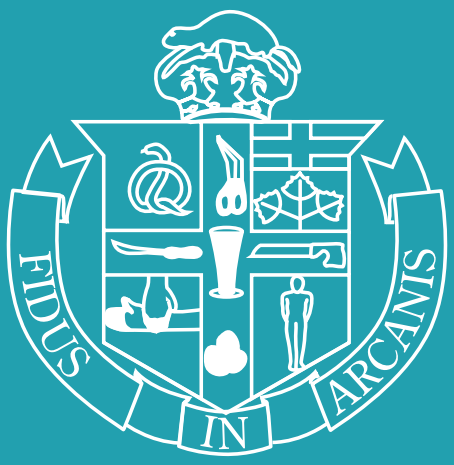
The College of Physicians and Surgeons of Ontario

Meeting of Council



September 8 and 9, 2016

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
September 8 and 9, 2016 at 10:30 a.m.
Council Chamber, 3rd Floor, 80 College Street, Toronto

Thursday September 8, 2016

10:30 a.m.	**Call To Order**	
	President's Announcements	
Motion	**Council Meeting Minutes of May 30-31, 2016**	**1**
	Executive Committee's Report to Council – April to June, 2016	**14**
IN CAMERA		
	Sexual Abuse Task Force - Update	
COUNCIL AWARD PRESENTATION		
11:30 a.m.	**Council Award Winner -** Dr. Martin White of Carleton Place, Ontario	**16**
12:00 p.m.	**LUNCH**	

PRESENTATION		
1:00 p.m.	**Quality Management Partnership: Quality Reports** The Quality Management Partnership is a strategic initiative of the College focused on the implementation of quality management programs in colonoscopy, mammography, and pathology services provided in all facility types in Ontario. This presentation to Council by guests representing CCO's Partnership team provides an overview of the development and implementation of the Quality Management Partnership's facility quality reports which began its dissemination July 8th 2016.	**17**
FOR DECISION		
Motion	**By-law Amendments – Public Register** Council is being asked whether it wishes to pass By-Law No. 110 to enact the proposed amendments to the register provisions in the General By-law following the consultation process. *For Approval*	**27**
Motion	**College Oversight of Fertility Services – Regulation Change Proposal** Council is provided with draft amendments to Ontario Regulation 114/941, Part XI that would allow the College to enter and inspect premises where fertility services are performed. Council is asked for feedback on the draft regulation change proposal and is asked whether the draft regulation can be released for external consultation. *For Approval*	**39**

Motion	**Proposed Regulation under the *Safeguarding our Communities Act (Patch for Patch Return Policy), 2015*** The Ministry of Health and Long Term Care is introducing legislation which will require patients to return their used fentanyl patches to a pharmacy in order to receive new ones. This legislation sets out specific requirements for physicians and pharmacists when prescribing and/or dispensing fentanyl patches. Council is asked to consider approving amendments to the Prescribing Drugs policy which reflect this legislation, as well as a Fact Sheet that has been developed by this College in collaboration with the Ontario College of Pharmacists. *For Approval*	**49**
Motion	**Governance Committee Report** **Items for Decision:** I Election of 2016/2017 Academic Representatives on Council II 2017 Chair Appointments **Items for Information:** III Committee Appointments IV Public Member Reappointments V 2016 District 1, 2, 3 and 4 Election Update VI Completion of 2016 Council Performance Assessment (Form)	**8**
MEMBER TOPICS		
	Adjourn	

Friday September 9, 2016

9:00 a.m.	**CALL TO ORDER**	
	President's Announcements	
	REGISTRAR'S REPORT	
	Strategic Update - Dashboard	**94**
	PRESENTATION	
10:00 a.m.	**Ronnie Gavsie, President and CEO, Trillium Gift of Life 'Our Call to Action'** Ms. Gavsie will provide an overview of the *Donation and Transplantation Process in Ontario*, how it works from a physician to patient perspective, and issues that have arisen.	
10:45 a.m.	Break	
	PRESENTATION	
	Update on Education Strategic Initiative (ESI) The progress of the Education Strategic Initiative will be presented to Council for discussion.	
12:00 p.m.	**LUNCH**	
	PRESENTATION	
	Data and Information Management Strategy Update The progress of the Data and Information Management Strategy will be presented to Council for discussion.	

FOR INFORMATION		
1.	2017 Council and Executive Committee Meeting Dates	**101**
2.	Policy Report	**102**
3.	Government Relations Report	**123**
4.	Medical Assistance in Dying Update	**125**
ADJOURN		

COUNCIL MEETING MINUTES OF MAY 30 AND 31, 2016
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8, 2016

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

The Council accepts as correct the minutes of the meeting of the Council held on May 30 and May 31, 2016

- OR -

The Council accepts the minutes of the meeting of the Council held on May 30 and May 31, 2016 with the following corrections:

1.

IN-CAMERA MOTION

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8, 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)(b) of the Health Professions Procedural Code.

<< BY-LAW AMENDMENTS FOR REGISTER CONTENT>>

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8, 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. 110:

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.

COLLEGE OVERSIGHT OF FERTILITY SERVICES – REGULATION CHANGE PROPOSAL

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8, 2016

It is moved by ……..,

and seconded by ……..……..……....., that:

The Council approve in principle and circulate to the membership and other interested parties and stakeholders for feedback the following proposed amendments to Ontario Regulation 114/94 ("O.Reg. 114/94") made under the *Medicine Act, 1991*:

1. That Subsection 44(1) of O.Reg. 114/94 be amended by adding 44(1)(b.1), 44(1)(e) and 44(3), as highlighted below:

44. (1) In this Part,

"inspector" means a person designated by the College to carry out an inspection under this Part on behalf of the College;

"premises" means any place where a member performs or may perform a procedure on a patient but does not include a health care facility governed by or funded under any of the following Acts:

1. The *Long-Term Care Homes Act, 2007*.
2. The *Developmental Services Act*.
3. The *Homes for Special Care Act*.
4. Revoked: O. Reg. 134/10, s. 1 (2).
5. Revoked: O. Reg. 192/14, s. 1.
6. The *Ministry of Community and Social Services Act*.
7. The *Ministry of Correctional Services Act*.
8. The *Ministry of Health and Long-Term Care Act*.
9. Revoked: O. Reg. 134/10, s. 1 (2).
10. The *Private Hospitals Act*.
11. The *Public Hospitals Act*;

"procedure" means,

(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 anaesthesia,

(ii) parenteral sedation, or

(iii) regional anaesthesia, 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 anaesthetic,

(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,

(b.1) any act that is performed in connection with,

(i) in vitro fertilization,

(ii) intra-uterine insemination, or

(iii) fertility preservation for medical purposes,

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. O. Reg. 134/10, s. 1 (1, 2); O. Reg. 192/14, s. 1.

(e) the sole act of counseling or referral for the procedures set out in subsection (b.1).

(2) Anything that may be done by the College under this Part may be done by the Council or by a committee established under clause 94 (1) (i) of the Health Professions Procedural Code. O. Reg. 134/10, s. 1 (1).

(3) For the purposes of procedures included in subsection 44(1)(b.1) the definition of “premises” shall include a health care facility governed by or funded under The *Public Hospitals Act*.

2. That Subsection 47(c) of O.Reg. 114/94 be amended by adding the words highlighted below:

47. It is the duty of every member whose premises are subject to an inspection to,

(a) submit to an inspection of the premises where he or she performs or may perform a procedure on a patient in accordance with this Part;

(b) promptly answer a question or comply with a requirement of the inspector that is relevant to an inspection under this Part; and

(c) co-operate fully with the College and the inspector who is conducting an inspection of a premises, including collection and provision of information requested, in accordance with this Part. O. Reg. 134/10, s. 1 (1).

3. That Section 49 of O.Reg. 114/94 be amended by adding Subsection 49(6), as highlighted below:

49. (1) No member shall commence using premises for the purposes of performing procedures unless the member has previously given notice in writing to the College in accordance with subsection (5) of the member's intention to do so and the premises pass an inspection or pass an inspection with conditions. O. Reg. 134/10, s. 1 (1).

(2) The College shall ensure that an inspection of the premises of a member referred to in subsection (1) is performed within 180 days from the day the College receives the member's notice. O. Reg. 134/10, s. 1 (1).

(3) A member whose practice includes the performance of a procedure on a patient in any premises on the day this Part comes into force shall give a notice in writing to the College in accordance with subsection (5) within 60 days from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(4) The College shall ensure that an inspection of the premises of a member referred to in subsection (3) is performed within 24 months from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(5) The notice required in subsections (1) and (3) shall include the following information, submitted in the form and manner required by the College:

1. The full name of the member giving the notice and the full name of the owner or occupier of the premises, if he or she is not the member who is required to give notice under this section.
2. The full name of any other member who is practising or may practise in the premises with the member giving the notice.
3. The name of any health profession corporation that is practising at the premises.
4. The full name of any hospital where the member or other members at the premises have privileges or where arrangements have been made to handle emergency situations involving patients.
5. The full name of any other regulated health professional who is practising or may practise in the premises with a member at the premises, along with the name of the College where the regulated health professional is a member.
6. The full address of the premises.
7. The date when the member first performed a procedure on a patient in the premises or the proposed date when the member or another member intends to perform a procedure on a patient at the premises.
8. A description of all procedures that are or may be performed by a member or other members at the premises and of procedures that may be delegated by the member or other members at the premises.
9. A description of any equipment or materials to be used in the performance of the procedures.
10. The full name of the individual or corporation who is the owner or occupier of the premises, if different from the member giving the notice.
11. Any other information the College requires that is relevant to an inspection conducted at the premises in accordance with this Part. O. Reg. 134/10, s. 1 (1).

49(6) All timelines and notice requirements provided in this section apply to every premises where a member performs or may perform a procedure listed in subsection 44(1)(b.1) with reference to the day that section 44(1)(b.1) comes into force.

PROPOSED REGULATION UNDER THE *SAFEGUARDING OUR COMMUNITIES ACT (PATCH FOR PATCH RETURN POLICY), 2015.*

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8 , 2016

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

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

PROPOSED REGULATION UNDER THE *SAFEGUARDING OUR COMMUNITIES ACT (PATCH FOR PATCH RETURN POLICY), 2015.*

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8 , 2016

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

The Council approves the College issuing a fact sheet regarding the provincial government's fentanyl return program and, if possible, to do so jointly with the College of Pharmacists (a copy of which forms Appendix " " to the minutes of this meeting).

APPOINTMENT OF 2016-2017 ACADEMIC ADVISORY COMMITTEE MEMBERS TO COUNCIL

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 8, 2016

It is moved by ……,

and seconded by ……..,

that:

The Council appoints the following members of the Academic Advisory Committee to the Council, as of the close of the annual general meeting of Council in December 2016:

1. _____
2. _____
3. _____

APPOINTMENT OF 2017 CHAIRS

September 8, 2016

It is moved by ……, and seconded by

……., that:

The Council appoints the following committee members as chairs, co-chairs or vice chairs of the following committees as of the close of the annual general meeting of Council in December 2016:

Council Award Selection Committee:
Dr. Joel Kirsh

Discipline Committee:
Dr. Peeter Poldre
Dr. Carole Clapperton

Education Committee:
Dr. Barbara Lent

Executive Committee:
Dr. David Rouselle

Finance Committee:
Mr. Pierre Giroux

Fitness to Practise Committee:
Dr. Dennis Pitt

Governance Committee:
Dr. Joel Kirsh

Inquiries, Complaints and Reports Committee:

Dr. Carol Leet, Chair, ICRC, Co-Vice Chair, Settlement Panels

Dr. Edith Linkenheil, Co-Vice Chair, Settlement Panels

Ms. Lynne Cram, Co-Vice Chair, General

Mr. Harry Erlichman, Co-Vice Chair, General

Dr. Dale Mercer, Vice Chair, Surgical

Dr. Lawrence Oppenheimer, Vice Chair, Obstetrical

Dr. Akbar Panju, Vice Chair, Internal Medicine

Dr. Lesley Wiesenfeld, Vice Chair, Mental Health and Incapacity

Dr. Steven Whittaker, Vice Chair, Family Practice

Methadone Committee:

Ms. Diane Doherty

Outreach Committee:

Ms. Lynne Cram

Patient Relations Committee:

Ms. Lisa McCool-Philbin

Premises Inspection Committee:

Dr. Dennis Pitt

Quality Assurance Committee:

Dr. Brenda Copps

Dr. Patrick Safieh

Registration Committee:

Dr. Barbara Lent

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
May 30, 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
Dr. Marc Gabel
Mr. Pierre Giroux
Dr. John Jeffrey
Major Abdul Khalifa
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Richard (Rick) Mackenzie
Dr. Haidar Mahmoud
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Dennis Pitt
Dr. Peeter Poldre
Ms. Joan Powell
Mr. Ron Pratt
Dr. John Rapin
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Eric Stanton
Dr. Peter Tadros
Mr. Emile Therien
Dr. Andrew Turner
Dr. James Watters

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

Regrets: Ms. Debbie Giampietri, Mr. Arthur Ronald, Ms. Peggy Taillon and Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

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

Council Meeting Minutes of February 26, 2016

01-C-05-2016

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

The Council accepts the minutes of the meeting of the Council held on February 26, 2016 with the following correction:
1. Dr. John Rapin was present.

CARRIED

Executive Committee's Report to Council – April 2015 to March 2016
Received.

FOR DECISION

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

02-C-05-2016

It is moved by Mr. Sudershen Beri and seconded by Dr. Steven Bodley that:

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

CARRIED

Proposed Changes to OHPIP Standards – Accountability of Medical Director, Staff Qualifications, Infection Control and Quality Assurance

03-C-05-2016

It is moved by Mr. Emile Therien and seconded by Dr. Jerry Rosenblum 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 "B " to the minutes of this meeting).

CARRIED

Compensation of Public Members

04-C-05-2016

It is moved by Dr. Barbara Lent and seconded by Dr. Marc Gabel that:

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

CARRIED

Transparency Initiative: Proposed By-Law Amendment re Posting QAC SCERPs

05-C-05-2016

It is moved by Mr. Peter Pielsticker and seconded by Ms. Lynne Cram that:

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.

CARRIED

By-law Amendments for Register Content

06-C-05-2016

It is moved by Dr. Steven Bodley and seconded by Dr. Marc Gabel that:

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 Practice Committee in respect of the member is in the register,

   i. the date on which the Fitness to Practice Committee made the finding,

   ii. the effective date of any order of the Fitness to Practice 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 license 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.

CARRIED

COUNCIL AWARD WINNER

Dr. Brenda Copps presented the Council Award to Dr. Amanda Bell of Port Colborne, Ontario.

FOR DISCUSSION

Continuity of Care Planning and Proposal

Mr. Craig Roxborough, Senior Policy Advisor provided Council with an update of the preliminary considerations and the work relating to continuity of care, including an analysis and recommendation regarding the development of a new policy.

Work has now begun on this issue and a working group is currently being formed and will be chaired by Dr. Brenda Copps.

FOR DECISION

Physician-Assisted Death / Medical Assistance in Dying: Federal Activity and College Policy

Dr. Carol Leet provided Council members with an update on the activity on the current status and the guidance that has been prepared for approval.

07-C-05-2016

It is moved by Dr. Barbara Lent and seconded by Ms. Joan Powell that:

If there is no federal legislation regarding medical assistance in dying in effect as of June 6, 2016, the Council approves the "Physician-Assisted Death" policy (a copy of which forms Appendix "C " to the minutes of this meeting), to be effective as of June 6, 2016.

1 Abstain – Dr. Peter Tadros
CARRIED

08-C-05-2016

It is moved by Mr. Sudershen Beri and seconded by Dr. Marc Gabel that:

If federal legislation regarding medical assistance in dying will be in effect as of June 6, 2016, the Council approves the Medical Assistance in Dying Policy (a copy of which forms Appendix "D" to the minutes of this meeting), to take effect on June 6, 2016. If any amendments are required to this policy to bring it into compliance with the federal legislative scheme, which had not been finalized when Council considered this policy, Council directs staff to amend the policy as required, to be approved by the Executive Committee on June 6, 2016, or as close to that date as possible, and reported back to Council at its next meeting.

1 Abstain – Dr. Peter Tadros
CARRIED

09-C-05-2016

It is moved by Ms. Lynne Cram and seconded by Mr. Peter Pielsticker that:

As of June 6, 2016, the Council rescinds the Interim Guidance on Physician-Assisted Death.

CARRIED

ANNUAL FIRE DRILL AND EVACUATION PROCEDURES

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

FOR DECISION

Planning for and Providing Quality End-of-Life Care – Post Approval Amendments

Dr. Carol Leet presented the feedback recently received about the expectations as well as the amendments proposed by the working group in response to the feedback received.

10-C-05-2016

It is moved by Dr. Steven Bodley and seconded by Dr. Eric Stanton that:

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

CARRIED

ADJOURNMENT

President adjourned the meeting at 2:35 p.m. with a reminder that Council will reconvene on Tuesday May 31, 2016 at 9:00 a.m.

