The College of Physicians and Surgeons of Ontario

Meeting of Council

November 30 and
December 1, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Thursday November 30 and Friday December 1, 2017 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

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

Rocco Gerace, MD
Registrar

Nov. 10, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL
November 30 and December 1, 2017
Council Chamber, 3rd Floor, 80 College Street, Toronto

Thursday November 30, 2017

CALL TO ORDER

9:00 President's Announcements

9:05 Council Meeting Minutes of September 8, 2017 ……..1

Executive Committee's Report to Council, August – November 2017 ……9

PRESENTATION

9:10 Policy: Enhancing Accessibility

- ***For Discussion***

Council will be provided with a presentation on work that's currently underway to enhance the readability, navigability and accessibility of CPSO policies.

9:40 Uninsured Services: Billing and Block Fees – Consultation Report and Revised Draft Policy ……20

- ***For Decision***

The draft *Uninsured Services: Billing and Block fees* policy was released for external consultation following the February 2017 meeting of Council. Council is provided with a report on the feedback received during the consultation period and an overview of the revisions that are proposed.

Council is asked whether the revised draft *Uninsured Services: Billing and Block Fees* policy (attached as Appendix "A") can be approved as a policy of the College.

10:15 ***Break***

10:30 Motion to go In-Camera

IN CAMERA

COUNCIL AWARD PRESENTATION

11:30 Council Award Winner: Dr. Kenneth Fung of Toronto, Ontario**…….38**

12:00 Noon ***Lunch***

FINANCE COMMITTEE REPORT – 2018 BUDGET

Materials will be circulated on November 23, 2017

2:00 ***Break***

PRESENTATION

2:15 Bill 160, Schedule 9 *Oversight of Health Facilities and Devices Act, 2017*……40

Council is provided with an overview of Bill 160, Schedule 9 *Oversight of Health Facilities and Devices Act* (OHFDA) and a summary of the College's concerns with the OHFDA. The College's submission to the Standing Committee, approved by the Executive Committee, can be found on the College's website.

REGISTRAR'S REPORT

3:00 Corporate Report and Dashboard – 2017 Q3…….49

ADJOURNMENT DAY 1

Friday December 1, 2017

CALL TO ORDER

9:00 President's Announcements

PRESENTATIONS

9:05 Registration Pathways Program Evaluation……..57

- ***For Discussion***

Council will be provided with a background and context for the evaluation, an overview of key findings and a discussion of linkages to other College initiatives.

9:45 ***Break***

10:00 Physician Health Program – Update

Guest Speaker: Dr. Joy Albuquerque, Medical Director
Physician Health Program, Ontario Medical Association

Council will be provided with an overview of the program, which provides confidential support for individuals struggling with substance abuse and mental health concerns, as well as other behaviours that have a personal and professional impact.

11:00

REGISTRAR'S FORUM

11:30

PRESIDENT'S TOPICS

Presidential Address: Dr. David Rouselle

Induction of New President: Dr. Steven Bodley

GOVERNANCE COMMITTEE REPORT

Materials will be circulated on November 23, 2017

MEMBER TOPICS

ANNUAL COMMITTEE REPORTS

INFORMATION ITEMS

ADJOURNMENT

***DRAFT* - PROCEEDINGS OF THE**
MEETING OF COUNCIL OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
SEPTEMBER 8, 2017

Attendees:

Dr. David Rouselle (President)
Dr. Steven Bodley
Ms. Lynne Cram
Mr. Harry Erlichman
Dr. Marc Gabel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. Joel Kirsh
Mr. John Langs
Dr. Carol Leet
Dr. Barbara Lent
Dr. Haidar Mahmoud
Ms. Judy Mintz
Mr. Peter Pielsticker
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Mr. Arthur Ronald
Dr. Jerry Rosenblum
Mr. Emile Therien
Mr. Andrew Turner
Dr. James Watters
Dr. Scott Wooder

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

Regrets: Dr. Brenda Copps, Dr. Richard (Rick) Mackenzie, Mr. Roy Marra, Dr. Dennis Pitt, Ms. Gerry Sparrow

CALL TO ORDER

President's Announcements

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

FOR DECISION

Council Meeting Minutes of May 25/26, 2017:

01-C-09-2017

It is moved by Dr. Deborah Hellyer and seconded by Dr. Jerry Rosenblum that:

The Council accepts the minutes of the meeting of the Council held on May 25/26, 2017.

