accordance with the federal *Marihuana for Medical Purposes Regulations* (MMPR), the College sets out expectations for physicians who prescribe marijuana in the Marijuana for Medical Purposes policy.

The College notes that, in the interest of protecting public health, the MOHLTC's public consultation paper: *Strengthening Ontario's Smoking and Vaping Laws* proposes to apply the same "no-smoking" framework that is applied to tobacco products to medical marijuana.

As the second-hand smoke and vapour produced by medical marijuana may cause some of the same harmful effects as tobacco (in addition to their psychoactive properties), the College is supportive of restricting the consumption of medical marijuana in public places where others may be exposed; however, these restrictions must be balanced against the fact that courts have upheld the right of patients to access and consume it for medicinal purposes.

The College's specific comments with respect to the public consultation paper are set out below, and are organized by section.

Sections 1 and 2: Expanding no smoking rules to apply to medical marijuana / Prohibiting the use of e-cigarettes in enclosed public spaces, enclosed workplaces, and other specified outdoor areas.

The College notes that both sections contemplate the possibility of patients smoking or vaporizing medical marijuana in a car, provided that there is no one present who is under the age of 16. Given the psychoactive properties of marijuana and its second hand smoke and vapour, it should never be considered acceptable to smoke or vaporize marijuana in a motor vehicle.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Section 3: Permitting parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes.

The consultation paper appears to propose prohibiting the sale of e-cigarettes, including vaporizers, to anyone under the age of 19, while permitting parents, guardians or caregivers to supply e-cigarettes to minors for medical purposes.

While the College is aware of specific risks that arise when prescribing to younger patients[1], there is currently no legal minimum age for obtaining authorization to possess medical marijuana, and individuals under the age of 19 may be legally authorized by their physician to consume it, provided that prescribing takes places in accordance with the policy. The decision to pursue treatment with medical marijuana may be one that is made directly between the patient and their physician[2], without any involvement of a parent, guardian, or caregiver.

As evidence suggests that using a vaporizer may be less harmful than smoking, prohibiting patients under the age of 19 from legally obtaining or purchasing a vaporizer may effectively force them to consume marijuana in a manner that is more harmful to their health (i.e. smoking).

Furthermore, permitting parents, guardians, or caregivers to supply a vaporizer to the patient would not be an appropriate alternative, as this would effectively require patients to disclose their personal health information in order to receive treatment. This approach would fail to respect patient autonomy or uphold the patient's legally protected right to privacy.

The College hopes that these comments are helpful in refining the MOHLTC's approach to strengthening Ontario's smoking and e-cigarette (vaping) laws.

Yours very truly,

Rocco Gerace MD
Registrar

[1] Specific expectations for prescribing marijuana to patients under the age of 25 are set out in the College's *Marijuana for Medical Purposes* policy. Among these expectations is the requirement that all other conventional therapeutic options have been attempted, and that they have failed to alleviate the patient's symptoms.
[2] Provided they have capacity to make the decision in accordance with the *Healthcare Consent Act, 1996*.

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
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. The draft policy was considered at the December 2015 Council meeting and was approved for release to consult externally. The consultation ended on February 12, 2016. The feedback received has been reviewed and revisions to the draft policy made in response. The revised draft policy will be presented to Council at the May, 2016 meeting for final approval.	2016
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 May 31 meeting of Council.	2017
Changing Scope of Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation commenced on April 4. 2016. This consultation will also inform work	2017

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	and sets out requirements of physicians in demonstrating their competence in the new area of practice.	happening at the national level regarding physician scope of practice.	
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.	2017
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.	2017
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	2017

POLICY STATUS REPORT – MAY 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.	
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 *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.	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 Force on the Prevention of Sexual Abuse of Patients.	2017
Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their	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.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation will commence after the May meeting of Council.	2017

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Practice Due to Relocation			
Physicians and Health Emergencies	The purpose of this policy is to reaffirm the profession's commitment to the public in times of health emergencies.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation will commence following the meeting of Council in May.	2017
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	This policy is currently under review and the initial stages of the policy review are underway. A preliminary consultation will be commencing after the May 31, 2016 meeting of Council. This review will be coordinated with any work that is undertaken as a part of the development of a new policy on *Continuity of Care*.	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	The Executive Committee has directed staff to undertake preliminary work on the issue of continuity of care, including an analysis and recommendation regarding the development of a new policy. A *Continuity of Care Planning and Proposal* document will be presented to Council for review and discussion at the May, 2016 meeting. Any work relating to the development of this new policy will be coordinated with the *Test Results Management*	2018

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		policy review.	

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015/16	This policy provides guidance to physicians on disclosing harm to patients.
Fetal Ultrasound for Non-Medical Reasons	2015/16	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds.
Anabolic Steroids	2016/17	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)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation.
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine.
Dispensing Drugs	2016/17	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016/17	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Confidentiality of Personal Health Information	2016/17	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information. The review of this policy is currently on hold pending the introduction of new legislation by the Ministry.
Third Party Reports	2017/18	This policy clarifies the College's expectations regarding physicians' roles in and

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
		standards of care for conducting medical examinations and/or preparing reports for third parties.
Delegation of Controlled Acts	2017/18	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Medical Records	2017/18	This policy sets out the essentials of maintaining medical records.
Mandatory and Permissive Reporting	2017/18	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.
Prescribing Drugs	2017/18	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.
Social Media – Appropriate Use by Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
		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)	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making for the End of Life)	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne

POLICY STATUS REPORT – MAY 2016 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
		virus.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family Members	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNMENT RELATIONS REPORT

FOR INFORMATION

Items:

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

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1. Ontario's Political Environment

- The spring session of the Ontario Legislature is scheduled to end on June 9th, after an eleven week session.
- We are approaching the half-way point in the government's mandate and pressure is being felt by both the government and the opposition parties to make their mark in the current parliament and prepare for the next election, which in political terms, is just around the corner.
- At Queen's Park, the issues of political party fundraising practices, changes to the Ontario Drug Benefit Program and other health care funding concerns, government funding of autism services for children, and the majority sell-off of Hydro One have been the focus of considerable discussion and scrutiny.
- The liberal government has continued to face challenges and criticism around accusations of corruption, most recently around the OPP's investigation surrounding allegations of wrongdoing involving a cancelled wind energy project.

2. Current Issues of Interest

- Health care issues have been top of mind with Ontario's political parties given the tension with Ontario's doctors and hospital funding concerns.
- Broader health care reform issues have also been a focus in Ontario with the release of numerous papers and reports that outline changes across the system.
- At the end of 2015, the government released Patient Firsts: A proposal to Strengthen Patient-Centred Health Care in Ontario. This paper identifies the gaps or short comings with the health care system and proposes significant structural solutions.