Dr. Joel Kirsh, President

Franca Mancini, Recording Secretary

PROCEEDINGS OF THE
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
May 31, 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
Dr. Marc Gabel
Mr. Pierre Giroux
Major Abdul Khalifa
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Richard (Rick) Mackenzie
Dr. Haidar Mahmoud
Mr. Peter Pielsticker
Dr. Judith Plante Dr.
Dennis Pitt
Dr. Peeter Poldre Ms.
Joan Powell Mr. Ron
Pratt
Dr. John Rapin
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Eric Stanton
Dr. Peter Tadros Mr.
Emile Therien Dr.
Andrew Turner Dr.
James Watters

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

Regrets: Ms. Debbie Giampietri, Dr. John Jeffrey, Mr. Arthur Ronald, Ms. Peggy Taillon and Dr. Ronald Wexler

CALL TO ORDER

President's Announcements

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

FOR DECISION

Governance Committee Report - 2017 Executive Committee Vote

11-C-05-2016

It is moved by Dr. Eric Stanton and seconded by Mr. Sudershen Beri that:

Council appoints Dr. David Rouselle (as President), Dr. Steven Bodley (as Vice President), Dr. Peeter Poldre (as physician member), Ms. Lynne Cram (as public member), Mr. Pierre Giroux (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.

CARRIED

REGISTRAR'S REPORT

Strategic Update – Dashboard

Dr. Rocco Gerace provided an update on the Strategic Priorities Report and Dashboard (a copy of which forms Appendix "F" to the minutes of this meeting).

DIVISIONAL ANNUAL REPORTS

Corporate Services

Information Technology

Investigations, Resolutions, Hearings, Compliance Monitoring and Supervision

Legal

Policy and Communications

Quality Management

Research and Evaluation

MEMBER TOPIC

Dr. Gabel invited Council Members to comment with respect to communication of a specific issue that was published in the Toronto Star. The President asked Louise Verity to provide an overview of the process followed to respond to media inquiries and the steps taken in the case identified.

PRESENTATION

Karen McKibbin, Director of Ontario Public Health Integrated Solutions and Dr. Robin Williams, Special Advisor, and Chair of the Clinical Data Working Group provided an overview of key

services to support medication and immunization management in Ontario (a copy of which forms Appendix "G" to the minutes of this meeting).

FOR DECISION

Audited Finance Statements-2015

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

12-C-05-2016

It is moved by Mr. Emile Therien and seconded by Dr. Jerry Rosenblum that:

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

CARRIED

Appointment of the Auditor for 2016

Mr. Dale Tinkham of Tinkham & Associates, presented the audit report.

13-C-05-2016

It is moved by Dr. John Rapin and seconded by Dr. Eric Stanton that:

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

CARRIED

TOPICS FOR INFORMATIOIN

Government Sexual Violence and Harassment Initiatives

Grey Areas – Commentary on Legal Issues Affecting Professional Regulation

Policy Report

Government Relations Report

Discipline Committee – Report of Completed Cases, May 2016

Draft Revised: IHF Clinical Practice Parameters and Facility Standards for Sleep Medicine

Motion to go In Camera

14-C-05-2016

It is moved by Dr. John Rapin and seconded by Dr. Eric Stanton 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.

CARRIED

IN CAMERA

Council entered into an In-Camera session at 1:30 p.m. and returned to open session at 1:40 p.m.

ADJOURNMENT

President adjourned the meeting at 1:40 p.m. and thanked everyone for their time.

_____
Dr. Joel Kirsh, President

_____
Franca Mancini, Recording Secretary

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

April 26, 2016 EXECUTIVE COMMITTEE MEETING

1. Interventional Pain Management (IPM) Procedures: Working Group Recommendations

An Interventional Pain Management (IPM) Working Group was convened to provide advice to the College regarding concerns raised by physicians specific to IPM procedures being performed in out-of-hospital premises (OHPs), namely the paravertebral nerve block (PVNB).

The Working Group provided definitions for the current list of IPM procedures in College documents and made key recommendations to require assessors to focus assessments on optimal patient outcomes rather than technique.

The Executive Committee accepted the Interventional Pain Management (IPM) Working Group's recommendations, and directed that the proposed nerve block definitions be added to the College document *"Expectations of Physicians Who Have Changed or Plan to Change their Scope of Practice to Include IPM".*

2. Governance Committee Report - Request to rescind ICR Committee Appointment– Dr. Eugenia Piliotis

The Executive Committee rescinds the ICR Committee appointment for Dr. Eugenia Piliotis.

June 21, 2016 EXECUTIVE COMMITTEE MEETING

1. Expert Advisory Group on Methadone Treatment and Service Report: CPSO Feedback

The Ministry of Health and Long-Term Care formed an Expert Advisory Group to review best practices on methadone treatment and service and make recommendations for opioid use disorder treatment. The CPSO Methadone Committee reviewed the recommendations of the Expert Advisory Group and provided feedback. The Executive Committee reviewed the Methadone Committee's feedback and considered next steps.

The Methadone Committee's response was that the advisory group was unable to do justice to a wide variety of complicated topics in a short period of time. None of the recommendations involving the CPSO were seen to have enough detail to determine if they will have significant organizational impact.

The Executive Committee directed staff to provide to the Expert Advisory Group on Methadone Treatment and Service Report, a letter supporting in principle only those recommendations aligned with existing College positions, such as the need for a better Narcotics Monitoring System and more physician education.

2. Pilot Project for Independent Legal Advice to Complainants/ Witnesses in Discipline Hearings relating to Sexual Misconduct

The Executive Committee supported a 12-month pilot project to provide independent legal advice to complainants/witnesses who are expected to testify in a College discipline hearing relating to sexual misconduct.

The College's goal is to help improve the process of testifying in sexual misconduct hearings for witnesses, and to demonstrate to other potential victims and the public that the College takes these matters seriously and wants to do what it can to make the experience less difficult for witnesses.

3. Supervised Injection Services Request for Support from the Medical Officer of Health

The Medical Officer of Health has asked for the CPSO's support of the introduction of supervised injection services in three clinics in Toronto.

The Executive Committee approves sending a general letter of support to the Medical Office of Health stating that supervised injection services are consistent with the College's public protection mandate, and with the goals of the methadone program, including harm reduction. The College's letter will not address the specific locations of the proposed supervised injection services.

4. Physician-Assisted Death/Medical Assistance in Dying: Update

Now that Bill C-14 has received royal assent, the draft *Medical Assistance in Dying* policy, approved by Council in May 2016, was updated to reflect the final language of the federal law. As contemplated by Council, the Executive Committee reviewed the updated version and approved the policy on its behalf.

The Executive Committee directed that the *Physician- Assisted Death* policy be rescinded.

The Executive Committee approved the *Medical Assistance in Dying* policy.

September 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 September 8, 2016 meeting of Council, **Dr. Martin White** of Carleton Place, Ontario will receive the Council Award

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DECISION FOR COUNCIL:

No decisions required

CONTACT: Tracey Sobers, ext. 402

DATE: August 22, 2016

Appendices: N/A

September 8, 2016

COUNCIL
BRIEFING NOTE

TOPIC Quality Management Partnership: Dissemination of Facility Quality Reports for Mammography, Colonoscopy and Pathology Services

For Discussion

ISSUE

- The Quality Management Partnership (*click for a link to the Partnership infographic*) is a strategic initiative of the College and this note provides Council with an overview of the development and implementation of the Partnership's facility quality reports that began dissemination July 8th 2016 and will continue into the Fall.
- A presentation by CCO Partnership staff at the September 8th meeting will provide additional background for Council.

BACKGROUND

- At its July 26th meeting, Executive Committee had a presentation about the development, purpose and dissemination of the facility quality reports. Executive agreed it would be useful for Council to have this information.

- Council has been updated regularly on this strategic initiative.

- On March 5, 2015 Council approved the Partnership's Phase Two report entitled *Provincial Quality Management Programs for Colonoscopy, Mammography and Pathology in Ontario* for submission to the Ministry of Health on March 31st, 2015. An overview of the QMPs and implementation considerations was presented to Council as well.

- Council fully supported the ongoing involvement of the College in the Partnership with the acknowledgement that the College's participation in the Quality Management Programs outlined in the report is contingent upon the outcomes of the HQO Review.

- In December 2015, in an announcement that was released to all stakeholders, the MOHLTC asked the Partnership to proceed with implementation of the provincial quality management programs.

- Once fully implemented, the quality management programs will:
    - Increase consistency in the quality of care provided across facility types (e.g. hospitals and Independent Health Facilities),
    - enhance quality of care, and
    - improve patient safety and public confidence by increasing accountability and transparency.

CURRENT STATUS

- Implementation planning of the quality management programs for colonoscopy, mammography and pathology is underway with activity expected to span a three year period starting in 2015/16.

- To facilitate sharing of information, and discussion of implementation and operation strategies specific to the College, a staff working group has been formed and meets bi-monthly.

- To support the College's contribution to implementation, an Evaluation Specialist, Stakeholder Relations Lead and Physician Education-Quality Specialist have been added to the College's Partnership staff team.

- Funding for the College's Partnership activities is provided by CCO.

Implementation of the Quality Management Model

- The quality management model consisting of three tiers of clinical accountability for the quality management programs is being implemented and includes:
    - **Provincial Leads:** Drs. David Morgan, Rene Shumak and Katherine Chorneyko as our Partnership Provincial Clinical Leads for Colonoscopy, Mammography, and Pathology, respectively have been completed.
    - **Regional Leads:** CCO's regional lead structure for colonoscopy and mammography has been leveraged and leads are now in place. Recruitment for pathology Regional Leads is occurring separately and closed on August 22nd, 2016. Regional leads will help to foster continuous quality improvement, sharing of best practice and support Facility Leads within their respective regions.

- **Facility Leads:** Each facility where services are provided is identifying a facility lead. In OHPs this may be the Medical Director and in IHFs the Quality Advisory. These leads will be the primary contact and recipient of quality reports and help to foster continuous quality improvement for the facility and physicians providing services in it.

- A Provincial Quality Committee for each service has been formed. These committees will be chaired by the provincial lead; members will include the regional leads. Each committee will provide overall guidance and leadership for the quality management programs. For example, they will advise on program priorities and identify opportunities for system recommendations.

Implementation of the Facility Quality Reports

- The aim of the facility quality reports is to provide a core set of standards for colonoscopy, mammography, or pathology facilities that will help assure consistent delivery of patient care.

- The quality reports will be used as an input into the quality management programs for each service area which will monitor quality at the provider, facility, regional and provincial level and support continuous quality improvement. The Partnership is currently defining the types of desired activities facilities and physicians could take upon receiving quality reports. It is also considering the training that physicians may need in support of these activities.

- Wherever possible, the Partnership is aiming to minimize the data collection burden for facilities by leveraging CCO's existing datasets and data collection systems. For example the mammography facility quality reports will reflect data currently collected by CCO's Ontario Breast Screening Program (OBSP). Radiologists reading mammography will be familiar with data in these reports as it will be the same as that provided in their Radiologist Outcome Reports (ROR) though presented differently.

- The objectives of these first facility quality reports is to engage facilities in the work of Partnership, create awareness and understanding of what the indicators mean and spark quality improvement discussions within facilities.

- The facility quality reports (and the provider reports to be released in 2017/18) will not be made public. However, the Partnership is considering a future public reporting strategy and Council will be engaged in future discussions. Some public reporting considerations currently under discussion include identifying the audience(s) and purpose of public reporting as well the feasibility of aligning with other public reports in the system, for example with

Health Quality Ontario's *Measuring Up – A yearly report on the performance of Ontario's health system.*

- On July 8th 2016 the regional and provincial view of mammography facility quality reports were issued to CCO mammography regional leads, samples of which are attached as Appendix A. The facility level view of mammography quality reports will be issued to facilities, regional leads and the provincial lead in September of this year and will be formatted as in Appendix A (i). Following are the tentative release dates for the additional view of the mammography report and other service area facility quality reports:

    - Colonoscopy – October 2016
    - Mammography (Facility Reports) – November 2016
    - Pathology – November, 2016

- Physician (provider) level quality reports for all three service areas will be issued in 2017/18. Council will be kept informed of timing and plans for dissemination of these reports.

Distribution and Review of QMP Facility Quality Reports

- Facility quality reports will be provided to physicians, along with feedback from the Facility Lead to ensure a focus on continuous quality improvement. As outlined below in Table 1, the distribution and review of the facility quality reports is an interaction where the feedback identifies opportunities for improvement and were continuing professional development may be required or desired. This process does not replicate or replace College peer assessments or facility inspection-assessments.

- College staff will see only annonymized and aggregated information rolled-up to a regional or provincial level. However, a process is being developed requiring facility and regional leads to inform the College should a patient safety concern be identified as a result of reviewing the facility quality reports (and provider level quality reports when issued).

- Facilities will receive quality reports with comparators to their region and the province that provide owners, medical directors, or chief of departments the opportunity to see facility level performance information and where issues are that need the facility's attention. However, where there are three (3) or fewer providers in a facility, data will be suppressed to ensure confidentiality.

Table1: Distribution and Review of Facility Quality Reports

Report Recipient:	Providers	QMP Facility Leads	QMP Regional Leads	QMP Provincial Leads
Facility Quality Reports	Identified facility data for their facility (e.g., wait times for facility A)	Identified facility data for their facility	Identified facility data for facilities within their region	Identified facility data for all facilities
	Facility comparator data (e.g., wait times for all facilities in Ontario)	Facility comparator data	Facility comparator data	Facility comparator data

Development of Quality Reports

- Wherever possible clinical indicator data has been used from existing CCO data sources as such the facility quality reports are a mix of rolled-up physician level clinical indicators and self-reported information for each facility. The pathology facility quality report will consist only of self-reported aggregated and annonymized physician level indicators as there are no agreed upon clinical indicators at this time.

- Development of the Partnership quality reports for both the facility and physician are being led by CCO.

- The mammography facility quality reports have been focused tested with end-users (1 provincial lead, 3 regional leads, and 3 College assessors and 1 IHF administrator [representing facility leads]) with the aim of confirming that performance can be correctly identified and that the design of the quality report supports the assessment of performance. User testing is currently being completed to ensure data is represented accurately.

- This process will be replicated for colonoscopy and pathology as those facility quality reports are developed.

- Overtime all Partnership quality reports are expected to evolve to include increased interactivity, improved comparators (e.g. improvement over time), and improved reporting frequency, i.e., more than annually.

- Over the next three years facility quality reports and provider level quality reports, when issued, will be evaluated to ensure they are meaningful, reliable and useful.

NEXT STEPS

In Support of the Facility Quality Reports

- Administrative and physician contacts responsible for quality in each facility have been identified. To facilitate utilization of the facility quality reports, the Partnership will support Regional Leads and facility staff by:
    - Providing training on how to read and interpret reports as well as the methodology behind the indicators.
    - Delivering training on continuous quality improvement methods.
    - Developing Regional Communities of Practice and facilitating their understanding of the facility quality reports, the indicator methodology and work with a Provincial Quality Committee for each health service area to determine if any action could be taken based on them.
    - Providing guidelines to help physicians participating in quality improvement opportunities access Continuing Professional Development (CPD) credits. Where feasible, the Partnership will work to accredit planned training for these participants.
    - Continuing our engagement through presentations, newsletters, teleconferences and its website.
- Additional supports may be identified through a needs assessment which will conclude later in 2016/17. It is anticipated that training needs will include constructive peer feedback, quality improvement skills and methods, as well as application of pertinent policy. Foundations for training delivery are under development and will include virtual communities of practice.

CONSIDERATIONS

- As noted above, development of a Quality Assurance Reporting process has begun with Partnership clinical leads. This is a process requiring facility and regional leads to inform the College should a patient safety concern be identified as a result of reviewing the facility quality reports (and provider level quality reports when issued) The process would be an expectation of the QMPs until such time that regulation is developed and put in force to make this mandatory.
- Activity to assess the possible risks related to the dissemination of the facility quality reports is underway. Staff are meeting with Provincial Leads to further define the risks and issues which may include: misinterpretation of the data;

miss-aligned facility quality reports with CPSO facility inspection outcomes, e.g., OHP that has a conditional pass when a facility quality report indicates they are meeting the standard outlined in that report. Once risks are identified staff from both organizations will develop strategies to respond.

- It is not clear to what extent College assessors and investigators may want or need to have access to these quality reports. Work is ongoing to consider the utility of them in these contexts.

DECISION

None – for discussion.

CONTACT: Robin Reece, Ext. 396
Wade Hillier, Ext. 636

DATE: September 8, 2016

Attachment: Mammography Facility Quality Report – 3 page regional view

- Mammography Facility Quality Report - regional view i
- Mammography Facility Quality Report - regional view ii
- Mammography Facility Quality Report - regional view iii (OBSP data only)

Mammography QMP 2016 Regional Report

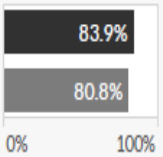
Your region: Central East

Quality Management Partnership

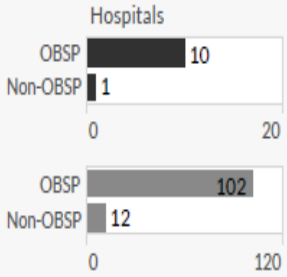
QMP Recommendations

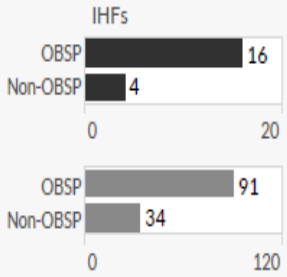
Your region | Province

All facilities should participate in the OBSP — 26 / 31

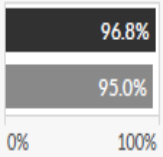


Participation by facility type

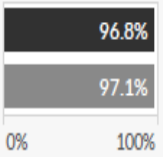




All facilities should maintain CAR-MAP accreditation (currently mandatory for IHFs and OBSP sites) — 30 / 31



All mammography units should be digital — 30 / 31



*For 2013 screen year, except "post-screen invasive cancer rate," for 2009-2011 screen year
**For 2014 screen year

The targets listed are for a different age range than the data used to calculate the indicator values, and so should be used for illustrative purposes only. In addition, indicator results are most reliable for 2,000 or more screens. For fewer than 1,000 screens, the results may not be as reliable.