CARRIED

Executive Committee's Report to Council – April to June, 2017

Received.

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

02-C-09-2017

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

The College engage in the consultation process in respect of the draft policy "Physician Services During Disasters and Public health Emergencies" (a copy of which forms **Appendix "A"** to the minutes of this meeting).

CARRIED

PRESENTATION

Opioids Strategy Status Update

Maureen Boon, Director Strategy, provided Council with a status update and an overview of planned communicators, including an interim status update on the opioids investigations.

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

03-C-09-2017

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

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

CARRIED

PRESENTATION

Anne Coghlan, Executive Director & CEO of the College of Nurses of Ontario, provided Council with an update on the CNO's governance vision for the future and how the process has unfolded.

COUNCIL AWARD WINNER

Dr. Jerry Rosenblum presented the Council Award to Dr. Michael Stephenson of Kitchener, Ontario.

Motion to Go In Camera

04-C-05-2017

It is moved by Dr. Marc Gabel and seconded by Ms. Debbie Giampietri that:

The Council exclude the public from the part of the meeting immediately after the lunch break under clauses 7(2)(b), (d), and (e) of the Health Professions Procedural Code.

CARRIED

IN CAMERA

Council entered into an in-camera session at 1:15pm and returned to open session at 2:30pm.

MEMBER TOPICS

There were no member topics.

REGISTRAR'S REPORT

Corporate Reporting and Dashboard – 2017 Q2

New Member Orientation – New Applicant Credentialling Requirement

05-C-09-2017

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

The College create a new applicant credentialing requirement related to professionalism and self-regulation and in particular, focusing on boundary violations and the prevention of sexual abuse.

CARRIED

New Member Orientation – Costs Associated with New Applicant Credentialling Requirement

06-C-09-2017

It is moved by Dr. Joel Kirsh seconded by Dr. Peeter Poldre:

The cost associated with the creation and delivery of the new applicant credentialing requirement be borne by the general membership, as opposed to by the new applicants.

CARRIED

Governance Committee Report

Facilitating Public Member Presidents

07-C-09-2017

It is moved by Dr. Carol Leet seconded by Major A. Khalifa:

The Council supports the proposed approach outlined below for facilitating public member presidents as well as the consequential changes to Executive Committee composition. The Governance Committee is directed to proceed with the development of applicable by-law changes that can be considered by Council at a future meeting.

Proposed Approach:

- The Council supports the proposed approach outlined below for facilitating public member presidents as well as the consequential changes to Executive Committee composition. The Governance Committee is directed to proceed with the development of applicable by-law changes that can be considered by Council at a future meeting.

Proposed Approach

- Public members of Council should be encouraged to serve as College Vice-President and President.
- The Executive Committee will continue to be composed of six members, but a new minimum of two public members and a minimum of two physician members will be instituted. The By-laws will be amended to reflect this composition of the Executive Committee.
- The Past President will continue to serve as a member of the Executive Committee.
- The current Vice-President will generally progress to be President. An election would still take place to satisfy the *Medicine Act* but by convention and support for a progression path to the President position, the only nominee will normally be the current Vice-President. This will not be written in the College By-laws, but this progression will be clearly communicated to ensure awareness and transparency.
- There will no longer be an assumed progression path to Vice-President Position, but ideally nominees will have recent experience serving on the Executive Committee. The election for the Vice-President position will be open (by convention and to support this experience criterion) to any current member of the Executive Committee (other than the current Vice-President, President or Past President) or a member of Council who had been on Executive Committee during their current Council term. This will not be written in the College By-laws but this approach be clearly communicated to ensure awareness and transparency.
- The remainder of the Executive Committee (other than the Past President) will be elected after the President and Vice-President. One or more elections may be needed to properly fill the minimum requirements for 2 physician and 2 public members.