- The four components addressed by the paper include: more effective integration of services and greater equity; timely access to primary care and seamless links between primary care and other services; more consistent and accessible home and community care; and stronger links between population and public health and other health services.
- The central recommendation is the proposal to significantly expand the role of local health integration networks (LHINs).
- We expect that initial legislation to implement some of these reforms will be introduced this spring or next fall.
- 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 was released in October 2015. The "Baker-Price" report recommends the creation of Patient Care Groups, based on geography that would offer access to interprofessional primary care with hours including weekends and evenings.
- Patients would retain their ability to choose their health care providers but this new organization of primary care would ensure every resident has a patient care group responsible to oversee their primary health care.
- Most recently, at the beginning of May, the government released Health Quality Ontario's Building an Integrated System for Quality Oversight in Ontario's Non-Hospital Medical Clinics.
- This report contains twelve recommendations including that a single system of oversight be developed for all of Ontario's non-hospital medical clinics and that new quality oversight legislation be established.
- This session has been relatively quiet in regards to legislation that impacts the College, with some exceptions.
- *Bill 119, Health information Protection Act, 2015* has now passed third reading and is currently awaiting Royal Assent.
- 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.
- Although the Bill has now passed through the legislative process, it must be proclaimed by the Lieutenant Governor prior to it being in force. Staff will continue to monitor any developments.
- We anticipate that the fall 2016 session of the Legislature will bring forward a robust agenda.

3. Government Relations Activities

- The College is in contact with a variety of government decision-makers including the Minister of Health and Long-Term care and his office, the opposition health critics, and MPPs from all three parties, to ensure that they have accurate and up-to-date information about the College and our activities.
- At the beginning of May, the College made submissions to both the House of Commons and Senate Standing Committees considering the federal Bill C-14, An Act to amend the Criminal Code and to make related amendments to other

Acts (medical assistance in dying). Our appearance before the Senate Committee and a new release on our recommendations was widely distributed.

- Provincially, we have worked particularly closely with government decision makers on areas of shared focus including medical assistance in dying, prevention of sexual abuse, transparency, and assisted reproduction.

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

DATE: May 12, 2016

Discipline Committee
Report of Completed Cases
May 2016

Covering cases completed between February 4, 2016 and May 12, 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 February 2016 Report to Council. The decisions are organized according to category, and then listed alphabetically by physician last name.

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

Sexual Abuse – 3 cases

1. Dr. C. Krishnalingam

Name:	Dr. Chinniah Krishnalingam
Practice:	Psychiatry
Practice Location:	Richmond Hill
Hearing:	Uncontested Facts and Penalty
Decision Date:	February 8, 2016
Written Decision Date:	April 8, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

On February 8, 2016, the Discipline Committee found that Dr. Chinniah Krishnalingam committed professional misconduct in that he sexually abused a patient; and 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.

Dr. Krishnalingam pleaded no contest to the allegations. The Committee found that:

- Dr. Krishnalingam treated Patient A on at least 26 separate occasions between May and June 2011, and during follow-up appointments in 2011 and 2012. During appointments, Dr. Krishnalingam asked Patient A insensitive and inappropriate questions about her sex life and made inappropriate comments about her appearance.
- On several occasions, Dr. Krishnalingam asked Patient A to attend the hospital on weekends when he was on call so they could be alone. He gave his personal phone number to her and asked that she call to arrange meetings while he was on call at the hospital.
- Dr. Krishnalingam grabbed and hugged Patient A on several occasions despite her clear indications on each occasion that she did not consent to physical contact. On one occasion, at the end of a session as Patient A was leaving, Dr. Krishnalingam grabbed and hugged her with both arms, pressing his chest against hers, and attempted to kiss her.

The evidence on penalty of a caution in 1996, a discipline finding of professional misconduct in 2005 for disgraceful, dishonourable and unprofessional conduct, and several prior attempts at remediation all confirmed a persistent pattern of behaviour over many years of subjecting patients to behaviour and remarks of a sexual nature.

Disposition

The Committee ordered and directed that:

- The Registrar revoke Dr. Krishnalingam's certificate of registration, effective immediately;
- Dr. Krishnalingam post security to reimburse the College for therapy funding for the patient in the amount of $16,060;
- Dr. Krishnalingam appear before the panel to be reprimanded; and
- Dr. Krishnalingam pay costs to the College in the amount of $5,000, within 30 days.

2. Dr. M. E. McIntyre

Name:	Dr. Mary Elizabeth McIntyre
Practice:	Family Medicine
Practice Location:	Chatham
Hearing:	Contested
Finding / Written Decision Date:	July 6, 2015
Penalty / Written Decision Date:	March 22, 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**

Summary

On July 6, 2015, the Discipline Committee found that Dr. Mary Elizabeth McIntyre committed an act of professional misconduct in that she engaged in the sexual abuse of a patient, in that she failed to maintain the standard of practice of the profession and she 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. McIntyre admitted the allegations in the Notice of Hearing, except for the allegation of sexual abuse of a patient, Patient Y, and the allegation of disgraceful, dishonourable or unprofessional conduct in relation to Patient Y.

The Committee found that Dr. McIntyre failed to maintain the standard of practice of the profession, and engaged in disgraceful, dishonourable or unprofessional conduct in her dealings with six patients (Patients A to F) and their families by:

- Failing to respond appropriately to requests by the College and the patients for their medical records;
- Failing to appropriately maintain patient records;
- Improperly storing vaccines, resulting in a suspension of vaccination privileges from Public Health;
- Not responding to patients' care concerns;
- Failing to appropriately make referrals for patients;
- Failing to complete forms required by patients;
- Behaving rudely to patients and discharging them without justification or notice and without following the College policy;
- Leaving the patients waiting for hours or more on one occasion;
- Failing to safeguard the patient's privacy; and
- Mismanaging appointments with specialists.

Registrar's Investigation – Clinical Care

The Registrar of the College ordered an investigation of Dr. McIntyre's practice under s.75(1)(a) of the Code. The College-retained expert concluded that Dr. McIntyre failed to maintain the standard of practice of the profession and/or engaged in disgraceful, dishonourable or unprofessional conduct with respect to her clinical care and treatment of patients, her failure to maintain boundaries, her failure to maintain proper records, her failure to comply with public health requirements including unsafe storage of vaccines, and her failure to respond in a timely way to requests for patient records. The deficiencies in Dr. McIntyre's practice and record keeping included (but were not limited to):

- The Patient Profile was frequently incomplete, making it difficult to determine the general medical health of the patient from the chart;
- The charting of medications was unusual, with a separate sheet listing medications prescribed in an alphabetized format, as a summary of the medications the patient is taking regularly, but with no diagnosis associated with the medication. There was no way of determining the amount of medication prescribed at each visit;
- The most significant concern was that the lines of professionalism and relationships were often blurred, with Dr. McIntyre showing the greatest lack of judgment in cases of patients with whom she had some type of relationship outside the doctor-patient context.