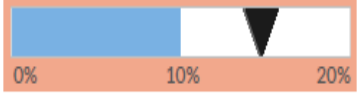
See www.qmpontario.ca for methodology.

Radiologist Outcomes (OBSP Screening)*

Meets target | Does not meet target | No target | Your region | Province | Target zone

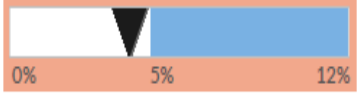
Abnormal calls (%)
Initial Screens (Target: <10%)

14.8%
2,054 / 13,839 Province: 14.7%



Positive predictive value
Initial screens (Target: ≥5%)

4.2%
84 / 2,023 Province: 4.3%

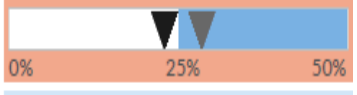


Invasive cancer detection rate
Initial screens (Target: >5/1,000)

5.1/1,000
71 / 13,808 Province: 5.0/1,000

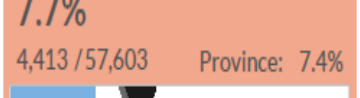
Tumour size (Target: >25% ≤1cm)

23.0%
59 / 256 Province: 28.5%



Abnormal calls (%)
Rescreens (Target: <5%)

7.7%
4,413 / 57,603 Province: 7.4%



Positive predictive value
Rescreens (Target: ≥6%)

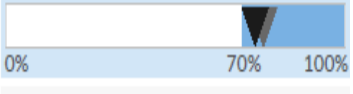
5.8%
253 / 4,371 Province: 7.0%

Invasive cancer detection rate
Rescreens (Target: >3/1,000)

3.6/1,000
206 / 57,561 Province: 4.2/1,000

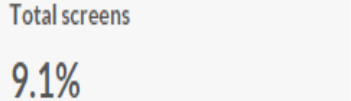
Negative nodes (Target: >70%)

73.5%
189 / 257 Province: 75.9%



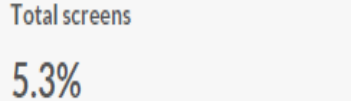
Abnormal calls (%)
Total screens

9.1%
6,467 / 71,442 Province: 8.7%



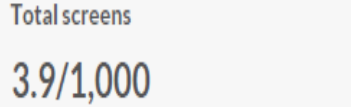
Positive predictive value
Total screens

5.3%
337 / 6,394 Province: 6.2%



Invasive cancer detection rate
Total screens

3.9/1,000
277 / 71,369 Province: 4.3/1,000

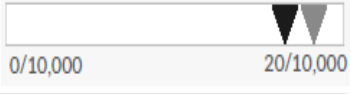


DCIS detection rate

0.7/1,000 Province: 0.9/1,000
52 / 71,369

Post-screen invasive cancer rate

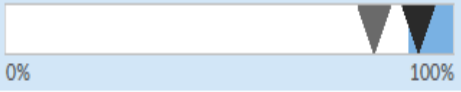
13.1/10,000 Province: 14.5/10,000
187 / 143,286



Wait Times (OBSP)** (Target ≥90%)

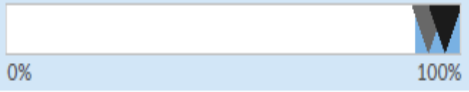
Wait time to first assessment (≤3 weeks)

92.1%
6,060 / 6,579 Province: 82.0%



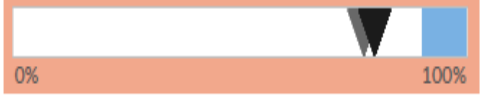
Wait time to diagnosis without tissue biopsy (≤5 weeks)

96.6%
5,360 / 5,546 Province: 92.8%



Wait time to diagnosis with tissue biopsy (≤7 weeks)

79.3%
796 / 1,004 Province: 77.1%



Mammography QMP 2016 Facility Summary Report (OBSP data only)

Your region: Central East

Meets target | Does not meet target | No data | <3 radiologists

Quality Management Partnership

CONFIDENTIAL: Please note, Cancer Care Ontario (CCO) has provided this report solely for the purposes of performance management for the Quality Management Partnership. Do not use, publish or disclose the contents of this report without CCO's prior consent.

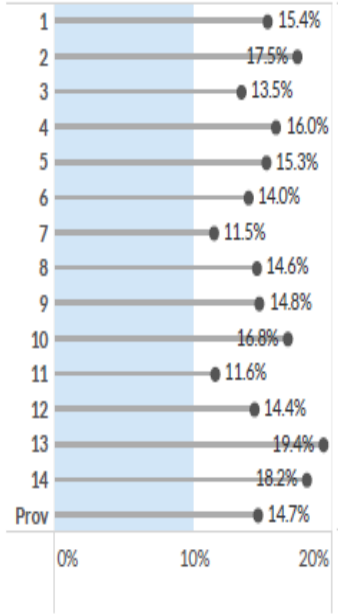
	Abnormal calls (%): Initial screens	Abnormal calls (%): Rescreens	PPV: Initial screens	PPV: Rescreens	Invasive cancer detection rate: Initial screens	Invasive cancer detection rate: Rescreens	Tumour size	Negative nodes	Wait time to first assess-ment (≤3wks)	Wait time to diagnosis w/o tissue biopsy (≤5wks)	Wait time to diagnosis w/tissue biopsy (≤7wks)
[redacted]	No data	No data	No data	No data	No data	No data	No data	No data	90.4%	100.0%	50.0%
[redacted]	4.2%	4.2%	7.1%	6.0%	10.1	2.5	40.0%	80.0%	82.5%	100.0%	90.0%
[redacted]	12.1%	12.1%	6.8%	6.0%	6.5	5.7	27.3%	72.7%	98.1%	99.1%	83.7%
[redacted]	10.1%	10.1%	5.0%	6.1%	9.4	4.8	42.9%	71.4%	97.8%	99.1%	86.0%
[redacted]	7.8%	7.8%	0.9%	4.9%	1.6	3.4	31.6%	68.4%	95.6%	99.7%	87.3%
[redacted]	2.6%	2.6%	11.3%	14.8%	6.5	2.8	33.3%	77.8%	90.6%	94.6%	69.4%
[redacted]	9.1%	9.1%	5.8%	3.8%	6.6	3.0	8.3%	66.7%	94.8%	98.1%	71.7%
[redacted]									96.6%	99.2%	90.9%
[redacted]									93.8%	99.0%	90.0%
[redacted]	9.3%	9.3%	1.1%	4.8%	2.3	3.2	18.2%	80.0%	96.6%	98.2%	87.5%
[redacted]	4.6%	4.6%	2.0%	9.4%	1.7	4.3	16.7%	83.3%	60.9%	84.4%	60.0%
[redacted]	10.5%	10.5%	3.7%	7.2%	4.7	6.8	42.3%	74.1%	92.6%	97.7%	85.4%
[redacted]									90.0%	94.0%	76.5%
[redacted]	3.8%	3.8%	4.1%	11.0%	3.8	3.1	14.3%	61.9%	98.7%	99.2%	69.2%
[redacted]	8.2%	8.2%	11.4%	7.7%	9.2	5.9	19.2%	73.1%	56.9%	91.5%	85.7%
[redacted]	12.2%	12.2%	2.4%	2.3%	4.9	1.9	10.0%	90.0%	96.1%	97.4%	71.7%
[redacted]	11.0%	11.0%	2.9%	3.2%	3.5	2.0	12.5%	75.0%	96.1%	97.7%	85.4%
[redacted]	10.6%	10.6%	3.2%	5.8%	6.0	4.2	16.0%	76.9%	93.9%	95.5%	79.7%
[redacted]	11.6%	11.6%	0.0%	2.8%	0.0	2.4	33.3%	100.0%	100.0%	98.1%	100.0%
[redacted]	7.8%	7.8%	4.6%	4.7%	6.8	3.0	11.8%	76.5%	92.8%	92.7%	51.6%
[redacted]	3.9%	3.9%	5.4%	6.6%	4.9	1.7	0.0%	25.0%	91.9%	97.1%	92.9%

Mammography QMP 2016 Regional Summary Report (OBSP data only)

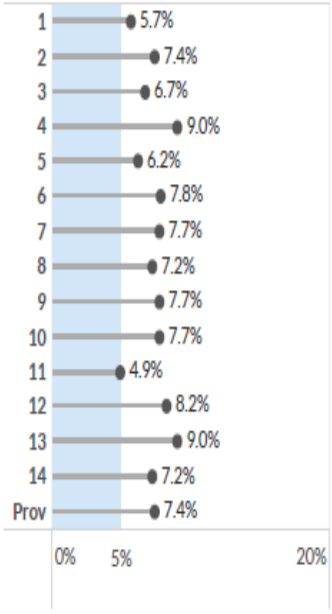
Target zone

Quality Management Partnership

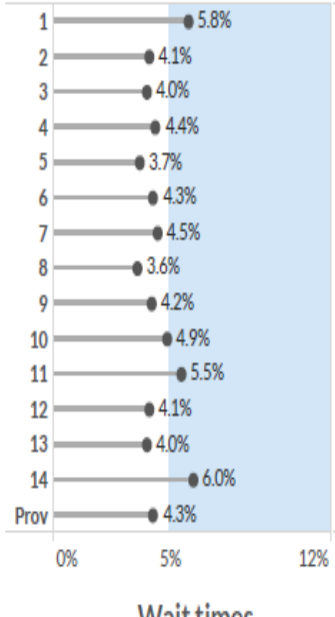
Abnormal calls (%)



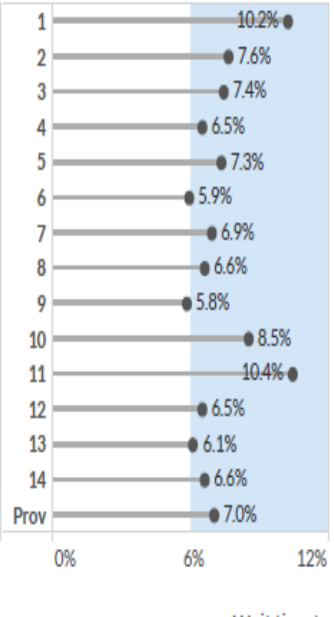
Abnormal calls (%)



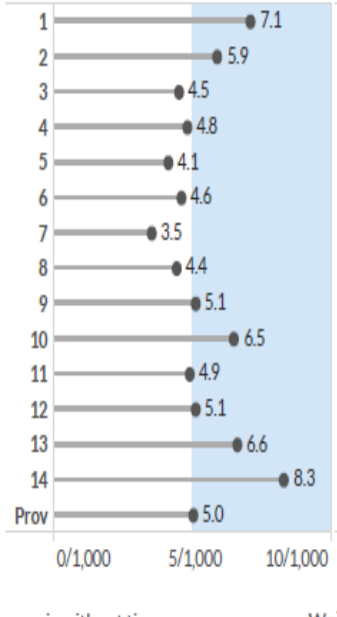
Positive predictive value



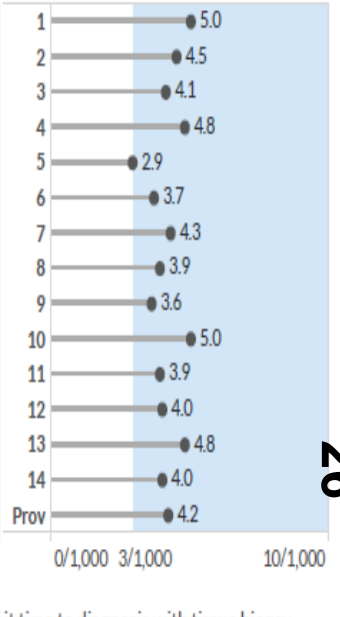
Positive predictive value



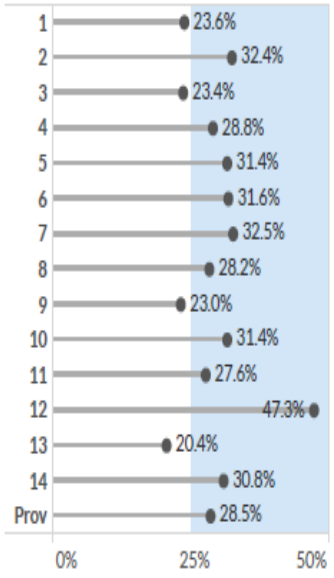
Invasive cancer detection rate



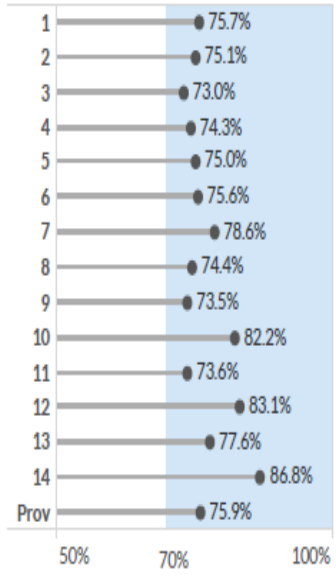
Invasive cancer detection rate



Tumour size

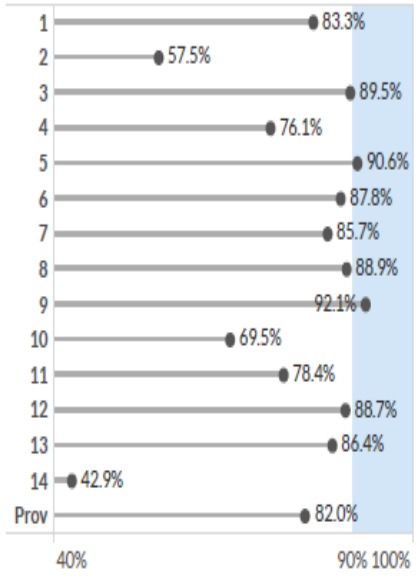


Negative nodes

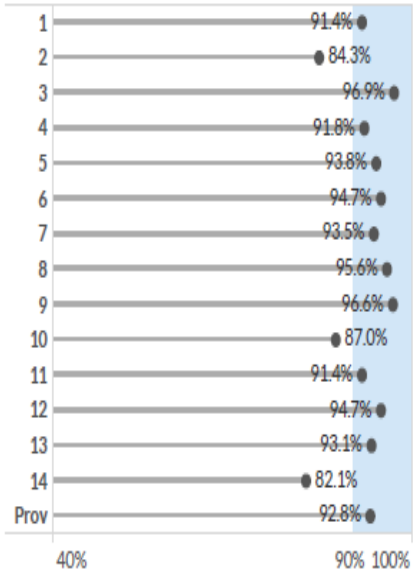


Wait times

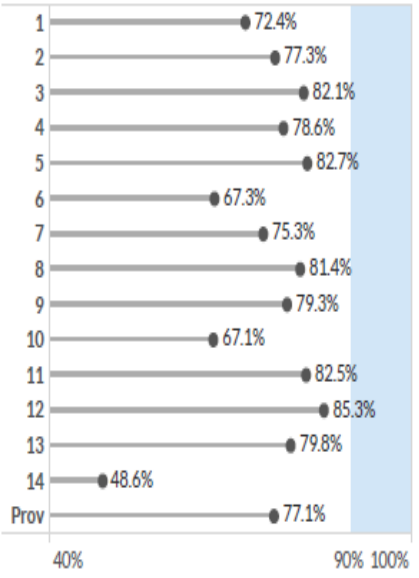
Wait time to first assessment (≤3 weeks)



Wait time to diagnosis without tissue biopsy (≤5 weeks)



Wait time to diagnosis with tissue biopsy (≤7 weeks)



COUNCIL BRIEFING NOTE

TOPIC: By-Law Amendments – Consultation Report

FOR DECISION

ISSUE:

Approval of proposed amendments to the By-law register provisions (By-Law No. 110).

BACKGROUND:

- A list of proposed amendments to the By-law register provisions were presented to Council at the May 2016 meeting. 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.

- The proposed amendments were approved by Council for external consultation at the May 2016 meeting.

- The proposed amendments were circulated for external consultation between May 31 and August 12, 2016.

CURRENT STATUS:

- Council is provided with a report on the consultation.

Consultation process

- Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the entire CPSO membership. 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 CPSO's public e-newsletter, formerly *Noteworthy*).

- A consultation specific page was created, giving stakeholders the option of submitting their feedback in writing, via email or regular mail, or by posting comments to an online discussion page.

Feedback Received

- The CPSO received a total of three consultation feedback responses, all from organizations. The three organizations were The Professional Associations of Residents of Ontario, the Ontario Trial Lawyers Association and the College of Physicians and Surgeons of Saskatchewan.

- All written feedback received during the consultation is posted on the CPSO website in keeping with regular consultation processes and posting guidelines.

- Stakeholders provided feedback on two of the proposed by-law amendments. A summary of the key comments received is set out below along with an explanation addressing the issue raised for purposes of this briefing note (these explanations were not provided to the commenters).