Timing for the By Laws Implementation

There is time to do this by the general election in May 2018. The only person affected is Dr. Brenda Copps who is not present today, therefore, there is no conflict to discuss at the table. Council is in agreement to wait and have the By Laws revised and available for the May 2019 general election, noting that the new Registrar will have been in place for a while by that time.

Two abstentions.

CARRIED

2017-2018 Academic Members to Council

Council voted to accept the three academic representatives for 2017-2018 Councilors, as proposed by the Academic Advisory Committee that include, Dr. Paul Hendry, Dr. Barbara Lent and Dr. Akbar Panju.

2018 Chair Appointments

08-C-09-2017

It is moved by Dr. Marc Gabel seconded by Dr. Judith Plante:

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 2017:

Council Award Selection Committee:
Dr. David Rouselle

Discipline Committee:
Dr. Carole Clapperton
Ms. Debbie Giampietri

Education Committee:
Dr. Akbar Panju

Executive Committee:
Dr. Steven Bodley

Finance Committee:
Mr. Peter Pielsticker

Fitness to Practise Committee:
Dr. Dennis Pitt

Governance Committee:
Dr. David Rouselle

Inquiries, Complaints and Reports Committee:
Dr. David Rouselle, Chair, ICRC
Ms. Lynne Cram, Co-Vice Chair, General Panels
Mr. Harry Erlichman, Co-Vice Chair, General Panels
Dr. James Edwards, Co-Vice Chair, Settlement Panels
Dr. Carol Leet, Co-Vice Chair, Settlement Panels
Dr. Edith Linkenheil, Vice Chair, Obstetrical Panels
Dr. Dale Mercer, Vice Chair, Surgical Panels
Dr. Akbar Panju, Vice Chair, Internal Medicine Panels

Dr. Brian Burke, Vice Chair, Mental Health and Health Inquiry Panels
Dr. Steven Whittaker, Vice Chair, Family Practice Panels

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. Deborah Robertson

Registration Committee:
Dr. Akbar Panju

CARRIED

TOPICS FOR INFORMATION

Policy Report

2018 Council and Executive Committee Schedule

Governance Relations Report

FMRAC Future of the Organization – Snapshot 2016/'17

September 2017 Discipline Committee Report of Completed Cases

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 4:05pm.

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Dr. David Rouselle, President

_____
Franca Mancini, Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

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

FOR INFORMATION

August 8, 2017 Executive Committee Meeting

1. Governance Committee Report

Rescind Patient Relations Committee Appointment

The Executive Committee rescinded the appointment of Dr. Pauline Abrahams to the Patient Relations Committee.

2. Medical Assistance in Dying: Update

The Committee was provided with an update on MAID-related initiatives currently underway by the provincial and federal governments. In order to ensure that the College continues to provide accurate and timely guidance on MAID to the profession, the *Medical Assistance in Dying* policy has been updated to reflect amendments to provincial legislation contained in Bill 84.

3. Marijuana for Medical Purposes Update: Draft *Cannabis Act*

On April 13, 2017, the Government of Canada introduced Bill C-45, *An Act respecting cannabis and to amend the Controlled Drugs and Substances Act, the Criminal Code and other Acts* (the Cannabis Act). While the draft *Cannabis Act* does not propose to alter the process for accessing marijuana for medical purposes in Canada, and has no direct implications for College policy, there are a number of ways in which the proposed legislative requirements for accessing marijuana for recreational purposes differ from the existing requirements (in policy and legislation) for accessing marijuana for medical purposes. In particular, the draft *Cannabis Act* appears to propose establishing a

framework for accessing and possessing recreational marijuana that may be more permissive than the parallel medical framework. Staff will continue to monitor the progress of the *Cannabis Act* and any related legislation to determine whether further consideration or action is needed.