The College obtained extensive documentation from the Public Health Unit documenting Dr. McIntyre's repeated failures to comply with public health requirements and repeated breaches of public health protocols (incorrect refrigeration temperature, incorrect vaccine storage, failure to maintain log books, maintenance of expired vaccines). After attempted and failed remediation plans, Dr. McIntyre's office was

ultimately suspended from the public health programme through which physicians receive vaccines to administer to their patients.

Registrar's Investigation - Disgraceful, Dishonourable, Unprofessional Conduct

Patient X, who was a patient of Dr. McIntyre's for about 20 years, suffered from a mental illness and was recovering from substance abuse. During the course of the doctor-patient relationship, Dr. McIntyre and Patient X became close friends, and she introduced Patient X to her family, with whom he formed personal relationships.

Around 2010, in part due to their increasingly close personal relationship, Dr. McIntyre and Patient X terminated their doctor-patient relationship. Approximately 12 months after the end of the doctor-patient relationship, they began a sexual relationship.

The Discipline Committee found that Dr. McIntyre engaged in disgraceful, dishonourable, or unprofessional conduct by failing to maintain appropriate professional boundaries with Patient X during the doctor-patient relationship (by engaging in a close friendship) and after the doctor-patient relationship, by commencing a sexual relationship with him.

Sexual Abuse and Disgraceful Dishonourable and Unprofessional Conduct regarding Patient Y

The Committee found that Dr. McIntyre engaged in boundary violations with her patient, Patient Y, in that a close personal relationship existed between the two. Dr. McIntyre allowed herself to become a close friend of Patient Y, often involving her in her personal and financial affairs, including helping her with loans, financial issues, and her bank account. Patient Y often travelled with Dr. McIntyre and her children. During these trips, Dr. McIntyre and Patient Y would share a bed. Dr. McIntyre engaged Patient Y in caring for her children and performing household chores. Dr. McIntyre was found in bed together with Patient Y, both partially unclothed and in the nude on separate occasions. The Committee also found that Dr. McIntyre sexually abused Patient Y by engaging in a romantic kiss with her in November or December 2010, while Patient Y was Dr. McIntyre's patient. Patient Y was a vulnerable patient. She had been a patient of Dr. McIntyre for many years and the doctor took advantage of her position of power to become involved with her socially and ultimately, sexually.

In its decision on penalty, the Discipline Committee found that "revocation in this case is appropriate because of the nature and context of Dr. McIntyre's boundary violations with vulnerable patients which took place over years, and her breach of the trust of her patients, the public, and the profession. Revocation serves the purpose of maintaining public protection and confidence in the profession. It should also serve as a deterrent to the membership in general."

Disposition

On March 22, 2016, the Discipline Committee ordered and directed that:

- the Registrar revoke Dr. McIntyre's certificate of registration, effective immediately;
- Dr. McIntyre reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, and an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts, in the amount of $16,060.00;
- Dr. McIntyre appear before the Committee to be reprimanded; and
- Dr. McIntyre pay costs of $13,380.00 to the College within 60 days.

Appeal Notation

On August 5, 2015, Dr. McIntyre appealed the decision on finding of the Discipline Committee to the Superior Court of Justice (Divisional Court).

3. Dr. J. Peirovy

Name:	Dr. Javad Peirovy
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Contested
Finding / Written Decision Date:	July 17, 2015
Penalty / Written Decision Date:	April 27, 2016
Supplemental Penalty Reasons Date:	April 29, 2016

Allegations and Findings

- Engaged in sexual abuse of a patient - **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Found guilty of an offence that is relevant to his suitability to practise – **proved**

Summary

The Discipline Committee found that Dr. Javad Peirovy committed acts of professional misconduct in that: he engaged in the sexual abuse of patients; 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; and, he has been found guilty of an offence that is relevant to his suitability to practise.

The Discipline Committee found that Dr. Peirovy sexually abused four patients, Patient U, Patient V, Patient W, and Patient X.

Regarding Patient U, the Committee found that Dr. Peirovy placed his stethoscope directly on her nipples and cupped her breasts with his hand, that he did not have consent to touch his patient in this manner and that there was no clinical reason to

examine Patient U in this way. The cupping of her breasts with his hand and the placing of the stethoscope directly on her nipples are actions which, to the objective observer, would be construed as sexual in nature. Regardless of Dr. Peirovy's motivation, this deliberate touching of the nipples and breasts during a chest examination was a violation of Patient U's sexual integrity and constitutes sexual abuse.

Regarding Patient V, the Committee found that Dr. Peirovy placed his stethoscope directly on her nipples during the course of his examination, that he did not have consent to touch his patient in this manner and that there was no clinical reason to examine Patient V in this way. The placing of the stethoscope directly on her nipples would, to the objective observer, be construed as sexual in nature. Regardless of Dr. Peirovy's motivation, this deliberate touching of her nipples during a chest examination was a violation of Patient V sexual integrity and constitutes sexual abuse.

Regarding Patient W, the Committee found that Dr. Peirovy touched her nipples with his fingers during the course of his examination, that Dr. Peirovy did not have consent to touch his patient in this manner and that there was no clinical reason to examine Patient W in this way. The touching of her nipples, to the objective observer, would be construed as sexual in nature. Regardless of Dr. Peirovy's motivation, the deliberate touching of her nipples during a chest examination was a violation of Patient W's sexual integrity and constitutes sexual abuse.

Regarding Patient X, the Committee found that during the course of his examination Dr. Peirovy cupped her breasts and used his fingers to put pressure on her nipples, which she described as "tweaking", that Dr. Peirovy did not have consent to touch his patient in this manner and that there was no clinical reason to examine Patient X in this way. The cupping of her breasts with his hand and "tweaking" of her nipples are actions which, to the objective observer, would be construed as sexual in nature. Regardless of Dr. Peirovy's motivation, the deliberate touching of her breasts and nipples during a chest examination was a violation of Patient X's sexual integrity.

The Committee found that Dr. Peirovy's conduct with respect to these four patients, Patient U, Patient V, Patient W, and Patient X, would also reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

Regarding a fifth patient, Patient Z, Dr. Peirovy conducted a cardiac examination during which Patient Z's breasts were left fully exposed due to a miscommunication between Dr. Peirovy and Patient Z. The Committee stated it was Dr. Peirovy's responsibility as the physician to take steps to ensure effective communication with respect to a sensitive examination of this nature and that he did not discharge this responsibility effectively. Further, when Dr. Peirovy realized that Patient Z's breasts were fully exposed, his decision to proceed with the examination without offering her privacy, by way of a gown for example, was a serious lapse of judgment. Regardless of time constraints or other issues, Dr. Peirovy should have recognized the vulnerable and compromised situation of Patient Z, and responded in a more professional manner by assisting in preserving her modesty. The Committee found his conduct in this regard unprofessional. Following the examination, Dr. Peirovy engaged Patient Z in conversation which culminated in asking her out on a date. He told her that she would have to sign a note for her chart

terminating the doctor/patient relationship, if they were to see each other outside the office. Dr. Peirovy demonstrated egregiously poor judgment in suggesting to Patient Z that they could see each other socially, in the context of just having compromised her privacy due to the ill-advised fashion in which he had examined her. The Committee found this conduct would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Committee also found that Dr. Peirovy has been found guilty of offences relevant to his suitability to practise in that he was found guilty of assault on Patient U and Patient W. The Court imposed a conditional discharge and eighteen months' probation, with conditions including that Dr. Peirovy attend counselling with Dr. D, perform community service, make a charitable donation, and have no contact with the six complainants in these proceedings.