  Support for the amendments

  - Broadly speaking, stakeholders expressed support for the amendments and their contribution to improving transparency.

  General Criticisms

  - One stakeholder questioned why hospital resignations would appear on the registry as they would unlikely be connected to findings.
    - CPSO explanation: The amendment reflects the language in Section 85.5 of the Health Professions Procedural Code (the "Code"). It is intended to capture situations in which a physician may resign in the face of anticipated discipline by the hospital or other practice-related problem.
  - Another stakeholder expressed concern over By-Law subsection 50.1(1) which they interpreted as removing the background behind a term, condition or restriction placed on a physician's profile. This stakeholder felt that a term, condition or restriction can reflect a serious breach in practice or knowledge and should be made public knowledge, even after the term, condition or restriction has expired.
    - CPSO explanation: The By-Law amendment does not change, but rather reflects, the current practice for posting and removing terms, conditions and limitations (TCLs) on the website. Also, expired TCLs imposed by the Discipline Committee and the Fitness to Practise Committee do remain on the register subject to section 23(11) of the Code.

Revisions in Response to Feedback

- All of the feedback received has been carefully reviewed. We do not believe that any revisions to the by-law amendments are necessary or appropriate in response to the feedback.

DECISION FOR THE COUNCIL:

Does Council wish to pass By-Law No. 110 to enact the proposed by-law amendments?

CONTACTS: Marcia Cooper, ext. 546
James Stratford, ext. 210

DATE: August 16, 2016

Attachments:

Appendix 1: By-law Amendments

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~~ny~~ 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.	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.
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~~	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.

Proposed Amendment	Explanatory Note
iv. ~~whether the member was certified by examination and, if not, by what process~~	
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 portion of this by-law went into effect.	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 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,	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.

Proposed Amendment	Explanatory Note
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.	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, 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.	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 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

Proposed Amendment	Explanatory Note
	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 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~~	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 history. Accordingly, the "fact" that a TCL had been imposed is technically public, but the contents of the TCL would no longer be posted.

~~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.	

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; (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	This amendment explicitly requires members to advise the College of a name change <u>within a given time period</u> (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 only for those changes in the member's name that the member will be practising under.

Proposed Amendment	Explanatory Note
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.	

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~~	Section 23(2)7 of HPPC requires the

Proposed Amendment	Explanatory Note
~~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.~~	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, ~~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	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 subsequent paragraphs in s. 49, it would be better to place this within para. 16 to which it relates.

Proposed Amendment	Explanatory Note
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")~~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 licen~~sc~~ed to practice medicine in another jurisdiction, and such licen~~c~~se or registration has been made known to the College as 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.

Proposed Amendment	Explanatory Note
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**.

August 2016

COUNCIL BRIEFING NOTE

TOPIC: College Oversight of Fertility Services – Regulation Change Proposal

FOR DECISION

ISSUE:

- The College has been asked by the Ministry of Health to develop and implement a quality and inspections framework for the delivery of fertility services across the province.

- In order to fulfill this request, the College needs authority to enter and inspect the premises where fertility services are performed, regardless of whether anesthesia or sedation is used.

- An amendment to *Ontario Regulation 114/94, Part XI (Inspections of premises where certain procedures are performed)* made under the *Medicine Act, 1991* is proposed as it would bring fertility services under the Out of Hospital Premises Inspection Program (OHPIP) and provide the College with the necessary authority to inspect.

- Council is provided with information regarding the development of this quality and inspections framework and is provided with a draft of the proposed regulation change. Council is asked whether the draft regulation can be released for external consultation.

BACKGROUND:

- In August 2015, Deputy Minister, Dr. Bob Bell wrote to the College requesting our participation in establishing a quality and inspections framework for the fertility services sector.

- Specifically, the Ministry asked that this framework include the development of:
    - Comprehensive quality assurance standards, including program standards, professional qualifications and embryology quality assurance standards;
    - Clinical guidance for fertility services;

- Enhanced performance and quality data reporting requirements for fertility clinics; and
- Implementation of a comprehensive inspections regime for the fertility services sector.

- The College agreed to work with the government to develop and implement the framework outlined above.

- In December 2015, the government launched its newly expanded government funded fertility program. This program funds one cycle of in vitro fertilization (IVF) per patient under age 43, per lifetime for all forms of infertility. Funding for unlimited cycles of intra-uterine insemination (IUI) and one fertility preservation (FP) cycle for medical reasons are also being provided. Currently, there are 52 clinics in the province that have received funding for the government's program through a Transfer Payment Agreement (TPA).

- The College's oversight, however, will apply to all facilities that offer fertility services, regardless of whether they are receiving funding under a TPA.

- In March 2016, an Expert Panel on Fertility Services was convened by the College to assist with the work of developing an effective quality oversight system. The Expert Panel is comprised of physician leaders in reproductive medicine and other health professionals such as embryologists.

- As of the end of August, the Expert Panel had met five times and is in the process of developing the Out of Hospital Premises Inspection Program (OHPIP) Standards to be used in facilities where fertility services are offered. The draft standards will be circulated for external consultation and subsequently approved by the Premises Inspection Committee in the coming months. Once approved, the standards will be provided to Council for information.

- The standards development as well as the development of a draft amended regulation, have taken place in cooperation with the Ministry of Health.

<u>CPSO and Facilities Regulation</u>

- The College's involvement in facilities regulation began in the early 1990s with the establishment of the Independent Health Facilities Act (IHFA) and a regulatory system for a subset of facilities; independent health facilities (IHFs).

- College involvement in facilities regulation was expanded in 2010 with the development of the Out of Hospital Premises Inspection Program (OHPIP), which was created to regulate another subset of facilities, namely, out of hospital premises (OHPs) providing health services under specified types of

anesthesia and sedation. This program was created through *Ontario Regulation 114/94* under the *Medicine Act, 1991.*

- Under OHPIP, the College is responsible for all of the program elements: the CPSO develops the standards and assessments tools; coordinates and conducts the facility assessments, and through the Premises Inspection Committee (PIC), determines the appropriate outcome for each facility.

- Although some fertility clinics offer services that are delivered under types of anesthesia and sedation and are therefore currently captured under OHPIP, not all fertility services, such as intra-uterine insemination (IUI), are currently subject to oversight.

- Bringing facilities that offer fertility services, regardless of the use of anesthesia or sedation, under the purview of OHPIP will respond to the government's request of developing and implementing a quality and inspections framework for this sector and will ensure high quality care for Ontario patients.

CURRENT STATUS:

- College staff, in consultation with the Expert Panel on Fertility Services, have developed a draft amendment to *Ontario Regulation 114/94, Part XI (Inspections of premises where certain procedures are performed)* which would provide the College with the authority to inspect premises that offer fertility services, regardless of whether anesthesia or sedation is used.

- The proposed amendments can be found in **Appendix 1**.

- The changes proposed in the draft revised regulation would allow the inspection of premises where:

  44.(1)(b.1) any act that is performed in connection with,
  - *i. in vitro fertilization,*
  - *ii. intra-uterine insemination, or*
  - *iii. fertility preservation for medical purposes,*

- These subsections were identified by the government as services to be captured by the quality and inspections framework.

- The proposed regulation is also amended to clarify that *44.(1)(b.1)* does not include "the sole act of counseling or referral for the procedures set out in subsection (b.1)."

- The drafting aims to strike a balance in defining what would be captured by the College's oversight regime. The wording above seeks to clarify that fertility counselling or referrals on the part of a family doctor, for example, would be outside of the scope of oversight. However, given that the field will continue to evolve, and based on the College's experience regulating other out-of-hospital premises, there is a risk that the current drafting may not cover advances in the field going forward.

- The regulation is amended to clarify that hospitals that are performing the procedures included in 44.(1)(b.1) are also subject to inspection and that the existing timelines in the regulation regarding notification and inspection will also apply to premises that offer fertility services.

- In order to fulfill the Ministry's request that performance and data reporting requirements be enhanced, a change is proposed in 47.(c) that would compel a member to provide this information, if requested.

- Further conversations with the Ministry of Health about data reporting will be required.

Assessment Related Costs

- In 2012, Council directed that premises captured under the Out-of-Hospital Premises Inspection Program (OHPIP) would be managed on a cost-recovery basis.

- Annual fees associated with the Program are classified by the level of anesthesia or sedation and procedures provided in the premises. The difference in assessment costs will differ depending on the scope of practice at the OHP, the time and resources needed to do the assessment and the number of assessors required.

- Fertility clinics captured as part of the amendment to the regulation will be invoiced an annual fee estimated to be in the range of $3,895 to $4,490, billed to the Medical Director.

- As in the other parts of the OHPIP program additional charges will be billed at cost to fertility OHP for subsequent assessments outside of the scheduled 5 year cycle of assessment.

- The annual fee supports the core program infrastructure (administration and oversight of the inspection process) staffing and technology support, and the Premises Inspection Committee. Start-up costs associated with the development of the quality and inspections framework for fertility services will also be cost-recovered.

NEXT STEPS:

- In keeping with College's statutory obligations, the next stage in the consideration of a regulatory change proposal is to solicit feedback on the draft regulation externally, through a consultation with the profession, the public and other interested parties.

- Subject to Council's approval, the consultation will be held in the fall and stakeholder feedback and a final regulation will be presented to both Executive Committee and Council in the winter.

- Once finalized by Council, the draft regulation will be submitted to government for their consideration.

DISCUSSION QUESTIONS AND DECISIONS FOR EXECUTIVE COMMITTEE:

1. Does Council have any feedback on the draft regulation change proposal?

2. Does Council recommend that the draft regulation change proposal be released for external consultation?

CONTACT: Wade Hillier Ext. 636
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Nathan Roth Ext. 274
Miriam Barna Ext. 557

DATE: August 24, 2016

Attachments:

Appendix 1: Tracked changes - *Ontario Regulation 114/94, Part XI (Inspections of premises where certain procedures are performed) made under the Medicine Act, 1991*

PART XI
INSPECTION OF PREMISES WHERE CERTAIN PROCEDURES ARE PERFORMED

44. (1) In this Part,

"inspector" means a person designated by the College to carry out an inspection under this Part on behalf of the College;

"premises" means any place where a member performs or may perform a procedure on a patient but does not include a health care facility governed by or funded under any of the following Acts:

1. The *Long-Term Care Homes Act, 2007*.
2. The *Developmental Services Act*.
3. The *Homes for Special Care Act*.
4. Revoked: O. Reg. 134/10, s. 1 (2).
5. Revoked: O. Reg. 192/14, s. 1.
6. The *Ministry of Community and Social Services Act*.
7. The *Ministry of Correctional Services Act*.
8. The *Ministry of Health and Long-Term Care Act*.
9. Revoked: O. Reg. 134/10, s. 1 (2).
10. The *Private Hospitals Act*.
11. The *Public Hospitals Act*;

"procedure" means,

(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 anaesthesia,

(ii) parenteral sedation, or

(iii) regional anaesthesia, 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 anaesthetic,

(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,

(b.1) any act that is performed in connection with,

(i) in vitro fertilization,

(ii) intra-uterine insemination, or

(iii) fertility preservation for medical purposes,

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. O. Reg. 134/10, s. 1 (1, 2); O. Reg. 192/14, s. 1.

(e) the sole act of counseling or referral for the procedures set out in subsection (b.1).

(2) Anything that may be done by the College under this Part may be done by the Council or by a committee established under clause 94 (1) (i) of the Health Professions Procedural Code. O. Reg. 134/10, s. 1 (1).

(3) For the purposes of procedures included in subsection 44(1)(b.1) the definition of "premises" shall include a health care facility governed by or funded under The *Public Hospitals Act*.

45. (1) All premises where a procedure is or may be performed on a patient by a member in connection with his or her practice are subject to inspection by the College in accordance with this Part. O. Reg. 134/10, s. 1 (1).

(2) In carrying out an inspection of a premises under subsection (1), the College may also require any or all of the following:

1. Inspection, examination or tests regarding any equipment, instrument, materials or any other thing that may be used in the performance of a procedure.

2. 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.

3. Inquiries or questions to be answered by the member that are relevant to the performance of a procedure on a patient.

4. Direct observation of a member in his or her practice, including direct observation by an inspector of the member performing a procedure on a patient. O. Reg. 134/10, s. 1 (1).

46. An inspector may, on the production of information identifying him or her as an inspector, enter and have access to any premises where a procedure is or may be performed by a member at reasonable times and may inspect the premises and do any of the things mentioned in subsection 45 (2) on behalf of the College. O. Reg. 134/10, s. 1 (1).

47. It is the duty of every member whose premises are subject to an inspection to,

(a) submit to an inspection of the premises where he or she performs or may perform a procedure on a patient in accordance with this Part;

(b) promptly answer a question or comply with a requirement of the inspector that is relevant to an inspection under this Part; and

(c) co-operate fully with the College and the inspector who is conducting an inspection of a premises, including collection and provision of information requested, in accordance with this Part. O. Reg. 134/10, s. 1 (1).

48. Where, as part of the inspection, an inspector directly observes a member in their practice, or directly observes the member performing a procedure on a patient, before the observation occurs, the inspector shall,

(a) identify himself or herself to the patient as an inspector appointed by the College;

(b) explain the purpose of the direct observation to the patient;

(c) inform the patient that information obtained from the direct observation, including personally identifiable information about the patient, may be used in proceedings under this Part or any other proceeding under the Act;

(d) answer any questions that the patient asks; and

(e) obtain the patient's written consent to the direct observation of the patient by the inspector. O. Reg. 134/10, s. 1 (1).

49. (1) No member shall commence using premises for the purposes of performing procedures unless the member has previously given notice in writing to the College in accordance with subsection (5) of the member's intention to do so and the premises pass an inspection or pass an inspection with conditions. O. Reg. 134/10, s. 1 (1).

(2) The College shall ensure that an inspection of the premises of a member referred to in subsection (1) is performed within 180 days from the day the College receives the member's notice. O. Reg. 134/10, s. 1 (1).

(3) A member whose practice includes the performance of a procedure on a patient in any premises on the day this Part comes into force shall give a notice in writing to the College in accordance with subsection (5) within 60 days from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(4) The College shall ensure that an inspection of the premises of a member referred to in subsection (3) is performed within 24 months from the day this Part comes into force. O. Reg. 134/10, s. 1 (1).

(5) The notice required in subsections (1) and (3) shall include the following information, submitted in the form and manner required by the College:

1. The full name of the member giving the notice and the full name of the owner or occupier of the premises, if he or she is not the member who is required to give notice under this section.
2. The full name of any other member who is practising or may practise in the premises with the member giving the notice.
3. The name of any health profession corporation that is practising at the premises.
4. The full name of any hospital where the member or other members at the premises have privileges or where arrangements have been made to handle emergency situations involving patients.
5. The full name of any other regulated health professional who is practising or may practise in the premises with a member at the premises, along with the name of the College where the regulated health professional is a member.
6. The full address of the premises.
7. The date when the member first performed a procedure on a patient in the premises or the proposed date when the member or another member intends to perform a procedure on a patient at the premises.
8. A description of all procedures that are or may be performed by a member or other members at the premises and of procedures that may be delegated by the member or other members at the premises.
9. A description of any equipment or materials to be used in the performance of the procedures.
10. The full name of the individual or corporation who is the owner or occupier of the premises, if different from the member giving the notice.

11. Any other information the College requires that is relevant to an inspection conducted at the premises in accordance with this Part. O. Reg. 134/10, s. 1 (1).

49(6) All timelines and notice requirements provided in this section apply to every premises where a member performs or may perform a procedure listed in subsection 44(1)(b.1) with reference to the day that section 44(1)(b.1) comes into force.

50. All premises where a member performs or may perform a procedure on a patient are subject to an inspection by the College once every five years after its initial inspection or more often if, in the opinion of the College, it is necessary or advisable to do so. O. Reg. 134/10, s. 1 (1).

51. (1) After an inspection of a premises, the College shall determine, in accordance with the accepted standards of practice, whether the premises pass, pass with conditions, or fail. O. Reg. 134/10, s. 1 (1).

(2) In determining whether premises pass, pass with conditions or fail an inspection, the College may consider,

(a) the inspection results provided to the College by the inspector;

(b) information provided by one or more members who perform or may perform procedures in the premises respecting the inspection, including the answers given by them in response to inquiries or questions asked by the inspector;

(c) the information contained in a notice given by a member under subsection 49 (1) or (3);

(d) any submissions made by the member or members practising in the premises that are relevant to the inspection; and

(e) any other information that is directly relevant to the inspection of the premises conducted under this Part. O. Reg. 134/10, s. 1 (1).

(3) The College shall deliver a report, in writing, to the owner or occupier of the premises and to every member who performs or may perform a procedure on a patient in the premises, within a reasonable time after the inspection is completed, in accordance with section 39 of the *Regulated Health Professions Act, 1991*. O. Reg. 134/10, s. 1 (1).

(4) Any report made by the College respecting an inspection of premises where a procedure is or may be performed shall make a finding that the premises passed, passed with conditions, or failed the inspection and shall provide reasons where the premises passed with conditions or failed the inspection. O. Reg. 134/10, s. 1 (1).

(5) Any report made by the College that makes a finding that the premises failed an inspection or passed with conditions is effective on the day that it is received by one or more members who perform or may perform a procedure within the premises, in accordance with section 39 of the *Regulated Health Professions Act, 1991*. O. Reg. 134/10, s. 1 (1).