4. Bill 87 Updates to College Policies and Boundaries & Sexual Abuse Module

Bill 87, the *Protecting Patients Act, 2017*, received Royal Assent May 30, 2017. Among other things, it contains a series of amendments to the *Regulated Health Professions Act, 1991 (RHPA)* responding partially to the Sexual Abuse Task Force report and the Goudge review. Minor updates have been made to related College policies (Maintaining Appropriate Boundaries and Preventing Sexual Abuse; Physician Treatment of Self, Family Members or Others Close to Them) and the College's Professionalism and Practice Program Boundaries & Sexual Abuse Module to ensure they accurately reflect the provisions in Bill 87 that are currently in force.

<u>September 28, 2017 Executive Committee Meeting</u>

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

In June 2016, the Executive Committee approved a 12-month pilot project to provide independent legal advice to complainants/witnesses involved in discipline hearings in which the allegations relate to sexual misconduct. To date, the number of participants has been too small to properly evaluate the program and assess whether to continue with the project. The pilot was developed as part of the College's sexual abuse initiative, to ensure that the College is doing everything possible to support and protect patients from physician sexual abuse.

At the time approval was initially sought, the Executive Committee was advised that the pilot project could cost as much as $17,500 - $20,000, based on the number of witnesses who took advantage of the program. To date, the College has paid significantly less than the estimate.

The Executive Committee approved extending the *Pilot Project for Independent Legal Advice to Complainants/Witness in Discipline Hearings relating to Sexual Misconduct* to December 2018.

2. Ministry of Transportation Consultation - Regulation Regarding Mandatory Reporting

The Ministry of Transportation is conducting a consultation on proposed amendments to regulations under the *Highway Traffic Act* in support of the mandatory reporting duty related to fitness to drive. As part of the consultation, the Ministry of Transportation is asking for feedback on a list of prescribed medical conditions, functional impairments and visual impairments that must be reported to the ministry.

The mandatory reporting duty is currently broadly framed. The intention of the list is to provide greater clarity to the medical profession by specifying conditions that would result in mandatory reports to the MTO. Medical practitioners would also be permitted to make permissive reports for conditions not listed, where they think an individual's ability to safely operate a motor vehicle may be compromised.

The Executive Committee recognized that such reporting can be very subjective, and directed that the College's response articulate general support for the proposed amendments and include constructive comments to assist with improving the clarity of reporting requirements.

3. Medical Assistance in Dying: Council of Canadian Academies (CCA) Consultation

The federal legislation on MAiD commits the federal Ministers of Justice and Health to initiate independent reviews relating to requests for MAiD by mature minors, advance requests for MAiD, and MAiD in the context of mental illness as a sole underlying condition.

An Expert Panel of the Council of Canadian Academies (CCA) is conducting a consultation on these three topics related to eligibility for MAiD and has asked the College to participate.

In its submission, the College does not take a formal position on any of the three topics under review. For instance, the draft submission does not advocate in favour of or against mature minors gaining access to MAiD. Instead, it highlights for the Expert Panel the issues and considerations the CPSO believes are critical in evaluating the three topics of study.

The Executive Committee recommended that the CPSO response be submitted to the Expert Panel of the Council of Canadian Academies.

4. Governance Committee Report

Appointment

The Executive Committee appointed Ellen Mary Mills to the Discipline and Premises Inspection Committees.

Contact: David Rouselle, President
Vicki White, ext. 433

Date: November 9, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: Uninsured Services: Billing and Block Fees – Consultation Report and Revised Draft Policy

FOR DECISION

ISSUE:

- The draft *Uninsured Services: Billing and Block Fees* policy was released for external consultation following the February 2017 meeting of Council.
- Council is provided with a report on the feedback received during the consultation period and an overview of the revisions that are proposed.
- Council is asked whether the revised draft *Uninsured Services: Billing and Block Fees* policy (attached as Appendix 'A') can be approved as a policy of the College.