Disposition

On April 27, 2016, the Committee ordered and directed that:

- The Registrar suspend Dr. Peirovy's certificate of registration for a period of six months, effective as of the date of this order at 11:59 pm.
- The Registrar impose the following terms, conditions and limitation of Dr. Peirovy's certificate of registration:
- Practice Monitor
    a) Dr. Peirovy shall not engage in any professional encounters with female patients of any age unless the patient encounter takes place in the presence of a monitor who is a female member of a regulated health profession and who is acceptable to the College (the "Practice Monitor"), to be reconsidered upon application to the Committee by Dr. Peirovy after a minimum of one year following his return to practice once his suspension has ended;
    b) At all times, Dr. Peirovy shall ensure that the Practice Monitor shall:
        i. Remain in the examination room or consultation room at all times during all professional encounters with all female patients, even if another person is accompanying the patient;
        ii. Carefully observe all of his physical examinations (including but not limited to breast and chest examinations) of all female patients, with an unobstructed view of the examination;
        iii. Refrain from performing any other functions, except those required in the Practice Monitor's undertaking attached as Appendix "A" (the "Practice Monitor's Undertaking"), while observing him in all his professional encounters with female patients;
        iv. Keep a patient log in the form attached as Appendix "B" to this Order of all the female patients with whom Dr. Peirovy has an in-person professional encounter in the Practice Monitor's presence (the "Log");
        v. Initial the corresponding entry in the records of each patient noted in the Log to confirm that the Practice Monitor was in the presence

of Dr. Peirovy at all times during each female in-person professional encounter;

vi. Submit the original Log to the College on a monthly basis; and

vii. Provide reports (as described in the Practice Monitor's Undertaking) to the College on at least a monthly basis.

c) Dr. Peirovy shall maintain a copy of the Log at all times, and shall make it available to the College upon request;

- Notification of Practice Locations
  d) Dr. Peirovy shall inform the College of each and every location that he practices including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within fifteen (15) days of this Order. Going forward, he shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;
- Posting a Sign
  e) Dr. Peirovy shall post a sign in his waiting room(s) and each of his examination and/or consulting rooms, in all of his Practice Locations, in a clearly visible and secure location, in the form attached hereto as Appendix "C";
  f) Dr. Peirovy shall provide patients with a guide to access the Discipline Committee's decision in this matter, if requested;
- Monitoring
  g) Dr. Peirovy shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution who may have relevant information in order for the College to monitor Dr. Peirovy's compliance with the terms of this Order and shall promptly sign such consents as may be necessary for the College to obtain information from these persons or institutions;
  h) Dr. Peirovy shall submit to, and not interfere with, unannounced inspections of his Practice Locations and to inspections of patient charts by the College and to any other activity the College deems necessary, including simulated patients, in order to monitor Dr. Peirovy's compliance with the terms of this Order;
  i) Dr. Peirovy shall consent to the College providing any and all information to the Practice Monitor that the College deems necessary or desirable in order to assist the Practice Monitor in fulfilling her Undertaking and in order to monitor Dr. Peirovy's compliance with the terms of this Order; and
  j) Dr. Peirovy shall consent to all Practice Monitors disclosing to the College, and to one another, any information relevant to this Order, relevant to the terms of the Practice Monitor's Undertaking and/or relevant for the purposes of monitoring Dr. Peirovy's compliance with this Order;
- Individualized Instruction
  k) Dr. Peirovy continue to undergo individualized instruction with Dr. D on issues of consent, the maintenance of boundaries, and doctor/patient communication, and that Dr. D report to the College on Dr. Peirovy's progress each six months, with a final report to follow prior to her

termination of instruction with Dr. Peirovy. Termination of the individualized instruction shall be at the discretion of Dr. D;

- Clinical Education Program
  l) Dr. Peirovy shall, within 90 days of the commencement of the suspension of his certificate of registration, meet with a physician advisor from the College to establish a clinical education program, directed by a supervisor acceptable to the College, regarding the issue of physical examination, with particular focus on issues of the sexual privacy of and sensitivity to female patients.
  m) All the above terms and conditions to be at Dr. Peirovy's expense.
- Dr. Peirovy reimburse the College for funding for patients therapy, pursuant to the program required under section 85.7 of the Code, and that he post an irrevocable letter of credit or other security acceptable to the College to guarantee payment, in the amount of $64,240.00.
- Dr. Peirovy appear before the Committee to be reprimanded, not later than six months from the date this Order becomes final.
- Dr. Peirovy pay costs to the College in the amount of $35,680.00 within sixty (60) days of the date of this Order.
- In light of the fact that this Order is different form the penalty proposed by either party, the parties have ten days from the date of this Order to make written submissions with respect to any issues related to the implementation of this Order. To be clear, the Panel is not inviting submissions with respect to the substance of this Order or the start date of the period of suspension, but simply wishes to provide the parties with an opportunity to address any potential difficulties with the implementation of this Order which may not have been apparent to the Committee.

Appeal Notation

On August 7, 2015, Dr. Peirovy appealed the decision on finding of the Discipline Committee to the Superior Court of Justice (Divisional Court).

On May 24, 2016, the College of Physicians and Surgeons of Ontario appealed the decision on penalty of the Discipline Committee to the Superior Court of Justice (Divisional Court).

Incompetence – 2 cases

1. Dr. S. James

Name:	Dr. Stephen Rose James
Practice:	Anesthesiology
Practice Location:	Toronto
Hearing:	Uncontested Facts and Joint Submission on Penalty
Finding Decision Date:	November 16, 2015
Penalty / Written Decision Date:	March 16, 2016

Allegations and Findings

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

Summary

The Discipline Committee found that Dr. Stephen Rose James committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and 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. The Committee also found that Dr. James is incompetent.

Dr. James, an anaesthesiologist practising in pain management, worked at the Rothbart Centre for Pain Care. The Committee found that he committed professional misconduct because of his care and treatment, as well as his infection control practices, of 13 patients.

In late 2012, Toronto Public Health notified the College of a suspected meningitis outbreak connected to Dr. James at the Rothbart Centre for Pain Care, which triggered an ICRC investigation of Dr. James.