(6) A member shall not perform a procedure on a patient in premises that fail an inspection until,

(a) the College delivers a report indicating that the premises passed a subsequent inspection, or passed with conditions; or

(b) after considering submissions under subsection (8), the College substitutes a finding that the premises pass or pass with conditions. O. Reg. 134/10, s. 1 (1).

(7) A member shall not perform a procedure on a patient in premises that pass an inspection with conditions except in accordance with the conditions set out in the report until,

(a) the College delivers a report indicating that the premises passed a subsequent inspection; or

(b) after considering submissions under subsection (8), the College substitutes a finding that the premises pass. O. Reg. 134/10, s. 1 (1).

(8) A member may make submissions in writing to the College within 14 days from the day he or she receives a report made by the College that finds that the premises passed with conditions or failed the inspection. O. Reg. 134/10, s. 1 (1).

(9) The College may or may not elect to re-inspect the premises after receiving a member's submissions, but no more than 60 days after a member provides his or her submissions, the College shall do one or more of the following:

1. Confirm its finding that the premises failed the inspection or passed with conditions.

2. Make a report and find that the premises pass with conditions.

3. Make a report and find that the premises passed the inspection. O. Reg. 134/10, s. 1 (1).

(10) Premises that fail an inspection or pass with conditions may be subject to one or more further inspections within a reasonable time after the College delivers its report, at the request of a member, any other person to whom the College gave the report, or at any time at the discretion of the College. O. Reg. 134/10, s. 1 (1).

(11) Where, as a result of an inspection carried out under this Part, a report made by the College finds that a member's knowledge, skill or judgment is unsatisfactory, the College may direct the Registrar to refer the report to the Quality Assurance Committee. O. Reg. 134/10, s. 1 (1).

(12) Where, as a result of an inspection carried out under this Part, a report made by the College finds that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the College may direct the Registrar to refer the report to the Inquiries, Complaints and Reports Committee. O. Reg. 134/10, s. 1 (1).

August 2016

COUNCIL BRIEFING NOTE

TOPIC: Proposed Regulation under the *Safeguarding our Communities Act (Patch for Patch Return Policy), 2015*.

FOR DECISION

ISSUE:

- The *Safeguarding our Communities Act, 2015,* establishes a "patch-for-patch" return program for Ontario which will require patients who receive prescriptions for fentanyl to return their used patches to a pharmacy in order to receive new ones.

- The Ministry of Health and Long-Term Care is proposing a new regulation under this Act which will set out specific requirements for both physicians and pharmacists related to the implementation of this program.

- Council is provided with an overview of the Act and draft regulation, along with a copy of the CPSO's response to the Ministry's consultation on the draft regulation (**Appendix A**).

- Council is also provided with an overview of two additional elements of work that are underway in response to the Act and the draft regulation: the development of a joint "fact sheet" with the Ontario College of Pharmacists (**Appendix B**), and several housekeeping amendments to the current Prescribing Drugs policy (**Appendix C**). Council is asked for its direction in relation to this work.

BACKGROUND:

- As has been reported in the media and elsewhere, communities across jurisdictions have been struggling with the consequences of fentanyl abuse and overdose.

- In an effort to reduce the abuse, misuse, and diversion of fentanyl patches, the provincial government passed the *Safeguarding our Communities Act, 2015*, which establishes a prescribing framework that will require patients to return used fentanyl patches to a pharmacy as a condition for receiving new ones (click here to view the Act).

- The Act received royal assent on December 10th, 2015; however, it is not yet in force.

- The Act sets out requirements for both physicians and pharmacists related to the prescribing of fentanyl patches, and the establishment of what is known as a "patch-for-patch" program.

- Under a patch-for-patch program, patients must return used fentanyl patches to a pharmacist in order to receive new patches. Where patients do not return their used patches to the pharmacy, pharmacists are authorized to withhold an equivalent number of new patches (the exchange occurs on a 1-to-1 basis).

- The bulk of the *Safeguarding our Communities Act, 2015,* sets out expectations for pharmacists, most importantly that they not dispense new patches to a patient unless their used patches have been collected, except as may be permitted by the regulations made under the Act.

- The Act also articulates two requirements for physicians:

    1. Physicians must note on each prescription for fentanyl patches the name and address of the pharmacy where the prescription will be filled; and
    2. Physicians must notify the pharmacy of every prescription, either by telephone or by faxing a copy of the prescription.

- Historically, the CPSO has been supportive of pilot patch-for-patch programs in various communities. Such programs are also highly supported by police forces, who see them as an effective way to control fentanyl abuse in communities.

CURRENT STATUS:

- Between June and July, 2016, the Ministry of Health and Long Term Care (MOHLTC) consulted on a draft regulation which sets out additional requirements for both physicians and pharmacists under the *Safeguarding our Communities Act, 2015* (click here to view the draft regulation).

- The development of this draft regulation was undertaken in consultation with the CPSO and the Ontario College of Pharmacists (OCP).

- In this section of the brief, Council is provided with an overview of the draft regulation, in addition to an overview of the CPSO's work in response to the Act and the draft regulation.

Overview of the Draft Regulation

- The draft regulation primarily articulates additional requirements for physicians and pharmacists under the Act which clarifies their respsective roles and responsibilities when prescribing and/or dispensing fentanyl.[1]

- Overall, the majority of the draft regulation applies to pharmacists; however, one substantive provision applies to prescribing physicians.

Requirements for physicians who prescribe fentanyl patches

- The draft regulation articulates one central requirement for physicians:

    - When writing their *first* prescription for fentanyl patches for an individual patient, the physician must note this on the prescription itself.

- This notation informs the pharmacist that, because it is the patient's *first* prescription for fentanyl patches, the patient will not have used patches that they can exchange for new ones. This will enable the pharmacist to dispense new patches without having collected used ones first.

- Writing 'first prescription' does not eliminate the potential for prescription fraud.

    - While requiring physicians to note "first prescription" will assist pharmacists in filling prescriptions for patients who have not received fentanyl before, the notation simply confirms that it is the first prescription that has been written by *that* physician. It cannot be treated as an assurance that the patient has not received a previous fentanyl prescription from another provider, or a concurrent fentanyl prescription from another provider.[2]

    - Physicians have limited access to information about a patient's past prescriptions from other providers, and must rely to a large degree on the patient being truthful with respect to whether they have previously received a fentanyl prescription from another prescriber.

    - This requirement of the draft regulation would not necessarily help to prevent patients from receiving multiple prescriptions from multiple prescribers, and may reduce the reliability of the notation "first prescription" as an indicator of the patient's actual past history with fentanyl.

[1] In addition to defining roles and responsibilities, the draft regulation also defines what constitutes a "fentanyl patch", prescribes persons who dispense fentanyl patches outside of a pharmacy as "dispensers" under the Act (e.g. dispensing physicians), and prescribes different classes of prescribers and dispensers.

[2] The draft regulation specifies that physicians can be "reasonably satisfied" that the patient has not obtained a prescription from another prescriber based on discussions with the patient, and any other available information.

Requirements for pharmacists

- The regulation sets out numerous requirements for pharmacists, but focuses primarily on providing clarity around how a pharmacist should respond in the following scenarios:

    - Where the pharmacy has not received advanced notice of a prescription from the prescribing physician's office (which is required under the Act);

    - Where the prescription lists a different pharmacy;

    - Where the patient does not return patches to the pharmacy, or returns a smaller number of patches than they were previously dispensed; and

    - Where the pharmacist has reason to believe that the returned patches are counterfeit or have been tampered with.

- Of particular relevance to physicians is how a pharmacist is expected to respond when a patient fails to produce any or all of the patches that were previously dispensed:

    - In these circumstances, the regulation permits pharmacists to use their "professional judgment" to dispense an "appropriate number of new patches based on an assessment of the patient, including an assessment of the patient's circumstances and the patient's medical condition". Depending on this assessment, the pharmacist may withold an equivalent number of new patches, or they may dispense new patches in accordance with the original prescription.

    - This flexibility will permit pharmacists to respond to the extenuating circumstances of the patient, where, for example, there is a valid reason why the patches have not been returned, and the patient is in urgent need of new ones.

    - Importantly, in *all* cases where used patches are not returned by the patient, or where the pharmacist suspects that the returned patches are counterfeit or tampered with, the pharmacist must always notify the prescribing physician.

CPSO's Work in Response to the Act and Draft Regulation

- The CPSO, together with the OCP, has been actively engaged in this issue as the Ministry has undertaken the development of the Act and the draft regulation.

- The CPSO has provided comments in response to the draft regulation, and has also undertaken two additional elements of work aimed to clarify obligations for physicians that flow from the Act and regulation.

- In light of the Ministry's intention to implement this legislation by October 1st, the CPSO's work flowing from the legislation has been undertaken within a highly accelerated timeframe.

1) Response to the draft regulation

- Analysis of the draft regulation did not reveal any substantive concerns. Accordingly, the CPSO's response (attached as Appendix A) expresses support for the regulation, and provides no specific comment with respect to its content.

- The submission emphasizes that the proposed regulation alone may have a limited effect on the overall incidence of opioid abuse and overdose. The submission recommends specific, proactive strategies to promote a more co-ordinated, system-wide approach to mitigating opioid abuse, including giving physicians greater access to provincial narcotics monitoring data to help them confirm the patient's prescription history.

- Although the submission had already been sent to the Ministry, it was also presented to the Executive Committee at their July 26th, meeting for information.

Decision for Council: As this feedback has already been submitted to the Ministry, this item is for Council's information only.

2) Housekeeping amendments to the CPSO's Prescribing Drugs policy

- Minor housekeeping amendments are proposed to the *Prescribing Drugs* policy to ensure it aligns with the Act and the regulation.

- The amendments will include the following:

    - The Legislative References on the front page of the policy will be updated to include references to the *Safeguarding our Communities Act, 2015;*
    - The section of the policy setting out the required content of prescriptions will be updated to make reference to the new legislation, and the specific requirements for the content of fentanyl prescriptions (**Appendix B**, page 5); and
    - A new subsection will be added to the policy articulating the requirement that physicians notify pharmacies where prescriptions have been written for fentanyl patches (**Appendix B**, page 8).

- In light of other ongoing developments related to opioids, two other small housekeeping amendments are proposed:

- A reference to the Centers for Disease Control and Prevention's (CDC) new guideline for prescribing opioids will be added to the list of general reference materials on the final page of the policy;

- An amendment was made to the *Prescribing Drugs* policy in February, 2016, which permitted physicians to distribute naloxone without a prescription for use in the event of an emergency opioid overdose. This step was undertaken because of the ongoing epidemic of overdose in Canada, and because naloxone is a highly effective treatment for overdose. Its status as a prescription-only drug was perceived to be a barrier to access. Since February, Health Canada has relisted naloxone to be available without a prescription, which renders the policy amendment unnecessary. As a result, it will be rescinded (a "track changes" version of this amendment is attached as **Appendix B**, page 4).

- These proposed amendments were presented to the Executive Committee at their July 26th meeting. The Executive Committee were supportive of the proposed amendments and had no substantive comments.

Decision for Council: Does Council approve the proposed housekeeping amendments to the Prescribing Drugs policy?

3) Joint "Fact Sheet" between the CPSO and the OCP

- Through conversations between the CPSO, the MOHLTC, and the OCP, a need has been identified to highlight the new requirements in the Act and the proposed regulation for both physicians and pharmacists, and to clarify issues that may arise from patch-for-patch that are not directly addressed by the regulation.

- As a result, a joint Fact Sheet has been drafted (**Appendix C**) which articulates both Colleges' general support for the patch-for-patch legislation as a key part of helping combat opioid abuse in Ontario.

- The draft Fact Sheet is also intended to serve as a a source of practical guidance for physicians and pharmacists, and will act as a supplemental document to the CPSO and OCP's general direction to its respective membership on drugs and prescribing.

- The draft Fact Sheet was circulated vie email for Executive Committee's review on August 12, 2016.

Decision for Council: Does Council approve the College issuing a fact sheet, and if possible, doing so jointly with the Ontario College of Pharmacists?

NEXT STEPS:

- Should Council approve the proposed housekeeping amendments to the *Prescribing Drugs* policy, the policy will be updated on the College's website and the changes will be noted in Dialogue.

- Should Council approve the College issuing the joint Fact Sheet, it will be posted on the CPSO website and disseminated via Dialogue.

DECISIONS FOR COUNCIL:

1. Does Council have any questions or comments with respect to the draft regulation or the CPSO's response to the Ministry's consultation?

2. Does Council approve the housekeeping amendments to the Prescribing Drugs policy as outlined above?

3. Does Council approve the College issuing a fact sheet, and if possible, doing so jointly with the Ontario College of Pharmacists?

CONTACTS: Cameron Thompson, ext. 246

DATE: August 18, 2016

Attachments:

Appendix A: CPSO response to the Ministry of Health and Long-Term Care
Appendix B: Proposed revisions to the Prescribing Drugs policy
Appendix C: CPSO/OCP Joint Fact Sheet

Appendix A

July 14, 2016

Executive Officer, Ontario Public Drugs Programs

Ministry of Health and Long-Term Care

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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Re: Proposed Regulations Under the Safeguarding our Communities Act (Patch for Patch Return Policy), 2015

The College of Physicians and Surgeons of Ontario appreciates the opportunity to comment on the Ministry of Health and Long-Term Care's proposed regulations under the Safeguarding our Communities Act (Patch for Patch Return Policy), 2015.

With the prevalence of opioid-related fatalities increasing across Ontario, the College is strongly supportive of efforts aimed at reducing the abuse, misuse, and diversion of prescription opioids.

In recent years, the College has undertaken its own policy efforts to help reduce opioid-related harm, including the recent adoption by CPSO Council of a statement supporting the wider availability of naloxone for the emergency treatment of opioid overdose in community settings.

While the College recognizes that transdermal fentanyl patches are a fast and effective pain relief medication for many patients, including those in palliative care or with cancer-related pain, the implementation of a patch-for-patch return policy represents an important opportunity to help address what has become a public health crisis of fentanyl abuse and overdose.

The College supports the proposed regulations and has no specific comments with respect to their content; however, it is our view that any individual effort to reduce the abuse, misuse, or diversion of a specific drug must be part of a co-ordinated, system-wide strategy in order to ensure a lasting effect.

For this reason, it is the view of the College that in addition to the proposed regulations, the Ministry of Health and Long-Term Care should take pro-active steps to:

1. Evaluate the outcome of the implementation of these regulations. In particular, history has shown that with any drug control mechanism that focuses on a specific drug, limiting access often results in increased demand for other prescription or illicit drugs. The Ministry should establish baseline data and monitor this anticipated consequence of the proposed regulations.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2. Ensure that physicians who prescribe opioids have more complete and timely access to information about a patient's opioid medication history prior to prescribing, such as through the provincial Narcotics Monitoring System (NMS). There may also be value in considering new or revised NMS alerts, particularly in order to better inform physicians when a new patient has previously received a fentanyl prescription from another prescriber.

We trust that you will find these comments helpful, and we thank you again for the opportunity to participate in this important initiative.

Yours very truly,

Rocco Gerace MD
Registrar

Prescribing Drugs

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

Introduction

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

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

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

Principles

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

1. Acting in patients' best interests;
2. Demonstrating professional competence, which includes maintaining the medical knowledge and clinical skills necessary to prescribe appropriately. This involves keeping abreast of current developments in:

    a. applicable legislation;
    b. CPSO expectations and guidelines regarding prescribing;

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

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

Purpose and Scope

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

Definitions

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

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

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

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

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

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

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

Policy

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

1. General Expectations

Before Prescribing

Physician-Patient Relationship

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

Assessment

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

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

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

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

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

Exceptions

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

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

If the prescription is for a fentanyl patch, physicians must include the following additional information on the prescription[1]:

- The name and address of the pharmacy where the prescription will be filled;[2]
- A notation that it is the patient's first prescription for fentanyl patches when:
  i. The physician has not previously prescribed fentanyl patches to that patient; and
  ii. The physician is reasonably satisfied[3] that the patient has not previously obtained a prescription for a fentanyl patch from another prescriber.

[1] Specific additional requirements for physicians who prescribe fentanyl patches are set out in the *Safeguarding our Communities Act, 2015.*
[2] Patient choice must be respected in selecting the pharmacy.
[3] A physician may be reasonably satisfied based on his or her discussions with the patient, as well as any other information available to the physician.

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
- 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 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.

Notifying pharmacies of a fentanyl prescription

Where a physician prescribes fentanyl patches, physicians must notify the pharmacy that will fill each prescription directly, either by telephone or by faxing a copy of the prescription.[4]

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
- 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

[4] *Safeguarding our Communities Act, 2015.*

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

Monitoring Patients: Misuse, Abuse and Double-Doctoring

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

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

Sharing Information

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

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

a. Circle of Care

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

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

b. Permitted Disclosure

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

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

i. Disclosure for authorized investigations or inspections

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

ii. Disclosures related to risks

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

Mandatory Reporting Obligation

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

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

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

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

Guidelines

Preventing Medication Errors

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

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

Verbal Prescriptions [71]

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

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

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

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

- Spelling of the drug name;
- Spelling of the patient’s name; and
- Dose confirmation expressed as a single digit (e.g., “one-six” rather than “sixteen”).
  In addition, to reduce the risk of error due to patients having the same (or similar) names, it is advisable to communicate at least one additional unique patient identifier to the dispenser.