BACKGROUND:

- The College's *Block Fees and Uninsured Services* policy, which was first approved by Council in 2000 and last updated in 2010, is currently under review in accordance with the College's regular policy review cycle.
- The policy sets out key principles and expectations for physicians charging for uninsured services and/or offering a block fee.
- The policy review was undertaken with the assistance of Dr. Michael Szul (Medical Advisor) and Morgana Kellythorne (Legal Counsel). Informal feedback was also provided by Council Members Dr. Barbara Lent and Mr. Arthur Ronald.
- Based on a comprehensive literature and jurisdictional review, feedback received during a preliminary consultation on the current policy, and public polling results, a newly titled draft *Uninsured Services: Billing and Block Fees* policy was developed. The draft policy was approved for external consultation at the February 2017 meeting of Council.

CURRENT STATUS:

A. Report on Consultation

- In accordance with standard practice, an external consultation[1] was held on the draft policy following the February 2017 Council meeting.

- In total, the College received 118 responses (70% physicians, 13% members of the public, 2% other health care professionals, 5% organizations,[2] and 10% prefer not to say). This includes 53 comments on the College's online discussion page and 65 online surveys.[3]

- In keeping with the College's consultation posting guidelines, all written feedback and a report of survey results can be found on the consultation-specific page of the College's website.

- In addition to the external consultation, Policy Staff was invited to consult the Inquiries, Complaints and Reports Committee (ICRC) via discussion sessions at both the Leadership and Business meetings in March and April, 2017 respectively.

B. Overview of Feedback Received

General Comments

- Broadly speaking, feedback from the external consultation was polarized. Many respondents, including both physicians and physician organizations, were supportive of the draft policy positions or recommended taking a more firm stance on key issues. In contrast, some physicians felt the draft policy would inappropriately compel them to work for free and that the College should not be interfering with the fees they charge.

- Notwithstanding the above, a strong majority of survey respondents felt that the draft policy was clearly written and easy to understand and agreed with the new draft policy expectations pertaining to physicians' role in educating patients about uninsured services, missed appointments, and how block fees are offered.

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[1] Invitations to participate in the consultation were sent via email to a broad range of stakeholders, including the College's entire membership. In addition, a general notice was posted on the College's website, Facebook page, and announced via Twitter. It was also published in *Dialogue* and Patient Compass (the College's public e-newsletter). Stakeholders were given the option of submitting their feedback in writing, via email or regular mail, via a brief online survey, or by posting comments to an online discussion page.

[2] The organizational respondents were: Canadian Doctors for Medicare, Credit Valley Family Health Team, FAIR Association, Ontario Medical Association, Ontario Medical Association Section on Sport & Exercise Medicine, and Ontario Medical Association Section on Respiratory Disease.

[3] 69 respondents started the survey, but of these, 4 did not complete any substantive questions – leaving 65 for analysis.

Specific Concerns and/or Recommendations for Improvement

Distinguishing uninsured and insured services

- Feedback from the external consultation suggested that the draft policy may require a more nuanced analysis of the distinction between insured and uninsured services recognizing that some uninsured services may be included in physician contracts.

Physicians' responsibility to help patients understand fees

- While external consultation survey respondents agreed with the principle that physicians should engage their patients in educational activities regarding uninsured services, some were concerned that advising physicians to provide patients with a copy of the College policy was too burdensome.

- Respondents also felt that physicians ought to be able to rely on their office staff to inform patients or third parties about any fees associated with uninsured services and to answer any questions about those fees, including questions about block fees.

Reasonableness of fees and patients' ability to pay:

- Some respondents voiced concern with the requirement that fees be "reasonable". In particular, that the term is ambiguous and that if the College is not prepared to define it, then we should not rely on it. Others agreed with the principle of reasonableness, but worried that there is no mechanism to monitor compliance.

- The requirement to consider patient's ability to pay was supported by many, but concerns regarding the need for patients to self-identify as being in need (which may cause reluctance or embarrassment) and physicians' ability to assess need (something they have no training in) were raised, as was the concern that this could incentivize physicians to practice in well-to-do areas.