In November 2012, Toronto Public Health learned that Dr. James had administered epidural injections which caused three different patients to be hospitalized with either staph aureus or meningitis infections. Toronto Public Health representatives attended Dr. James' clinic and noted that the patient's sterile field was not covered; a non-sterile gauze was used after a procedure to wipe the ooze from the patient's back; Dr. James' gloves were too big; Although Dr. James used a mask, the nose was not pinched; Dr. James did not always allow the Betadine antiseptic used to wipe the patients' skin to dry for long enough before he started a procedure; After Dr. James used an alcohol-based hand rub, and prior to donning sterile gloves, he touched many surfaces; Dr. James

opened sterile items onto a non-sterile field into a sterile container; and Dr. James' wedding band was not removed during the procedure.

At Toronto Public Health's request, Public Health Ontario attended the Clinic on December 7, 2012 to review the Clinic's IPAC practices. At that visit, Dr. James offered to provide a mock demonstration of a typical epidural procedure. The audit team observed the following issues that required immediate attention: Dr. James applied and removed his mask without performing hand hygiene; Dr. James' hand hygiene with the alcohol-based hand rub lasted less than 5 seconds; Dr. James stated that he does not wait for the skin prep to dry before inserting the needle; Abundant supplies (including unwrapped gauze pads) stored on the counter are subject to contamination; and Dr. James' mask was not adjusted at the bridge of his nose.

Toronto Public Health concluded that nine (9) patients developed serious infections after receiving an epidural steroid injection performed by Dr. James at the Clinic. Toronto Public Health's view regarding the cause of these infections was that Dr. James was colonized with staph aureus, and due to breaches in IPAC, transmission of staph aureus occurred from Dr. James to his patients.

The patients revealed in the Toronto Public Health investigation suffered serious complications, including:

- Patient T, who received lumbar injections from Dr. James starting in 2012. Following her last injection in October 2012, Patient T was admitted to hospital, vomiting and incoherent. She was diagnosed with bacterial meningitis.
- Patient U, who received lumbar injections from Dr. James starting in 2011. In October 2012, she received 3 lumbar/thoracic epidural injections. In late October or early November, Patient U began suffering from headaches, nausea, vomiting, confusion, blurred vision, tremors. In November, she notified the Clinic that she was suffering persistent headaches. Shortly after, she was admitted to hospital and diagnosed with meningitis.
- Patient V, who received lumbar injections from Dr. James starting in 2010. Following a lumbar injection in July 2012, she developed fever and went to the ER. She was discharged with negative blood and urine cultures. She subsequently sought treatment from her family physician complaining of pain, fever, and difficulty urinating. She received additional injections from Dr. James on two occasions in August 2012. In September 2012, she suffered a stroke. On investigation, it was discovered that many sites on her spine were infected with abscesses requiring hospitalization and the insertion of a PICC line.
- Patient W, who received lumbar injections from Dr. James in September and October 2012. Shortly after his injection in October 2012, Patient W experienced back pain and fever and went to the hospital, but an MRI revealed no abscesses. In November 2012, he was admitted to hospital with ongoing fever and increasing weakness. A lumbar epidural abscess was found and an emergency laminectomy was performed.
- Patient X, who he received lumbar injections from Dr. James starting in 2012. Following his last injection in November 2012, Patient X developed a fever and

was hallucinating. He was admitted to hospital where he was diagnosed with an epidural abscess and staph aureus infection requiring evacuation and spinal decompression. Patient X required further surgical intervention.

- Patient Z, who received lumbar injections from Dr. James starting in 2012. After her third injection in September 2012, Patient Z experienced increasing back pain and developed a fever. She was admitted to hospital with two epidural abscesses and sepsis.

The College-retained expert opined that Dr. James practices prior to their revision fell below the standard of infection control practice expected of a physician performing such procedures. He concluded that these breaches were of a major nature and resulted in an uncommon, serious outbreak.

The College also received several public complaints from patients who suffered serious complications:

- Patient A, who received lumbar steroid injections from Dr. James in August, September, and October, 2012. At the October appointment, Patient A noticed that Dr. James did not wear sterile gloves or a mask and recalled that she did not have iodine put on her back like previous times. She felt unwell soon after the October appointment. By November, Patient A felt extremely confused, weak, and lethargic, and had a fever. Patient A was admitted to hospital and found to have a staph aureus infection. She was diagnosed with meningitis and an epidural abscess precisely where the injection had taken place. Further, Dr. James made inaccurate statements to the College during their investigation about advising Patient A's attending physician to obtain a neurological consultation.
- Patient B, who received lumbar steroid injections from Dr. James in June, July, and August 2012 to treat debilitating back pain. In September 2012, Patient B was taken to the hospital with fever, confusion, and lower back pain. Patient B spent several days in the emergency, and was ultimately admitted to as an in-patient. The working diagnosis in respect of Patient B was an epidural abscess secondary to direct skin infection from the epidural injections. It was confirmed that Patient B had a positive blood culture for staph aureus. In addition, Dr. James made inaccurate statements to the College during their investigation about his interactions with the hospital. Another College-retained expert opined on Dr. James' treatment of Patients A and B and stated that Dr. James has demonstrated a lack of knowledge, lack of judgment and lack of skill in providing care to Patient B and Patient A, and his non adherence to appropriate aseptic technique in the invasive procedures provided has led to significant complications and morbidity.
- Patient C, who received epidural steroid injections from Dr. James seven times between April and August 2012 for management of lower back pain. In or around July 2012, Patient C started to experience increasing pain and decreasing stability on her feet. She reported these concerns to Dr. James, and on two occasions sought treatment at emergency. Patient C continued to see Dr. James throughout that summer. After the epidural injections failed to alleviate Patient

C's pain, Dr. James administered bilateral diagnostic lumbar facet blocks in July 2012. In August 2012, he performed a left rhizotomy on Patient C. At this appointment, he provided Patient C with a note to take to her family doctor recommending a neurosurgery consult and recommending that her family physician request an MRI. He engaged in no further follow up with Patient C. Patient C was diagnosed with a serious spinal infection. A sensitive strain of staph aureus was recovered from the surgical specimen and the infection was believed to be the direct result of steroid injections. The College expert stated that Dr. James failed to appreciate the patient's progressive symptoms and failed to realize that the symptoms could be signs of an infection in a high risk patient. He also failed to adequately document the patients progressive symptoms, failed to correctly diagnosis/work up possible complications of treatments he provided, failed to adequately inquire about the patients ER visits and failed to organize appropriate timely work up of the patient's symptoms.