Look-alike/Sound-alike Drug Names

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

- writing prescriptions clearly by printing the name of the product in block letters or using TALLman lettering, [74] by not using abbreviations, or by using electronic prescriptions;

- including more information about the drug (e.g., include both brand name and generic name, and the reason for prescribing the medication);
- ensuring that the strength, dosage and directions for use are clearly indicated on the prescription; and
- communicating to the patient (or a family member) the reason the medication has been prescribed and verifying that the patient can read the prescription.

High-alert Medications

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

Vulnerable Populations/High-alert Environments

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

Double-Checking

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

Patient Involvement

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

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

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

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

Reporting Adverse Drug Reactions or Medication Incidents

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

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

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

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

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

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

Narcotics and Controlled Substances

Responding to Requests for Narcotics and Controlled 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.

Identifying Aberrant Drug-Related Behaviour [81]

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

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

Office Practices and Policies: Setting and Managing Patient Expectations

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

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

Treatment Agreements

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

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

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

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

Monitoring Patients

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

Preventing Prescription Fraud [86]

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

- If using a paper prescription pad:
  - Use carbon copies or numbered prescription pads;
  - Write the prescription in words and numbers;
  - Draw lines through unused portions of the prescription; and
  - Keep blank prescription pads secure.
- If using desk-top prescription printing:
  - Use EMR-enabled security features such as watermarks.
  - Write a clear signature and do not use a scribbled initial.
- Promote the patient's use of a single dispensing pharmacy of their choice. Include the name of the pharmacy the patient would like to take the prescription to be dispensed, on the prescription.

- Fax (or electronically transmit when available) prescriptions directly to the pharmacy.
- If using fax or electronic transmission of the prescription (when permitted) ensure confidentiality, [87] confirm destination, and retain copies.

Security of Drugs

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

Advice for Patients [88]

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

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

Appendix C

PATCH-FOR-PATCH FENTANYL RETURN PROGRAM: FACT SHEET

In an effort to combat the abuse, misuse, and diversion of prescription fentanyl patches, the provincial government has introduced legislation[1] which requires patients who receive a prescription for fentanyl to return their used patches to a pharmacy before receiving new ones.

The College of Physicians and Surgeons of Ontario (CPSO) and Ontario College of Pharmacists (OCP) strongly support this legislation, as well as the government's approach to delineate specific roles and responsibilities for physicians and pharmacists when prescribing and dispensing fentanyl patches.

Requirements of the legislation:

When prescribing fentanyl patches:

1. Prescribers must record on every prescription for fentanyl the name and address of the pharmacy where the prescription will be filled.

2. Prescribers must notify the pharmacy that each prescription has been written, either by faxing a copy of the prescription to the pharmacy or by telephone.

3. When writing a patient's first prescription for fentanyl, prescribers must note "first prescription" on the prescription itself.[2] A prescription is considered a "first prescription" when:
   i. The prescriber has not previously prescribed a fentanyl patch for that patient; and
   ii. The prescriber is reasonably satisfied that the patient has not previously obtained a prescription for fentanyl patches from another prescriber.[3]

When dispensing fentanyl patches:

This is a partial list of the requirements for dispensers under the legislation. For a complete list, click here.[4]

1. Dispensers must confirm that the name and location of the pharmacy is recorded on the prescription by the prescriber, and that the pharmacy has been notified by the prescriber of the prescription before any patches are dispensed.

2. Unless a first time prescription, dispensers must only dispense fentanyl patches in exchange for used patches provided by the patient or his or her authorized representative.

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[1] *Safeguarding our Communities Act, 2015*.*A link to the final regulation will be added when available.*
[2] This notation will confirm for the dispensing pharmacist that the patient is not required to return previously used patches in order for the prescription to be filled.
[3] Prescribers can be "reasonably satisfied" based on a discussion with the patient and any other information available to the prescriber.
[4] As soon as it is available, a link will be added to the OCP's Fact Sheet for pharmacists.

3. Dispensers must examine and document returned patches, and store them in a secure location.

4. Where a dispenser receives a prescription for fentanyl patches but does not collect all of the patient's used patches, or collects fewer patches than the quantity to be dispensed under the prescription, he or she must:
   i. Use his or her professional judgment to dispense an appropriate number of patches based on an assessment of the patient, including an assessment of the patient's circumstances and the patient's medical condition; and
   ii. Notify the prescribing physician of the number of used patches that were collected as well as the number of new patches that were dispensed, if any.

Supplementary guidance for physicians:

Where applicable, the above requirements regarding fentanyl patches have been incorporated into the CPSO's Prescribing Drugs policy. The following guidance is intended to assist physicians in addressing anticipated practical issues that arise under the legislation:

1. Clearly communicate with patients: Physicians who prescribe fentanyl patches must ensure that patients understand the importance of keeping track of every patch that is dispensed, whether it is used or unused, as failing to do so may result in lost or stolen patches. Failing to return all used patches to the pharmacy may result in the pharmacist withholding new patches.

2. Respect patient choice of pharmacy: Patients are entitled to choose the pharmacy that will fill the prescription.

3. Collaborate professionally with pharmacists: A patch-for-patch program requires physicians and pharmacists to work in close partnership to ensure that patches are safely prescribed, dispensed, stored, and returned to the pharmacy. Physicians who prescribe fentanyl patches must respond in a timely and professional manner when contacted by a pharmacist to confirm the validity of a prescription, to raise questions or concerns regarding the patches that have been returned, or, where used patches have not been returned, to seek advice with respect to dispensing new patches based on the patient's specific circumstances.

4. Where patients fail to return used patches: Where a patient fails to return all of their used patches, and it is not the patient's first prescription, the regulation permits the pharmacist to use his or her professional judgment to dispense an appropriate number of new patches based on the specific circumstances of the patient. In all cases, pharmacists must notify the prescribing physician that used patches were not returned, and the number of new patches that were dispensed, if any.

Ontario College of Pharmacists
Putting patients first since 1871

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Supplementary guidance for pharmacists:

To review the Ontario College of Pharmacists' supplementary guidance for dispensing pharmacists, click here[5].

[5] As soon as it is available, a link will be added to the OCPs Fact Sheet for pharmacists.

September 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNANCE COMMITTEE REPORT

ITEMS FOR DECISION:
I Election of 2016/2017 Academic Representatives on Council
II 2017 Chair Appointments

ITEMS FOR INFORMATION:
III Committee Appointments
IV Public Member Reappointments
V 2016 District 1, 2, 3 and 4 Election Update
VI Completion of 2016 Council Performance Assessment (Form)

ITEMS FOR DECISION:

I Election of 2016/2017 Academic Representatives on Council

- The Deans of the six medical schools have appointed the following academic representatives for the 2016/2017 session of Council:
  Dr. Janet van Vlymen (Queen's University) (new)
  Dr. Joel Kirsh (University of Toronto)
  Dr. Barbara Lent (Western University)
  Dr. Akbar Panju (McMaster University)
  Dr. Robert Smith – (Northern Ontario School of Medicine)
  Dr. James Watters (Ottawa University)

- The academic representatives will meet, prior to the September Council meeting, and recommend the three voting academic representatives for the 2016/2017 session of Council.
- Dr. Janet van Vlymen's appointment as new Queen's University academic representative to the CPSO Council will be effective following the induction of new Council members at the annual meeting of Council on December 2, 2016.

FOR DECISION:

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

II 2017 Chair Appointments

- The Governance Committee nominates the following Chairs, Co-chairs, and Vice Chairs for 2016.
- In considering nominations for these leadership positions, the Committee followed the current Council's Nominations Guidelines **(Appendix A)**.

COMMITTEE	PROPOSED 2017 Chairs, Co-chairs, Vice Chairs
Council Award Selection Committee	**Dr. Joel Kirsh**
Discipline Committee	**Dr. Peeter Poldre** **Dr. Carole Clapperton *(non-Council)***
Education Committee	**Dr. Barbara Lent**
Executive Committee	**Dr. David Rouselle**
Finance Committee	**Mr. Pierre Giroux**
Fitness to Practise Committee	**Dr. Dennis Pitt**
Governance Committee	**Dr. Joel Kirsh**
Inquiries, Complaints and Reports Committee	**Dr. Carol Leet, *ICRC Chair*** **Ms. Lynne Cram/Mr. Harry Erlichman*, Co-Vice Chairs, General*** **Dr. Carol Leet/Dr. Edith Linkenheil *(non-Council), Co-Vice Chairs, Settlement Panel*** **Dr. Dale Mercer, *(non-Council), Vice Chair, Surgical*** **Dr. Lawrence Oppenheimer, *(non-Council), Vice Chair, Obstetrical*** **Dr. Akbar Panju, *(non-Council) Vice Chair, Internal Medicine*** ***TBA, Vice Chair, Mental Health and Incapacity Panels*** **Dr. Steven Whittaker, *(non-Council) Vice Chair, Family Practice***
Methadone Committee	**Ms. Diane Doherty**
Outreach Committee	**Ms. Lynne Cram**
Patient Relations Committee	**Ms. Lisa McCool-Philbin *(non-Council)***
Premises Inspection Committee	**Dr. Dennis Pitt**
Quality Assurance Committee	**Dr. Brenda Copps** **Dr. Patrick Safieh *(non-Council)***
Registration Committee	**Dr. Barbara Lent**

FOR DECISION:

Council will consider the slate of 2017 Committee Chairs, Co-chairs, and Vice-Chairs recommended by the Governance Committee.

ITEMS FOR INFORMATION:

III Committee Appointments

- The Executive Committee has made the following committee appointments since the May meeting of Council:

  - Dr. Tina Tao, non-council member (Quality Assurance Committee)
  - Dr. Dennis Pitt (Chair, Fitness to Practise Committee)

IV Public Member Reappointments

- Mr. Sudershen Beri has received a one-year public member reappointment to the CPSO Council, effective August 21, 2016 to August 20, 2017.
- Mr. Emile Therien has received a three-year public member reappointment to the CPSO Council, effective July 8, 2016 to July 7, 2019.

V 2015 District 1, 2, 3 and 4 Election Update

Background

- The notice of election, nomination and conflict of interest forms were included in the June/July issue of Dialogue.
- Again, this year, the College is utilizing on-line voting in the Council district election process and is working with an external vendor to facilitate the voting process.
- Eligible voters in Districts 1, 2 and 3 will vote for one candidate.
- Eligible voters in District 4 will be able to vote for two candidates.
- Election reminders will be distributed regularly to those who have not voted.
- Key dates include the following:

    - Notice of Election to Membership– June/July Issue of Dialogue
    - Notice of Election by e-mail – July 4
    - Notice of Election – August 12 (official date)
    - Nomination Papers Deadline – August 23 at 4 p.m.
    - Distribution of e-ballots – September 20
    - Election Day (deadline for voting) – October 11.

- The list of candidates in Districts 1, 2, 3 and 4 will be available at the Council meeting.

VI Completion of 2015 Council Performance Assessment (Form)

- **All Councillors are asked to please complete the 2016 Council Performance Assessment form, (Appendix B) and submit your completed form by the end of the September Council meeting to Debbie McLaren or Franca Mancini.**

- The results will be tabulated and presented at the December meeting of Council.

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

DATE: August 15, 2016

Nominations Guidelines

Introduction

Background

Nominations guidelines were adopted by the College Council in April 2005.

They were developed to address certain policy gaps faced by the Governance Committee in making recommendations to Council which included:

- the length of committee member terms;
- the length of committee chair terms;
- the specific competencies required to chair various committees; and
- over-all succession planning.

Council eliminated the College's former guidelines in 2002. The College's former Nominating Committee had used them previously.[1]

Purpose

The adoption and ongoing adherence to the nominations guidelines are central to achieving a key goal in the College's 2001 strategic plan, *to establish an effective and transparent governance model for the College*.

They were developed to ensure the transparency of decisions and enhance the quality of nominations recommendations to Council from the Governance Committee, and ultimately the nominations decisions made by Council.

The guidelines are designed to assist members of Council and CPSO committees to understand the processes and basis upon which nominating recommendations and decisions are made. They also convey important background information to individuals interested in participating in College activities. It is also hoped that they will be a useful tool in recruiting members who may wish to participate in the regulation of medicine in Ontario.

[1] The CPSO Governance Committee replaced the Nominating Committee. The Council Organization Renewal Committee had recommended the creation of the Governance Committee, which combined the College's nominating and governance policy function into one committee.

Committee Chair Selection

The nomination and selection of committee chairs is a very important function of the Governance Committee and Council. Committee chairs should have the necessary leadership characteristics and committee specific competencies. In addition, they need to meet nominations criteria, including the length of their tenure, as well as committee-specific chair characteristics outlined later.

Desirable Characteristics

A key behavioural competency model is set out in the *Governance Process Manual*. It identifies desirable characteristics for members of Council, as well as members of committees.

Desirable competencies outlined include:

Thinking Competencies
- creativity
- strategic thinking

Self-managing Competencies
- planning and initiative
- continuous learning

Influencing Competencies
- relationship building
- effective communications

Achieving Competencies
- results oriented
- stakeholder focus
- team work

Managing Competencies
- leadership

The managing competency, ability to take on a role as leader of the Council or a committee, is required to take the role of College President and Chair of Council as well as a College committee. Leaders create positive morale and spirit on their teams. They share wins and success and demonstrate a positive attitude, energy, resilience and stamina. Leaders also have the courage to take risks. Integrity is also recognized as a necessary leadership trait.

Committee Chair Role Description

Role descriptions for the key officers of the CPSO as well as committee chairs are also set out in the *Governance Process Manual*.

Chairs should have an understanding of and a commitment to the public interest mandate of the College. It is expected that all committee chairs will possess competencies, which include: strong knowledge of the regulatory processes; effective meeting management skills; excellent judgment; and strong leadership skills. Following is a summary of required competencies specific to individual committees.

Committee	Desirable committee-specific chair characteristics
Council Award	Past-President*
Education	Academic, strong foundation of knowledge and experience with Ontario medical schools
Executive	President*
Discipline	Effective manager, knowledge of I and R and QA processes, effective decision-writer
Finance	Good understanding of financial processes, significant budgeting experience
Fitness to Practise	Knowledge of I and R and QA processes
Governance	Past-President* (Whenever possible, it is recommended that the Chair should be a past president on Council or a past president who has not been off the Council more than 3 years)
Inquiries, Complaints and Reports (ICR)	Possesses considerable knowledge and understanding of the principles of administrative law and fairness, and proper conduct of an investigation, has past recent experience chairing a member-specific issue College screening committee, communicates effectively[2]
Methadone	Familiarity with methadone program, ability to manage conflict of interest scenarios
Outreach	Interest in member and public communications
Patient Relations	Understanding of boundary issues, knowledge of the field of psychological issues
Premises Inspection	Possesses considerable knowledge and understanding of the College's premises inspection program and applicable legislation, effective manager, knowledge of I and R and QA processes
Quality Assurance	Knowledge of I and R and QA processes, commitment to ongoing education
Registration	Strong technical understanding of registration/certification, understanding of academic issues would be an asset, able to evaluate credentials

*As per General By-Law

[2] Inquiries, Complaints and Reports ("ICR") Committee Competence Framework for Chairs and Panel Members, April 14, 2009

Succession Planning

Succession planning is a critical component of the nominations process. Early identification and training for potential chairs as well as setting and adhering to term limits are two ways of planning for future selection.

Participation in Training Opportunities

The College occasionally brings in external expertise to conduct a chair training session. Council members interested in chairing a College committee are also encouraged to participate in training when these opportunities are available and accommodations can be made.

Length of Terms

Prior to 2006, there were no term limits for committee chairs. Term limits had been discussed prior to that time, but were not adhered to. Although chairs are nominated and elected annually, it was found to be very difficult to make changes to the leadership of College committees. This absence of any rules to guide leadership nominations decisions blocked succession planning and committee renewal. This was a major problem and one of the reasons why the nominations guidelines were developed.

Currently, nominations recommendations must be based on a number of factors including succession planning and the results of performance assessments. Chair performance assessment results now assist the Governance Committee make chair nominations recommendations.

It is recommended that chairs serve for no more than three years as chair of a specific committee. As per the College's by-laws, chairs will continue to be nominated and elected annually. Reappointment will depend on performance and other factors that have been identified. In cases where committees have two chairs, it is recommended that chair turnover be staggered, to ensure that there is some consistency in leadership from one year to the next.

Capping or prescribing the length of chair terms has the added benefit of clearly managing expectations, facilitating succession planning and renewal of College committees.

Link to Council

It is critical that committees have a strong link to Council. Many College committees are independent in their decision-making. Examples include the Discipline, ICR, and Quality Assurance Committees. It is the College Council, however, that develops and sets the overall policy framework that guides, together with relevant statutes, the work of these committees. Many other College committees make recommendations to Council. Examples include the Outreach and Governance Committees.

Both Council and non-Council members chair CPSO committees. Generally, in the cases where non-Council members chair CPSO committees, a member of Council also chairs them. It is recommended that all College Committees be

chaired by a member of College Council. Non-Council members can chair when the chair responsibility is shared with a member of Council.

Following are the key considerations that are made by the Governance Committee in making any chair nominations recommendations to Council.