Providing insured and uninsured services together

- External consultation feedback indicated that the draft policy could more comprehensively address issues that arise when insured services are bundled with uninsured services or uninsured services are offered as an alternative to insured services (most notably, cataract surgery or in the dermatology context). In particular, recognizing that patients in these situations are often vulnerable and that the power imbalance in the physician-patient relationship may compound this vulnerability.

- ICRC provided similar feedback and also worried about physicians who 'upsell' patients on uninsured alternatives to insured care, or who offer faster access to insured services when bundled with uninsured services.

Missed or cancelled appointments

- The draft policy required that fees for missed or cancelled appointments be reflective of the costs incurred by the physician. A member of ICRC pointed out that in some settings (namely, family health teams), physicians would lose very little income (due to their payment structure) and so the requirement may not apply well in this context.

Block fees

- Respondents to the external consultation worried that physicians will continue to misrepresent block fees to their patients and that no matter what the College says, some patients will feel compelled to pay the fee for fear of retribution.

- Respondents to the external consultation also noted that patients may have a difficult time assessing whether a block fee is in their best interest and recommended that physicians provide additional supports for patients with low literacy or for whom English is their second language.

C. Additional Developments and Research

- With the release of the Ontario Health Coalition's (OHC) *Private Clinics and the Threat to Public Medicare in Canada* report, a string of media articles drew attention to a number of potentially inappropriate billing practices that may be occurring in Ontario.

- This prompted Policy Staff to review all media articles dating back to 2015 pertaining to issues identified in the OHC report. This included:

    - Physicians billing patients instead of or in addition to the province for insured services (e.g., extra-billing, double-billing, user-fees).

    - Conflicts of interest that may arise when physicians direct patients to facilities in which they have a financial stake.

    - Physicians offering faster access to insured services when bundled with uninsured services.

    - Executive or boutique clinics offering a range of uninsured and insured services and in some cases linking access to payment of a large annual fee.

D. Proposed Revisions

- Overall, the revised draft policy retains the key content and central principles of the draft policy. However, in light of the feedback received and the additional research conducted, a number of revisions are proposed and have been incorporated into the revised draft policy, attached as Appendix 'A'. A summary of the key proposed revisions is set out below.

Key Revisions and Additions

Executive Summary

- Both external and internal stakeholders have commented that it is sometimes difficult to navigate policies to identify relevant policy content, due in part to the increasing length and detail of our policies. Council provided similar feedback at its September 2017 meeting.

- In response to this feedback and Council's direction, an Executive Summary has been included at the beginning of the revised draft policy in order to provide a quick overview of the top issues and key expectations that are addressed in the policy (*Lines 2-24*).

Enhancing clarity and precision

- Minor revisions were made to enhance clarity or improve precision. Most notably:

    - The revised draft policy now recognizes that some physician services which are strictly speaking uninsured are paid for by the government and prohibits physicians from charging patients for these services (*Lines 89-91*).

    - In determining what is reasonable to charge, the revised draft policy now also requires physicians to consider any recommended fees set out by relevant specialty association(s) in addition to those provided by the Ontario Medical Association (*Lines 103-104*).

    - The revised draft policy also clarifies that the requirement to consider the patient's ability to pay applies in the block fee context as well (*Line 114*).

    - The revised draft policy more clearly allows for office staff to play a role in communicating and answering questions about individual fees, answering questions about block fees, and assisting patients in assessing whether a block fee is in their best interest while still holding physicians responsible for their billing policies and practices (*Lines 122-125, 235-237*).

Confirming the profession's commitment to protecting patients

- The "Principles" section of the draft policy was significantly revised to better reflect the substance of the revised draft policy (*Lines 42-47*).

- In response to consultation feedback and feedback from ICRC, the revised draft policy includes new language that identifies the vulnerability of patients when paying privately for uninsured services and that emphasizes that patients rely on the honesty and integrity of physicians in these instances (*Lines 30-33*). The proposed language was adapted from a recent decision of the College's Discipline Committee.

Prohibitions on billing for insured services

- In response to the OHC report and recent media articles, new language is proposed to remind physicians of their obligations under the *Commitment to the Future of Medicare Act, 2004* (*CFMA*) and the *Canada Health Act* (*Lines 84-86*).