- Patient D, who received injections from Dr. James starting in 2010. In October 2011, Dr. James administered a lumbar epidural injection. Less than two weeks later, Patient D began to experience fever, increasing confusion, neck pain, nausea, vomiting, and occipital headaches. She was admitted to hospital. The suspected etiology was an infection secondary to epidural injections received from Dr. James. Patient D was readmitted to the hospital in November 2011 for a twelve day period. Her headache, nausea and vomiting continued. An MRI demonstrated an epidural fluid collection with a diagnosis of a likely enlarging epidural abscess. Patient D required extensive surgical laminectomies.
- Patient E, who received treatment from Dr. James for pain in her right elbow. In January 2012, Dr. James injected her elbow with cortisone and performed a caudal epidural injection the same day. Soon after the injection, Patient E's right arm became painful and red. She began calling the Clinic to get an appointment with Dr. James so that he could look at her arm. Subsequently, Patient E attended at the clinic, and asked that someone look at her red and swollen elbow. After she waited for about 90 minutes, Dr. James saw her, told her it was likely nothing, gave her a prescription for antibiotics, and told her to follow up in two weeks. Patient E's arm remained very painful, swollen, and red. In March 2012, Dr. James immediately sent her to the Emergency Department. Patient E was found to have a post-injection abscess and a heavy growth of staph aureus and was referred for both orthopedic and plastic surgery consults. The College expert opined that failing to offer urgent follow-up for a potential infection after a procedure, even if there is no fever, is failing to maintain the standard of care.
- Patient F, who received a lumbar epidural injection for lower back pain from Dr. James in May 2012. Less than two weeks later, Patient F developed a high fever, delirium, and increasing back pain while out of the country. Patient F was admitted to hospital in the United States, critically ill. He was found to have an epidural abscess and sepsis (staph aureus bacteremia), requiring ICU admission, intubation, neurosurgical evacuation, and hemi laminectomies. The likely etiology of the epidural abscess was believed to be the epidural injection.

The findings of disgraceful, dishonourable and unprofessional conduct also related to the following conduct:

- Providing an Interview Prep document to nursing staff at the Clinic in order to influence the nurses' responses to the College investigation;
- Misstating the purpose of the Interview Prep Document to the College;
- Misstating the steps he took when learning of Patient A and Patient B's complications caused by his inadequate Infection Prevention and Control (IPAC) procedures; and
- Failing to make himself available, and communicating inappropriately through his nursing staff, when Patient E suffered complications.

On October 8, 2014, after allegations had been referred to the Discipline Committee, Dr. James executed an undertaking with the College agreeing to co-operate with specific infection control guidelines provided to him and to submit to unannounced inspections by the College to ensure his infection control practices were acceptable. Unannounced inspections found that Dr. James was meeting infection control requirements.

Disposition

On December 15, 2015, the Discipline Committee ordered and directed that:

- the Registrar suspend Dr. James' certificate of registration for a period of ten (10) months, effective immediately;
- the Registrar impose the following terms, conditions and limitations on Dr. James' certificate of registration:
    a) Dr. James be prohibited from holding the position of Medical Director in any facility;
    b) Dr. James shall perform all injections in the presence of a regulated health professional who observes each injection and who contemporaneously signs and dates the patient record confirming he/she has observed the injection. Dr. James shall provide the College with a list of regulated health professionals with whom he works and provide copies of their signatures within seven (7) days of the date of this Order, and within fourteen (14) days of employing any additional regulated health professional thereafter;
    c) If Dr. James becomes aware that a patient developed an infection following a procedure that he performed, Dr. James shall, within 7 days of date on which he became aware, report the infection to the College;
    d) Dr. James shall complete the next available medical record keeping course approved by the College and provide proof of successful completion within three (3) weeks thereof;
    e) Dr. James shall successfully complete individualized education in communication, approved by the College at the instructor's earliest availability and provide proof of successful completion within three (3) weeks thereof. The course will involve a series of one-on-one sessions with a College-approved instructor (the "Instructor"), incorporating

principles of guided reflection, tailored feedback, and other modalities customized to the specific needs of Dr. James as assessed by the Instructor. The Instructor will make reports to the College regarding Dr. James' progress and compliance;

f) Dr. James shall successfully complete individualized instruction in ethics approved by the College at the instructor's earliest availability and provide proof of successful completion within three (3) weeks thereof. The instruction will involve a series of one-on-one sessions with a College-approved instructor (the "Instructor"), incorporating principles of guided reflection, tailored feedback, and other modalities customized to the specific needs of Dr. James as assessed by the Instructor. The Instructor will make reports to the College regarding Dr. James' progress and compliance;

g) Dr. James shall retain a clinical supervisor, approved by the College, who will sign an undertaking in the form attached hereto as Schedule "A" (the "Supervisor") no later than 30 days prior to Dr. James' return to practice after the suspension referred to in paragraph 4 above. Dr. James shall practice under the guidance of the Supervisor for a period of period of twelve (12) months. Dr. James shall meet with the supervisor monthly to discuss any concerns arising from patient care, including infection prevention, control and treatment.

h) Dr. James shall engage a preceptor acceptable to the College to provide education in the indications and treatment for infection in Interventional Pain Medicine for a minimum period of (4) four hours. The preceptorship shall be completed within (3) months of Dr. James' return to practice after the end of the suspension referred to in paragraph 4 above, and the preceptor shall confirm such completion in writing to the College;

i) Dr. James shall be subject to a reassessment of his practice including an observation of his sterile technique, within six (6) months of his return to practice after the end of the suspension referred to in paragraph 4 above, and shall be subject to periodic assessments (announced and/or unannounced) thereafter at the discretion of the College, including a reassessment following the completion of supervision described in paragraph g above. Dr. James shall abide by the recommendations of the assessors;

j) Dr. James shall cooperate with unannounced inspections of his practice and patient records by a College representative for the purposes of monitoring his compliance with the provisions of this Order and his infection control practices; and

k) Dr. James shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the provisions of this Order.

- Dr. James appear before the panel to be reprimanded;
- Dr. James pay costs to the College in the amount of $4,460.00 within thirty (30) days of the date of this Order.

2. Dr. A. T. Wojcicki

Name:	Dr. Andrzej Tomasz Wojcicki
Practice:	Internal Medicine
Practice Location:	Mount Albert
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	February 22, 2016
Written Decision Date:	April 14, 2016

Allegations and Findings

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

Summary

The Committee found that Dr. Wojcicki failed to maintain the standard of practice of the profession, that he engaged in disgraceful, dishonourable or unprofessional conduct and that he is incompetent.

The Committee found that he failed to maintain the standard of practice in several areas in his Complementary and Alternative Medicine (CAM) practice, including failing to follow the guidelines set out by the CPSO's CAM Policy by:

- engaging in inadequate record-keeping, including lack of Cumulative Patient Profiles documenting patients' medical history and treatments;
- failing to obtain consent from his patients;
- failing to explain standard medical treatments to his patients;
- ordering unnecessary tests;
- treating patients who did not demonstrate signs and symptoms of the condition he was treating, and
- ordering medications which were inappropriate, considering the diagnosis.

The Committee also found that Dr. Wojcicki failed to maintain the standard of practice of the profession in his internal medicine hospital practice because of his:

- lack of knowledge, demonstrated by prescribing incorrect dosages of medication;
- lack of judgement with respect to the management of patients in the ER; and
- inadequate consult notes and discharge summaries.