Governance Committee checklist in making chair nominations decisions:

1. ***Does the candidate have the necessary leadership skills to chair a committee?***

2. ***Does the candidate have the required committee-specific characteristics to effectively chair the committee?***

3. ***If the candidate chaired a CPSO committee previously, how did he/she perform in the chair performance feedback assessment?***

4. ***Is the candidate willing to chair the committee?***

5. ***How many more years of eligibility does the candidate have on the College Council? (for succession planning)***

Committee Composition

Just as College committees need to be led by skilled chairs, they also need to be balanced with of the right mix of members who together have the ability to effectively discharge the responsibilities of the Committee. Committees must also be rejuvenated with new ideas and people on an annual basis. This helps ensure that adequate succession planning measures are in place.

Desirable Characteristics

A key behavioural competency model was discussed earlier. Desirable characteristics for members of Council as well as members of committees are highlighted.

Committee Member Role Description

Role descriptions for Council members, Council committee members and non-Council committee members are set out in the Governance Process manual.

Succession Planning

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

Participation in Training Opportunities

Council and committee members have a formal orientation program. All members of Council as well as members of College committees are strongly

encouraged to participate in the annual orientation program, normally held in February each year.

Committee-specific orientation is also necessary for all committee members. This orientation and training should be led by committee chairs and supported by College staff.

Length of Terms

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

It is also recommended that committee members should serve no longer than four consecutive years on a committee. This would not apply to committee chairs. The committees that are exempt from this term limit include the Discipline and ICR Committees. They are exempt from the four-year rule to ensure that they are able to meet the quorum rules set out in the RHPA as well as to ensure they have a roster able to perform the work of the Committee.

As per the College's by-laws, committee members are nominated and elected annually. Reappointment will depend on performance and other factors that have been identified.

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

Following are the key considerations that are made by the Governance Committee in making any committee membership nominations recommendations to Council.

Governance Committee checklist in making committee membership nominations recommendations:

1. ***Does the committee have the necessary expertise and core competencies/skills to adequately discharge its mandate?***

2. ***Are there any new members on the committee?***

3. ***How many more years of eligibility does the candidate have on the committee?***

4. ***How many more years of eligibility does the candidate have on the College Council? (for succession planning)***

5. ***How has a committee member performed?***

6. ***Does the candidate member function in the public interest?***

Appendix B
Please return to: Debbie McLaren
Communications Dept., 6th Floor

2016 Council Performance Assessment Form

Your Name: (optional) _____

INSTRUCTIONS:

This questionnaire requires you to focus on and assess key areas that affect the Council's performance as a whole and its key responsibilities for governance of the CPSO.

Please answer each question by indicating the most applicable response. At the end of each section of the survey there is an opportunity for you to provide qualitative comments. At the end of the questionnaire there is also an opportunity for you to provide further input regarding your perspective of the Council's strengths and developmental opportunities for improved performance. Please answer all questions as candidly as possible. Thank you for your time in contributing to the growth and development of the Council.

Number of Years on Council: ☐**1<** ☐**1–2** ☐**3–4** ☐**5–6** ☐**7>**

A. VISION AND MANDATE

QUESTIONS	**RATING**			
	Yes	**Somewhat**	**No**	**Don't know**
1. I understand the vision and the mandate of the College.				
2. The Council formally reviews its vision.				

COMMENTS: _____

B. STRATEGIC PLAN AND PRIORITIES

QUESTIONS	**RATING**			
	Yes	**Somewhat**	**No**	**Don't know**
1. The College's strategic plan is documented.				
2. The Council creates a set of key priorities that must be implemented in support of the strategic plan of the College.				
3. The Council establishes a small number of strategic initiatives to focus attention and resources to help achieve the College vision.				
4. The dashboard report presented by the Registrar clearly reports progress on College priorities				

COMMENTS: _____

Appendix B
Please return to: Debbie McLaren
Communications Dept., 6th Floor

Performance Feedback Process and Forms
Council Performance Assessment Form

C. COUNCIL'S ROLE AND RESPONSIBILITIES

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't know
1. I am familiar with the College's governance practices and policies.				
2. The Council effectively develops and approves principles and policies that fulfill its duty to protect the public interest.				
3. The Council effectively discharges its statutory functions.				
4. The Council periodically monitors and assesses its performance against its strategic direction and goals.				
5. The College has an effective system of financial oversight.				
6. The Council meets with external auditors, reviews their reports and recommendations and, ensures any deficiencies are corrected.				

COMMENTS:

D. GOVERNANCE OPERATIONS

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't know
1. As a Council member I understand my fiduciary obligations.				
2. I know and understand the Code of Conduct.				
3. I understand the Conflict of Interest Policy.				
4. As a member of Council, I declare potential conflicts of interest according to Council's conflict of interest requirements.				

COMMENTS:

Appendix B
Please return to: Debbie McLaren
Communications Dept., 6th Floor

Performance Feedback Process and Forms
Council Performance Assessment Form

E. COUNCIL OPERATIONS

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't know
1. I receive appropriate information for Council meetings.				
2. I receive information for Council meetings on a timely basis.				
3. Council's meetings are effective and efficient.				
4. The President chairs Council meetings in a manner which enhances performance and decision-making.				
5. I feel comfortable participating in Council discussions.				
6. Council has a formal written orientation package for Council members.				
7. My orientation to the College Council was effective.				
8. I am aware that Council has a mentorship program.				
9. Council's mentorship program is helpful				
10. I find Council's continuing education activities useful.				

COMMENTS:_____

_____

_____

F. RELATIONSHIP WITH REGISTRAR

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't know
1. I understand that a committee of Council that reports to the Executive Committee approves the Registrar's annual performance objectives and conducts the Registrar's annual performance review.				
2. The President asks Council for feedback which informs the Registrar's performance review and advises Council of the outcome of the review.				
3. The Council maintains a collegial working relationship with the Registrar.				

Appendix B
Please return to: Debbie McLaren
Communications Dept., 6th Floor

Performance Feedback Process and Forms
Council Performance Assessment Form

F. RELATIONSHIP WITH REGISTRAR (continued)

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't know
4. The Council does not get involved in day-to-day operational matters.				
5. Committees do not get involved in day-to-day operational matters.				

COMMENTS:

STRENGTHS AND DEVELOPMENTAL NEEDS

1. List two strengths of the Council

2. List two ways Council could be improved

3. Additional Comments

Last Updated: September 3, 2014 by the Governance Committee

September 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.

The strategic framework has been modified slightly to reflect the fact that transparency includes some limited elements of Quality Assurance.

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 second quarter dashboard for 2016, reflecting information from March to May.

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.

CONTACT: Rocco Gerace
Maureen Boon, extension 276

DATE: August 18, 2016

Appendix A: Strategic Framework
Appendix B: Strategic Update Q2 2016

CPSO Strategic Framework 2015-2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

VISION

QUALITY PROFESSIONALS, HEALTHY SYSTEM, PUBLIC TRUST

PRIORITIES

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

STRATEGIC INITIATIVES

- QUALITY MANAGEMENT PARTNERSHIP
- EDUCATION
- TRANSPARENCY
- INFORMATION MANAGEMENT

PRINCIPLES

- INTEGRITY
- ACCOUNTABILITY
- LEADERSHIP
- COLLABORATION

Strategic Dashboard – Q2 2016

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Comments
Optimize Registration	Target to be developed for 2017				
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year			790 assessments completed in Q2 for a total of 1431 year to date, represents 55% of target.
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology			Data not yet available Initial reports will be provided to physicians later in 2016/17

Operational Dashboard – Q2 2016

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 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 2467 of 2468 applications (99%) Registration Committee Applications 344 of 345 applications (99%)
Assure/Enhance Physician Competence	Increase input in policy	130 responses/policy			In Q2 - 5 policy consultations have taken place with an average of 75 responses/policy. The combined Q1/Q2 average is 137 (which meets target). Time of year and subject matter can both impact response rate. Continuity of Care (60); Test Results Management (97); Re-entry to Practice (25); Cease to Practice (32); and Changing Scope (163).
	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.			January 1st - June 30th, 2016: 90% of high risk investigations were completed in an average of 205 days, (20 investigations involving 18 unique physicians).

[1] Does not include registration policies

Strategic Priority	Objective	Measure/Target	Q1 Status	Q2 Status	Comments
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year			Jan 1 - Jun 30, 2016: 90% of hearings (12) began on average, 382.1 days (12.6 months) from the NOH date
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>			Jan 1 - Jun 30, 2016: 90% of uncontested decisions (10) were released , 51.1 days (1.7 months) from the last hearing date
		<u>6 months for contested (C)</u>			Jan 1 - Jun 30, 2016: 90% of contested decisions (5) were released, 122.2 days (4.0 months) from the last hearing date.
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)			A&C: 86% (10,179 of 11,829 calls) managed live PPAS: 91% (17,169 of 18,793 calls managed live) Combined: 89% (27,438 of 30,622) live response rate
	Improve service level targets	10% call abandonment			A&C 1,374 calls abandoned -12% PPAS 1,096 calls abandoned -6% Combined call abandonment rate is (8%)
	Media coverage	80-100% positive or neutral			Of 457 news items (extremely high volume), 91% were positive or neutral and 9% were 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%

COUNCIL PRESENTATION

Ronnie Gavsie
President and CEO, Trillium Gift of Life

“Our Call to Action”

Ms. Gavsie will provide an overview of the Donation and Transplantation Process in Ontario, how it works from a physician to patient perspective, and issues that have arisen.

The College of Physicians and Surgeons of Ontario

2017 Council and Executive Committee Meeting Dates

Meeting	Date
Executive Committee	Tuesday, January 17
Council Orientation	Thursday, February 23
Council	Friday, February 24
Executive Committee	Tuesday, March 21
Executive Committee	Tuesday, April 25
Council	Thursday, May 25 Friday, May 26
Executive Committee	Tuesday, June 20
Executive Committee	Tuesday, August 8
Council	Thursday, September 7 Friday, September 8
Executive Committee	Thursday, September 28
Executive Committee	Tuesday, October 31
Council	Thursday, November 30 Friday, December 1

September 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

Updates:

2. Marijuana for Medical Purposes - Update

3. Policy Consultation Update

    I. Continuity of Care
    II. Test Result Management
    III. Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation
    IV. Re-entering Practice

4. 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*

- The College of Optometrists of Ontario is recirculating 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*.

- If approved, the amendments proposed would: (a) allow optometrists to prescribe all topical and oral drugs that are approved by Health Canada within the scope of

practice of optometry; (b) allow optometrists to remove superficial foreign bodies from below the surface of the cornea; (c) allow optometrists to dispense drugs for the sole purpose of trialling a therapy; and (d) specify diagnostic ultrasound as a prescribed form of energy for the performance of corneal pachymetry or ocular ultrasonography.

- The CPSO initially provided written feedback on the above proposed regulatory changes in March 2016. This response was provided as part of the Policy Report included in the May 2016 Council materials. At that time, the CPSO expressed general support of most of the proposed amendments, but also articulated key concerns with respect to patient safety.

- The proposed regulatory amendments are currently being recirculated by the College of Optometrists. The CPSO continues to be concerned that these amendments may exceed the scope of practice for optometrists, posing a risk to patients. As such, the CPSO has once again reiterated its concerns in letter dated August 12th, 2016. The final response is attached as **Appendix A.**

2. Marijuana for Medical Purposes - 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 Marijuana for Medical Purposes policy reflects the requirements set out in the MMPR, and was approved by Council in March, 2015.

- Since the policy was approved, there have been significant shifts in the regulatory landscape which have raised questions about the future of the Canada's medical marijuana regime.

- Legal challenges have been successfully made against two provisions in the MMPR, altering some of the restrictions against marijuana use and access. Additionally, the federal government has begun to engage in a consultation process to legalize marijuana.

Challenges against the MMPR

- Legal challenges in relation to the MMPR have related to two elements of the regime: the forms of marijuana accessible to users, and the sources from which patients can obtain marijuana:

a) Forms of marijuana

- Under the original MMPR, licensed producers were only permitted to sell (and patients were only permitted to possess) marijuana in a dried form.

- This restriction was struck down by the Supreme Court of Canada on June 11, 2015.

- Health Canada subsequently issued an exemption under the *Controlled Drugs and Substances Act* (CDSA) which permits licensed producers to sell cannabis oil and fresh marijuana.

b) Source of marijuana

- Under the MMPR, patients are only permitted to obtain medical marijuana directly from a licensed producer.

- This prohibition was the subject of a legal challenge, and on February 24, 2016, a Federal Court judge struck it down, concluding that the prohibition unjustifiably infringed on the liberty and security interests of patients under the *Canadian Charter of Rights and Freedoms*.

- On August 11, 2016, the Federal Government announced the new *Access to Cannabis for Medical Purposes Regulations (ACMPR)*, which will replace the MMPR.

- These regulations, which come into force on August 24, 2016, permit patients to grow their own marijuana or to designate a representative to grow it for them.

- According the Health Canada, the ACMPR do not change the role of the physician in authorizing patient access to marijuana for medical purposes. In order for a patient to access a legal supply, whether access occurs through a licensed producer or the patient grows their own, a physician must still complete a medical document (i.e. a prescription).

Legalization of marijuana

- In the 2015 Speech from the Throne, the Federal Government committed to legalizing, regulating, and restricting access to marijuana for recreational uses. The Federal Government has publicly committed to have legislation in place sometime in 2017.

- A Federal Task Force has been struck with a mandate to engage with provincial, territorial, and municipal stakeholders to provide the government with advice on the design of a new federal framework.

- The Federation of Medical Regulatory Authorities of Canada will be providing advice to the task force from a medical regulatory point of view.

Implications for CPSO Policy

- Although it is clear that policy revisions will be required in response to these developments, it is proposed that revisions to the Marijuana for Medical Purposes policy be postponed until the Federal Government introduces its new legislation in 2017.

- The rationale being that this new legislation is likely to have a significant impact on the federal regime for medical marijuana, and therefore require significant additional policy revisions.

- 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 a future meeting.

3. Policy Consultation Update

I. Continuity of Care

- At the May 2016 meeting, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and recommendations regarding the development of a new policy.

- A joint Working Group has been struck to undertake this policy development process alongside the review of the *Test Results Management* policy.

    - The Working Group is comprised of Dr. Brenda Copps (Chair), Dr. Barbara Lent, Dr. Peeter Poldre, Dr. David Rouselle, Dr. Kevin Glasgow,[1] Ms. Joan Powell, Mr. Ron Pratt, and Mr. Arthur Ronald. The Working Group will also be supported by Alice Cranker (Legal Counsel) and Dr. Keith Hay (Medical Advisor).

- As part of the policy development process, a preliminary external consultation was conducted between June 13 and August 12, 2016.

- The College received a total of 64 responses to this consultation. These include 20 comments on the College's online discussion page (11 physicians, 3 members of the public, 3 anonymous, and 3 organizations[2]), and 44 online surveys[3] (31 physicians, 10 members of the public, 1 organization[4] and 2 other).

[1] Dr. Glasgow is a College Assessor with expertise in Walk-In Clinics.
[2] Organizations include: Information and Privacy Commissioner of Ontario, Professional Association of Residents of Ontario, and the Ontario Medical Association Section on General and Family Practice. The

- 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.

- Broadly speaking, stakeholders were supportive of the College's undertaking relating to continuity of care. In particular, the majority of survey respondents supported the working definition of continuity of care, agreed with the proposed list of pertinent issues identified by Council, agreed that continuity of care issues can negatively impact patient safety and quality of care, and agreed that physicians have a significant role to play in helping to address many of these issues.

- The Ontario Medical Association (OMA)[5] was also supportive of the College's work on this issue, but shared concerns about physicians being held responsible for issues beyond their control and ensuring that physician health is not compromised. Similarly, the OMA Section on General and Family Practice identified a number of systems constraints that hamper the provision of care, broader contractual and legislative changes that will impact service delivery (e.g. *Patients First Act*), and expressed concern about the work-life balance and health of physicians.

- Many stakeholders provided substantive feedback identifying continuity of care issues, potential solutions, or barriers to improving continuity of care. For example:

    - Physician availability, including the timely availability of appointments and availability by phone, was identified as an issue.

    - The need for after-hours coverage was identified as being important, but some worried there might be practical challenges that would impact successful implementation.

    - Breakdowns in communication, especially between family physicians and walk-in clinic, specialist, and/or hospital physicians, were identified as a significant source of discontinuity.

    - Similarly, many felt breakdowns in the referral process negatively impacted continuity of care and offered solutions, such as prompt

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Ontario Medical Association has provided informal feedback, and will be counted once an official response is received.

[3] 52 respondents started the survey, but of these, 8 did not complete any of the substantive questions, leave 44 for analysis.

[4] The organization was the Listowel Wingham Hospitals Alliance.

[5] The OMA provided informal feedback to this effect. Council will be updated once an official response is received.

acknowledgements of referrals and the provision of estimated wait times, to address these issues.

- Many felt that a province wide, unified medical record would help improve continuity of care, however, some worried that this might lead to patient records being too large to manage. The Professional Association of Residents of Ontario also supported the implementation of a province wide "Pharmanet" system to track patient prescriptions.

- Some physician respondents also reflected on the role and responsibility of patients, noting that their choices and actions could negatively impact continuity.

- All feedback received will be carefully reviewed by the Working Group alongside the research findings as they work to develop a new draft policy.

- Once a draft policy has been developed, it will be presented to the Executive Committee and Council for consideration.

II. Test Results Management

- The *Test Results Management* policy is currently under review and is being considered alongside the Continuity of Care policy development process (see above).

- As part of the policy review process, a preliminary external consultation was conducted on the current policy between June 13 and August 12, 2016.