- In particular, that they are prohibited from charging patients for insured services or charging any amount in excess of what the provincial health insurance plan has or will pay (e.g., extra-billing and user fees).

Providing insured and uninsured services together or as alternatives

- In response to feedback obtained in the external consultation, feedback received from ICRC, and additional research that was undertaken in light of the OHC report and subsequent media attention, a new section was added to the revised draft policy to more comprehensively address issues that arise when insured and uninsured services are provided together.

- The revised draft policy reminds physicians that they must comply with the *CFMA* prohibition on accepting payment for preferential access to insured services (*Lines 143-149*).

    - Whether bundling insured services with uninsured services leading to faster access to insured services violates the *CFMA* is fact and case specific.

    - The revised draft policy content was left purposefully high level, leaving this determination to the professional judgment of physicians and advising them to seek independent legal advice if they are unsure.

    - Importantly, there are probable examples where this practice is permissible and others where it is likely impermissible. Unfortunately, the College is not aware of any legal proceedings on this issue to help set principled distinctions between permissible and impermissible practices.

- The draft policy content regarding the management of conflict of interests was also expanded to capture physicians' general responsibility in this regard and the issue of physicians referring patients to a private facility in which they have a financial stake without disclosing this interest (*Lines 150-154*).

Communication practices

- In light of feedback, content advising physicians to provide all patients with a copy of the College policy has been revised. The revised draft policy now advises physicians to direct patients, where appropriate, to the companion Patient Information Sheet (*Line 128-130*).

- Similarly, the expectation that physicians offering patients a block fee provide or direct patients to the College policy has been modified to only direct patients to the Patient Information Sheet, as this document was seen as being more beneficial to the patient (*Line 233-234*).

- In response to feedback, the requirement that physicians use plain language when offering a block fee has been expanded to require physicians to consider how to address language and/or communication barriers that may impede patients' understanding of what is being offered (*Line 225-227*).

Fees for missed or cancelled appointments without sufficient notice

- Recognizing that in some practice models physicians may incur very little cost or lose very little income when appointments are missed or cancelled without the required notice, the revised draft policy now identifies a variety of factors which will influence how fees are set.

- Notably, the revised draft policy recognizes that missed or cancelled appointments without notice negatively impact other patients and so directs physicians to consider, among other factors, a fee that would act as a reasonable deterrent to patients (*Lines 166-170*).

NEXT STEPS:

- Should Council approve the revised draft policy it will be published in *Dialogue* and will replace the current version of the policy on the College's website.

- Should Council approve the revised draft policy, a *Frequently Asked Questions* companion document and a *Patient Information Sheet* will be developed and posted alongside the policy on the College's website.

DECISION FOR COUNCIL:

1. Does Council have any feedback on the revised draft *Uninsured Services: Billing and Block Fees* policy?

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

Contact: Craig Roxborough, Ext. 339

Date: November 10, 2017

Attachments:
Appendix A: Revised Draft *Uninsured Services: Billing and Block Fees* policy

Uninsured Services: Billing and Block Fees

Executive Summary:

This policy sets out the College's expectations for physicians in relation to billing for uninsured services, including offering patients the option of paying for uninsured services by way of a block fee. Key topics and expectations include:

- *Charging for Services:* Physicians must not charge for the provision of insured services (including their constituent elements). Physicians are entitled to charge for the provision of uninsured services, unless the government has otherwise agreed to remunerate them.
- *Setting Fees that are Reasonable:* Physicians must ensure that the fees they charge are reasonable.
- *Communicating Fees:* Fees must be communicated before uninsured services are provided.
- *Combining Insured and Uninsured Services:* Physicians must be clear and impartial when proposing uninsured services as an alternative or adjunct to insured services. If physicians structure their practice in a manner that leads to faster access to insured services when combined with uninsured services, they must ensure that doing so complies with the legal prohibitions against granting preferential access to insured services.
- *Offering a Block Fee*: Physicians who offer a block fee must do so in writing, complying with the requirements set out below. This includes indicating that block fees are optional and that decisions regarding how to pay for uninsured services will not impact access care.