With respect to Dr. Wojcicki's OHIP billing practice, the Committee noted that Dr. Wojcicki billed OHIP for services for which there is no documentation.

The Committee noted that Dr. Wojcicki had entered into an undertaking agreeing to cease engaging in any CAM practice and not to apply or reapply to practice CAM in Ontario.

Disposition

The Committee ordered and directed that:

- the Registrar suspend Dr. Wojcicki's certificate of registration for two months, commencing from February 22, 2016;
- the Registrar impose terms, conditions and limitations on Dr. Wojcicki's certificate of registration, including:
    - Successful completion of educational courses in internal medicine and cardiac care guidelines;
    - Moderate level clinical supervision of his office practice for six months, which may be reduced to low level after 3 months, and a reassessment of his office practice;
    - Low level supervision of his hospital practice for three months and a reassessment of his hospital practice; and
    - Various monitoring provisions; and
- Dr. Wojcicki appear before the Panel to be reprimanded; and
- Dr. Wojcicki pay costs to the College in the amount of $5,000.00 within thirty days.

Disgraceful, Dishonourable, or Unprofessional Conduct – 3 cases

1. Dr. J. S. Bhatt

Name:	Dr. Jayant Shankerprasad Bhatt
Practice:	General Internist
Practice Location:	Brockville
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	April 4, 2016
Written Decision Date:	May 9, 2016

Allegation and Finding

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

Summary

The Committee found that Dr. Bhatt 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.

Dr. Bhatt, who has a history of disruptive, unprofessional and inappropriate conduct and behaviour towards colleagues, staff and patients in the hospital -- in particular female colleagues, staff, and patients), entered into a contract with the hospital in 2011 setting out expectations and providing a workplace monitor. He was released from the contract in January 2014 on the basis that his conduct and behaviour were satisfactory. By July 2014, the hospital had received seven new complaints regarding his conduct and behaviour. Dr. Bhatt entered into a new undertaking with the hospital to monitor his conduct and behaviour. The hospital made a report to the College.

The Committee found that colleagues, staff and patients at the hospital have been subjected to unprofessional, inappropriate and derogatory conduct and behaviour from Dr. Bhatt between 2008 and 2014. Specific examples include using vulgar, insulting and demeaning language to nurses, yelling at nurses, using intimidating and threatening language to a fellow physician and to a member of the hospital Board. Some patients specifically requested not to be seen by Dr. Bhatt because they felt uncomfortable interacting with him.

Following referral to discipline, Dr. Bhatt had an encounter with a newly-qualified female hospitalist during which time Dr. Bhatt questioned her management of the patient and made her feel professionally threatened.

Disposition

The Committee ordered and directed that:

- the Registrar suspend Dr. Bhatt's certificate of registration for four months, commencing from April 8, 2016;
- the Registrar impose terms, conditions and limitations on Dr. Bhatt's certificate of registration, including:
    - In his practice at Brockville General Hospital, Dr. Bhatt is only permitted to practice in Ambulatory Care Unit, Stroke Prevention Program and Brockville Cardiovascular Rehabilitation Program;
    - Dr. Bhatt will successfully complete the ProBE program in 2016;
    - Dr. Bhatt will comply with a monitoring program with a monitor appointed by the College, every four months for a minimum of two years;
- Dr. Bhatt appear before the Panel to be reprimanded; and
- Dr. Bhatt pay costs to the College in the amount of $5,000.00 within thirty days.

2. Dr. W. A. Botros

Name: Dr. Wagdy Abdalla Botros
Practice: Psychiatry and FRCPC
Practice Location: Kitchener and London
Hearing: Contested
Finding / Written Decision Date: April 21, 2015
Penalty / Written Decision Date: February 22, 2016

Allegation and Finding

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

Summary

On April 21, 2015, the Discipline Committee found that Dr. Wagdy Abdalla Botros committed an act of professional misconduct in that 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 allegation of disgraceful, dishonourable or unprofessional conduct in this case arose from Dr. Botros' alleged failure to comply with an Order of the ICRC.

In May 2013, the ICRC referred the disgraceful, dishonourable and unprofessional conduct allegation to the Discipline Committee because Dr. Botros allegedly failed to complete a Communications Skills course which the ICRC had ordered he do in 2011.

Dr. Botros appealed this referral to HPARB, which rejected his appeal. The ICRC Order therefore remained in effect. As of May 15, 2013, Dr. Botros had not attended a Communications Skills course.

The Discipline Committee found that, by failing to comply with the Order of the ICRC, Dr. Botros had committed an act of professional misconduct.

On December 16, 2015 – which was after the conclusion of the penalty hearing in this case – Dr. Botros' certificate of registration was suspended for six months by a differently-constituted panel of the Discipline Committee in another matter (*CPSO v. Botros*, 2015 ONCPSD 31). The panel in that case also ordered that Dr. Botros be reprimanded, that certain terms, conditions and limitations be placed on his certificate of registration, and that he pay costs.

In view of this, the Committee asked counsel for submissions as to when the suspension in the present Dr. Botros case should take effect: specifically, should it commence immediately upon the coming into effect of the Committee's order, such that it runs concurrently with the existing suspension; should it take effect upon the conclusion of the current suspension; or should it commence at some other time?

This Committee concluded that there is some commonality between this case and the other Dr. Botros case in relation to Dr. Botros' unprofessional conduct toward the College over a similar time period. The Committee therefore determined that a six-month suspension is necessary and appropriate in this case.

However, having regard to the degree of commonality in the two cases in regard to Dr. Botros' unprofessional conduct, the Committee deemed it appropriate to have two months of the six-month suspension run concurrently with, and the remaining four months to run consecutively to, the suspension in the other Dr. Botros case.

Disposition

On February 22, 2016, the Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Botros' certificate of registration commencing on the earlier of April 16, 2016 and the date of any stay of the Order in the other Dr. Botros case, and running until the later of: six months after the date the suspension commences; and the date Dr. Botros provides to the College proof of his compliance with the Specified Continuing Education and Remediation Program directed by the Inquiries, Complaints and Reports Committee in its March 16, 2011 decision.
- Dr. Botros appear before the panel to be reprimanded.
- Dr. Botros pay costs to the College in the amount of $24,656.10.

3. Dr. J. E. Esmond

Name:	Dr. John Edward Esmond
Practice:	Family Medicine
Practice Location:	Mississauga
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	December 18, 2015
Written Decision Date:	February 18, 2016

Allegation and Finding

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

Summary

On December 18, 2015, the Discipline Committee found that Dr. John Edward Esmond committed professional misconduct in that he failed to maintain the standard of practice of the profession and he 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. Dr. Esmond admitted to the allegations.