- The College received a total of 103 responses to this consultation. These include 31 comments on the College's online discussion page (20 physicians, 3 members of the public, 5 organizations[6], and 3 anonymous), and 72 online surveys[7] (51 physicians and 21 members of the public).

- 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.

- The majority of respondents found the current policy to be clear - it is easy to understand, well organized and clearly written. As well, the majority of respondents found the current policy to be comprehensive.

[6] The organizations who responded were: the Professional Association of Residents of Ontario, the Information and Privacy Commissioner of Ontario, the Ontario Association of Medical Laboratories, the Ontario Trial Lawyers Association and PatientCommando.com.

[7] 86 respondents started the survey, but of these, 14 did not complete any of the substantive questions, leaving 72 for analysis.

- A number of respondents made suggestions on how the policy could be improved, including:

    - Adding provisions with respect to patients checking their laboratory results on-line (although some respondents were not supportive of patients following-up on their results);
    - Providing guidance on what to do if a patient fails to respond to messages;
    - Adding expectations with respect to the responsibilities of physicians in the diagnostic field to notify clinicians of critical or time-sensitive results;
    - Updating the policy to address the privacy implications of receiving a test result in error;
    - Adding the results of specialist consultations;
    - Adding examples;
    - More detailed suggestions on the types of things that can be done to ensure proper follow-up on test results;
    - Providing information about Hospital Report Manager and the Ontario Laboratory Information System (OLIS); and
    - Adding provisions regarding the role and responsibilities of the patient.

- An opinion piece written in *Healthy Debate* that describes a patient's experience with a physician not following up on a clinically significant test result and provides recommendations for policy revisions was posted on the consultation page

- In the survey, the majority of public respondents (and a few physicians) stated that "no news is good news" policies in physicians' offices do not adequately protect them and they are not assured that important test results are not being missed.

- All feedback received will be carefully reviewed by the Working Group alongside the research findings as they work to develop a new draft policy.

- Once a draft policy has been developed, it will be presented to the Executive Committee and Council for consideration.

III. Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation

- The *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation* policy is currently under review.

- As part of the policy review process, a preliminary external consultation was conducted on the current policy between June 13 and August 12, 2016.

- The College received a total of 34 responses to this consultation. These include 10 comments on the College's online discussion page (8 physicians and 2 organizations), and 24 online surveys (22 physicians and 2 members of the public).

- 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.

- The majority of respondents found the current policy to be clear - it is easy to understand, well organized and clearly written. As well, the majority of respondents found the current policy to be comprehensive.

- A sampling of the feedback received is included below.

- A number of respondents made suggestions on how the policy could be improved, including:

    - Providing more guidance on situations where a physician takes a leave of absence or ceases to practise due to a sudden or unexpected illness or death;
    - Clarifying the application of the policy to specialists;
    - Suggestions in terms of establishing a minimum timeline for patient notifications and what classifies as a leave of absence;
    - Providing additional resources for physicians in helping patients obtain care from another health care provider;
    - Providing additional information about the duties physicians have in safeguarding and retaining personal health records; and
    - Clarifying the expectations that apply to physicians who are relocating instead of those ceasing to practise.

- A number of physician respondents expressed concern that the inability to arrange for another physician to assume care of their patients was outside of the physician's control due to factors such as inadequate physician supply.

- The Professional Association of Residents of Ontario also raised concerns about this issue and suggested that the College could provide advice on preventative measures (such as finding a replacement 1-2 years before retirement), listing helpful resources (such as HealthForceOntario), or offering advice on how to proceed if a replacement could not be found.

- A couple of physicians respondents expressed opposition to the policy; one stating that the expectations are so onerous it is not worth retiring and the other stating that "no one physician is so central and irreplaceable" that the policy is needed.

- All feedback received will be carefully reviewed alongside the research findings in the development of a new draft policy.

- Once a draft policy has been developed, it will be presented to the Executive Committee and Council for consideration.

IV. Re-entering Practice

- The *Re-entering Practice* policy is currently under review.

- As part of the policy review process, a preliminary external consultation was conducted on the current policy between June 13 and August 12, 2016.

- The College received a total of 29 responses to this consultation. These include 13 comments on the College's online discussion page (9 physicians, 3 organizations[8], and 1 anonymous), and 16 online surveys[9] (all of the survey respondents were physicians).

- 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.

- Respondents provided a variety of feedback on a range of topics related to re-entering practice after a prolonged absence. A few of the key themes that have emerged throughout the consultation are described below.

- **Clarity, Comprehensiveness:** Survey respondents were generally divided about whether they found the current policy to be clear, easy to understand, well organized and clearly written. Survey respondents were also generally divided about whether they felt the policy was comprehensive.

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

[8] The College of Physicians and Surgeons of Saskatchewan (CPSS), the Information and Privacy Commissioner of Ontario (IPC), and the Professional Association of Residents of Ontario (PARO) were the organizations that provided feedback on this policy.
[9] 19 respondents started the survey, but of these, 3 did not complete any of the substantive questions, leaving 16 for analysis.

- **Policy Application and Process:** A number of concerns were raised about the current policy and the re-entering practice process more generally. Some of these included:
    - A lack of standardization and clarity regarding the process for re-entering practice.
    - Concern that this policy may discriminate against those who are parents and choose to take an extended parental leave.
    - Concern about how a physician may source a supervisor and how that supervisor is paid.
    - Request for specific guidance regarding physicians who are re-entering their former practice after practicing in another area of medicine (PARO).

- A number of respondents also made suggestions on how the policy and re-entry process could be improved, including:
    - The College should consider the specific circumstances of each physician who are re-entering practice.
    - The requirement for physicians to maintain CME while they are absent from practice should be taken into consideration.
    - The College should require physicians to undergo privacy training prior to re-entering practice (IPC).

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

- Once a draft policy has been developed, it will be presented to the Executive Committee and Council for consideration.

4. Policy Status Table

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

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

DECISIONS FOR COUNCIL: For information only.

CONTACTS: Andréa Foti, ext. 387

DATE: August 18, 2016

Appendices:

Appendix A: CPSO Response to the College of Optometrists of Ontario.
Appendix B: Policy Status Table.

Appendix A

Rocco Gerace MD
Registrar
Telephone: (416) 967-2600 x400
Facsimile: (416) 967-2618
E-mail: rgerace@cpso.on.ca

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

August 15, 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 once again 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*. As you are aware, the CPSO provided written feedback on these proposed regulatory changes in March 2016. Given that the proposed amendments are now being recirculated, the CPSO felt it prudent to highlight some of our prior feedback.

As articulated in March, the CPSO is generally supportive of most of the proposed regulatory amendments. The CPSO, however, remains concerned that some of the proposed amendments may exceed the scope of practice for optometrists, posing a risk to patients. In particular, the CPSO would like to reiterate its feedback with respect to proposed amendments related to prescribing drugs, and the removal of foreign bodies from the cornea.

i. Proposed Amendments: Prescribing Drugs

As communicated previously, the CPSO has concerns with proposed amendments to the *Optometry Act, 1991* that would authorize optometrists to prescribe *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, and that some are not directly relevant to the day-to-day practise of optometry, the CPSO strongly recommends that prescribing authority be limited to broad categories of drugs (i.e. anti-infective agents, anti-inflammatory agents, mydriatics, anti-allergic agents, etc.) that are relevant to the practice of optometry.

Further, the CPSO would like to reiterate its prior feedback that any expanded scope with respect to prescribing and dispensing be coupled with the education and training in pharmacology that may be required to prescribe a broader range of drugs and to dispense drugs in a safe and effective manner.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

ii. Proposed amendments regarding removal of foreign bodies from the cornea

As articulated as part of our prior feedback, the CPSO is supportive of the proposed amendments regarding the removal of ***superficial*** foreign bodies from the *surface of the* cornea.

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 this consultation.

Yours very truly,

Rocco Gerace MD
Registrar

POLICY STATUS REPORT – SEPTEMBER 2016 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Re-entering Practice	The current policy sets out expectations for physicians who wish to re-enter practice after a prolonged absence from practice and sets out requirements of physicians in demonstrating their competency in the area of practice they are returning to.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken between June and August, 2016. Further updates with respect to the status of this review will be provided at a future meeting.	2017
Changing Scope of Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice and sets out requirements of physicians in demonstrating their competence in the new area of practice.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was undertaken from April 4 to June 2, 2016. This consultation will also inform work happening at the national level regarding physician scope of practice.	2017
Block Fees and Uninsured Services	The current policy sets out the College's expectations of physicians who charge patients for services not paid for by the Ontario Health Insurance Plan	This policy is currently under review. 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	2017

POLICY STATUS REPORT – SEPTEMBER 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	(OHIP).	this review will be provided at a future meeting.	
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.	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 undertaken between June and August, 2015. The working group is developing a revised draft policy informed by preliminary consultation feedback and research findings.	2017
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*	This policy 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. It is anticipated that the review may	tbd

POLICY STATUS REPORT – SEPTEMBER 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	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.	commence in 2016, but the specific timing will be dependent on the Ministry's work in the context of the Task Force.	
Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	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 was undertaken between June and August, 2016. Further updates with respect to the status of this review will be provided at a future meeting.	2017
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 September.	2017
Management of Test Results	The current policy articulates a physician's responsibility to: 1.	This policy is currently under review and the initial stages of the policy review are underway.	2018

POLICY STATUS REPORT – SEPTEMBER 2016 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	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.	A joint Working Group has been struck to undertake this review alongside the development of a new *Continuity of Care* policy. A preliminary consultation was undertaken between June and August, 2016. The working group will consider the feedback received and the research findings as it works to revise this policy.	
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of the *Test Results Management* policy. A preliminary consultation was undertaken between June and August, 2016. The working group will consider the feedback received and the research findings as it works to develop a new draft policy.	2018

POLICY STATUS REPORT – SEPTEMBER 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 – SEPTEMBER 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 – SEPTEMBER 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 – SEPTEMBER 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.
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.

September 2016

COUNCIL BRIEFING NOTE

TOPIC: GOVERNMENT RELATIONS REPORT

FOR INFORMATION

Items:

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

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1. Ontario's Political Environment

- The fall session of the Legislature is scheduled to begin on Monday, September 12th and is scheduled to sit until December 8th, 2016.
- On August 3rd the Premier called the byelection in Scarborough-Rouge for September 1st. This byelection will replace Liberal MPP Bas Balkissoon who resigned in March.
- On August 9th, Tim Hudak, former PC leader and MPP for Niagara West-Glanbrook, announced that he would be resigning from politics as of September 16th. Mr. Hudak has accepted the position of CEO of the Ontario Real Estate Association.
- The Premier will therefore be calling two byelctions in the coming months in order to replace former Liberal MPP Madeleine Meilleur, who resigned in June and now to replace MPP Hudak. As the Liberal government has a strong majority, the results of the byelctions will not change the government's standing.
- In June, as the Liberal government met the half-way mark of its made, the Premier announced a new cabinet including seven new MPPs to enter cabinet for the first time. Women now make up 40 per cent of the 30 members, the most gender-balanced cabinet in Ontario history.
- At the end of the last legislative session both the PCs and the NDP were focusing primarily on issues relating to health care – specifically hospital funding and the lengthy negotiations with the OMA over a renewed Physician Services Agreement, as well as issues relating to fiscal management and election financing.
- The recent vote against the proposed Physician Services Agreement, and the political fall-out from this, will likely be a significant focus when the Legislature returns. We also anticipate that the on-going concern regarding the majority sell off of Hydro One and the cancellation of the Ontario Retired Pension Plan could be a focus.
- In general, we anticipate a heavy fall legislative session as the government seeks to define the second half of their mandate and lay the groundwork for

electoral success in 2018.

2. Issues of Interest

- At the end of this legislative session, the government moved to introduce a number of significant Bills and initiatives that will likely be a major focus of the upcoming fall session.
- *Bill 210, Patients First Act* would fold the existing Community Care Access Centres (CCACs) into the Local Health Integration Networks (LHINs) and seeks to improve patients' access to care, provide for better coordination and continuity of care, and help improve access to primary care providers. We are reviewing the Bill and monitoring its progress through the Legislature.
- In the last week of the session, the government formally unveiled its five year, $8.3 billion Climate Change Action Plan following weeks of speculation. This 28-directive strategy includes means-tested "cash-for-clunkers" scheme to convince low- and moderate-income motorists to switch to electric cars, a hydro bill rebate to make it free to charge vehicles overnight at home, and measures to help homeowners make their houses more efficient. The government plans to fund it through the new cap-and-trade system and increases to the price of gasoline and Ontarian's monthly natural gas bill.
- *Bill 201, Election Finances Statute Law Amendment Act*, bans union and corporate donations as of January 1, 2017, drastically reduces donation limits, caps third-party advertising, and makes leadership and local nomination contests subject to election rules. The bill also includes rules around loans and guarantees and introduces a new per-vote allowance of public financing of elections. Hearings on this Bill continued over the summer.

3. Government Relations Activities

- The College is in contact with a variety of government decision-makers to ensure that they have accurate and up-to-date information about the College, our activities, and our role in protecting the public interest. We have regular interaction with the Minister of Health's office, the Premier's office, senior Ministry staff, and the opposition parties at Queen's Park.
- Recently, the College has worked particularly closely with government decision-makers on areas of shared focus including medical assistance in dying, the College's recommendations to strengthen the legislative framework with respect to sexual abuse, oversight of fertility services and the regulation of out-of-hospital facilities, compensation of public members of council, the ongoing work to increase College transparency, and issues surrounding opioid and medication management.

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Miriam Barna: 416-967-2600 x557

DATE: August 18, 2016

September 2016

COUNCIL BRIEFING NOTE

TOPIC: Medical Assistance in Dying Update

FOR INFORMATION

ISSUE

- As Council is aware, Bill C-14, the federal government's proposed legislation on medical assistance in dying (MAID), received royal assent on June 17th, 2016. The new legislation establishes a federal framework for medical assistance in dying in Canada.

- The CPSO and other key stakeholders have undertaken various activities to ensure that MAID-related policies, resources and tools comply with the new legislation.

- Council is provided with an update on this ongoing work.

BACKGROUND

- The draft *Medical Assistance in Dying* policy was approved at the May 2016 meeting of Council. This draft complied with Bill-C-14, the federal government's proposed legislation on medical assistance in dying.

- Prior to receiving royal assent in June 2016, Bill C-14 underwent minor amendments in the House of Commons.

- Therefore, to ensure the accuracy and comprehensiveness of the College's *Medical Assistance in Dying* policy, minor revisions were required to ensure alignment with the federal legislation.

- The Executive Committee considered these revisions, on Council's behalf, at its June meeting. The Committee approved the draft *Medical Assistance in Dying* policy as a policy of the College.

CURRENT STATUS

a) College Activity

- The *Medical Assistance in Dying* policy, as approved at the June Executive Committee meeting, is available on the College's website.

- Further, two separate FAQ documents, one for physicians and the other for patients, have been published online as companion resources to the policy. Both documents were written to reflect the content and language of the federal legislation.

- The College's Public and Physician Advisory Services (PPAS) continues to provide guidance and information to callers with MAID-related inquiries. College staff are provided with regular reports on the number and general nature of these inquiries to help ensure that College resources (e.g. FAQ documents) are responsive to patient and physician needs.

- Council will recall that examples of MAID drug protocols from Oregon and Quebec are available on the 'Members' Only' page of the College's website. In May, the College of Physicians and Surgeons of Alberta (CPSA) and the Alberta College of Pharmacists jointly authored a guidance document for physicians and pharmacists that includes medical assistance in dying pharmacy protocols. The College has obtained permission from Alberta to post this resource on the 'Members' Only' section of the College's website.

b) Key Stakeholder Activity

- The College continues to host regular meetings with the College of Pharmacists, College of Nurses and the Ministry of Health and Long-Term Care (MOHLTC). Recent stakeholder activities include the following:

i. Updated Policies / Resources

- The College of Nurses and the College of Pharmacists released updated MAID policy documents following the finalization of the federal legislation.

- The Ministry of Health and Long-Term Care (MOHLTC) published clinician aids/forms to support physicians who provide medical assistance in dying, and patients who request medical assistance in dying.

ii. MOHLTC Referral Support Line

- The MOHLTC's toll-free referral support line continues to assist Ontario physicians to arrange referrals for patients requesting MAID, and to identify physicians and/or nurse practitioners who are willing to provide a second opinion, as required under the federal legislation.

- According to the MOHLTC, approximately 100 physicians have registered as willing providers in Ontario, with coverage in each of the Ontario LHINs.

c) MAID Educational Resources

- The CMA has launched an online module to provide practising physicians with information on medical assistance in dying. According to the CMA's description, the module will enable physicians to:
  - understand what is involved;
  - advise their patients; and
  - make an informed decision about whether to include assisted dying in their practice.

- Completion of the online module is a pre-requisite for participation in a face-to-face course on MAID and end-of-life care that will be offered by the CMA in Vancouver and Toronto in the fall of 2016.

- College staff will keep Council up-to-date on any additional MAID–related educational materials/resources that are developed and made available to physicians.

NEXT STEPS:

- The College will continue to monitor all aspects of MAID closely and will keep Council apprised of developments. This includes, but is not limited to, any legislative changes brought forward by the Government of Ontario to support the implementation of MAID.

DECISION FOR COUNCIL

- This item is for information only.

CONTACT: Policy Department

DATE: August 18, 2016