The Committee found that:

- Dr. Esmond provided frequent care to a family member between 2007 and 2014, acting as the family member's primary care provider between 2007 and 2011 and following the family member for a number of serious medical conditions. In doing so, Dr. Esmond acted in direct contravention of the College Policy on Treating Self and Family Members.
- Between 2009 and 2011, Dr. Esmond treated and was treated by a physician, Dr. A, whom he was entrusted by the College to supervise. Later, Dr. Esmond developed a personal and intimate relationship her. While acting as her supervisor, Dr. Esmond sought and received medical treatment from Dr. A on about 40 occasions, including referrals to specialists, issuing prescriptions, completing disability forms, and ordering a CT scan and MRI. After his term as Dr. A's supervisor ended, Dr. Esmond continued to seek intermittent treatment from Dr. A, including for a UTI and anxiety. In addition, Dr. A completed an insurance assessment for Dr. Esmond's application for disability benefits. Dr. Esmond also treated Dr. A during and after his term as Dr. A's supervisor, including by providing allergy shots, assessing Dr. A for conjunctivitis, ordering an ultrasound, and referring Dr. A to a gynaecologist.
- Dr. Esmond failed to maintain the standard of practice in his care of patients with chronic pain, including his narcotics prescribing, and failing to maintain appropriate records of patient encounters. With respect to his prescribing, "Dr. Esmond's care exposed patients to a risk of harm by placing [them] in a situation of reliance on major analgesics for an undefined and indeterminate length of time."

Disposition

The Committee ordered and directed that:

- the Registrar suspend Dr. Esmond's certificate of registration for a period of four (4) months commencing immediately.
- the Registrar impose the following terms, conditions and limitations on Dr. Esmond's certificate of registration:
  a) Dr. Esmond shall not issue new prescriptions or renew existing prescriptions for any of the following substances:
     i. Narcotic Drugs;
     ii. Narcotic Preparations;
     iii. Controlled Drugs;
     iv. Benzodiazepines and Other Targeted Substances;
     v. All other Monitored Drugs
  b) Dr. Esmond shall post a sign that is clearly visible upon entering his office(s) in the form set out at Schedule "D" [to the Order]. For further clarity, this sign shall state as follows:

     IMPORTANT NOTICE
     Dr. Esmond must not prescribe any of the following:
     Narcotic Drugs
     Narcotic Preparations
     Controlled Drugs
     Benzodiazepines and Other Targeted Substances
     All other Monitored Drugs
     Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

     A sign reflecting this restriction will also be posted in Spanish.
  c) Dr. Esmond shall cooperate with unannounced inspections of his practice and patient charts and such other steps as the College may take for the purpose of monitoring and enforcing his compliance with the terms of this Order and will make his Ontario Health Insurance Plan billings and Narcotics Monitoring System data accessible to the College for this purpose.
  d) Dr. Esmond must successfully complete, at his own expense, the first available Professional Boundaries and Ethics ("ProBE") Canada course and University of Toronto Medical Record Keeping course, or, if these courses are unavailable, other courses acceptable to the College in ethics, boundaries, and medical record keeping, within four (4) months of the date of this Order.
- Dr. Esmond appear before the panel to be reprimanded.
- Dr. Esmond pay to the College costs in the amount of $4,460 within 30 days of the date of this Order.

May 2016

COUNCIL BRIEFING NOTE

TOPIC: **DRAFT REVISED: INDEPENDENT HEALTH FACILITIES CLINICAL PRACTICE PARAMETERS AND FACILITY STANDARDS FOR SLEEP MEDICINE**

FOR INFORMATION

ISSUE:

- For your information, the College is undertaking a consultation on the draft revised "Independent Health Facilities: Clinical Practice Parameters and Facility Standards for Sleep Medicine", which is an update to the parameters approved by the IHF Sleep Medicine Task Force in 2013 (3rd edition).

- This review is in accordance with the regular review cycle for CPSO documents.

BACKGROUND:

- The primary purpose of the parameters is to assist physicians in developing their own quality management program and act as a guide for assessing the quality of patient care provided in sleep medicine facilities.

- There are currently 62 sleep medicine facilities in the province.

- The role of the IHF program at the CPSO is to develop and maintain professional standards within facilities (quality assurance aspect of licensing) through regular assessments based on Clinical Practice Parameters and Facility Standards. This dovetails with the College's quality improvement mandate.

- The *Independent Health Facilities Act* (IHFA) gives the College of Physicians and Surgeons of Ontario the primary responsibility for carrying out quality assessments in Independent Health Facilities, which includes responsibility for developing and regular updating of clinical practice parameters and facility standards.

Key changes between the 2013 parameters and updated draft (April 2016) parameters

- A number of Appendices have been re-categorized as Chapters, as the Task Force decided that the content was sufficiently important that it should become part of the core document.

- The revised draft document now identifies what constitutes “Standards” versus “Guidelines” in some of the Chapters. This was done in order to assist assessors and facilities in understanding the College’s expectations with regard to compliance with various aspects of the parameters. Definitions for each are included in the Preface of the parameters, as follows:

    - A Standard is a generally accepted patient care strategy that reflects a high degree of clinical certainty.

    - A Guideline is a generally accepted patient care strategy that reflects a moderate degree of clinical certainty. Guidelines may be adopted, modified, or rejected according to clinical needs, individual patient considerations, local resources, and physician discretion. Guidelines do not establish inflexible protocols for patient care nor are they meant to replace the professional judgment of physicians.

- Chapter 7 – Performance, Diagnosis and Management of Pediatric Sleep Related Disorders – In addition to minor modifications throughout the Chapter, the definitions section was significantly updated.

- Chapter 13 - Sleepiness and Driving: Patient assessment, Patient Education and Obligations to Report – This Chapter was updated to provide clarity on reporting to the Ministry of Transportation of Ontario (MTO) in terms of who is responsible for making those reports, and when the reports should be made.

- Appendix II - Change in Scope of Practice Requirements and Forms – This appendix (which is also a Companion document to the CPSO’s Changing Scope of Practice policy), was due for review as per the College’s regular review process for all documents. With the exception of a few minor modifications, it was determined that the document is still current and not in need of any significant changes.

- Lastly, where applicable, the parameters were updated to coincide with changes to the recently updated (April 1, 2016) American Academy of Sleep Medicine Scoring Manual Version 2.3.

- The IHF Sleep Medicine Task Force, which updated the parameters included representatives from the following organizations: Canadian Sleep Society (CSS), Ontario Medical Association (OMA) Section on Sleep Medicine; in addition, IHF owner/operator, hospital-based rep; community-based rep; non-IHF academic rep; paediatric specialist; IHF assessors (physician and technologist), hospital-based physician/quality advisor of an IHF, and; CPSO staff members.

Next Steps

- The draft revised IHF Clinical Practice Parameters and Facility Standards for Sleep Medicine will be sent out for external consultation.

DECISION FOR COUNCIL:

For Information only

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DATE: May 16, 2016