Physicians must also consider the patient's ability to pay when charging for uninsured services, individually or by block fee, charging for missed or cancelled appointments without the required notice, and collecting outstanding balances. In particular, physicians must consider whether it would be appropriate to reduce, waive, or allow for flexibility on compassionate grounds.

Introduction

Some physician services are not covered by the Ontario Health Insurance Plan (OHIP). These services, referred to as uninsured services, include but are not limited to prescription refills and medical advice over the phone, sick notes for work, the copy and transfer of medical records, immunization for the sole purpose of travel, the completion of insurance and/or medical forms, and a number of medical procedures. As payment for uninsured services is not subject to the same external monitoring system as insured services, patients paying privately for uninsured services are particularly vulnerable and rely on the honesty and integrity of physicians to ensure that their needs and interests are put first.

This policy sets out the College's expectations of physicians in relation to billing for uninsured services, including offering patients the option of paying for uninsured services by way of a block fee.

Principles

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

1. Acting in the best interests of their patients;
2. Respecting and facilitating patient autonomy with respect to treatment decisions and decisions regarding payment for uninsured services;
3. Maintaining public trust by recognizing that the balance of knowledge and information about uninsured services favours physicians and not exploiting this imbalance for personal advantage;
4. Recognizing and appropriately managing any conflicts of interest;
5. Participating in self-regulation of the medical profession by complying with the expectations set out in this policy.

Definitions

Insured services:

Services listed in the *Health Insurance Act* and the Schedule of Benefits that are publicly funded under OHIP,[1] provided that the service is being rendered to an insured person.[2,3]

All insured services include the provision of the service itself, as well as any constituent elements associated with the service. Examples of constituent elements of insured services

[1] The services paid for by the Ontario Health Insurance Plan (OHIP) are set out in Section 11.2 of the *Health Insurance Act,* R.S.O. 1990, c. H.6 (hereinafter, *Health Insurance Act*) and the Schedule of Benefits: Physicians Services under the *Health Insurance Act* (hereinafter, Schedule of Benefits).

[2] An insured person is entitled to insured services as per provincial legislation and regulations. In Ontario the *Health Insurance Act* and its regulations set out the definition of insured persons who are covered by OHIP.

[3] The College acknowledges that individuals not covered by OHIP may be covered by other insurance programs such as the Interim Federal Health Programme (which provides basic health care for refugees or refugee claimants), the Non-Insured Health Benefits program (which provides coverage for certain services to eligible First Nations and Inuit people), or by another provincial health insurance plan. As there are unique requirements, processes, and challenges related to each of these programs, for the purposes of this policy, the definitions of insured and uninsured services or persons are framed in relation to the *Health Insurance Act* and OHIP.

include the referral of a patient to a specialist, the administrative processing for a new patient being accepted into a practice, and making arrangements for an appointment.[4]

Uninsured services:

Services provided by physicians that are not publicly funded under OHIP. This includes services provided to ~~uninsured~~ individuals not insured under OHIP.

Block fee:

A block fee is a fee that is charged to patients to pay for the provision of one or more uninsured services from a predetermined set of services during a predetermined period of time. At the time of payment it will not be possible for the patient to know how many, if any, services will be needed.[5] This ~~flat~~ fee may also be referred to as an 'annual fee' if it covers a period of 12 months.[6]

Purpose & Scope

This policy articulates the College's expectations of physicians in relation to billing for uninsured services, including offering patients the option of paying for uninsured services by way of a block fee. These expectations apply regardless of practice area or specialty and regardless of the type of uninsured services for which the patient is charged.

Policy

Physicians who charge for uninsured services, either per service or by way of a block fee, must comply with the expectations set out in this policy, other relevant College policies,[7] and applicable legislation.[8]

The first section of the policy sets out general expectations for physicians when charging for uninsured services, whether these services are paid for as they are provided or by way of a block fee. The second section of the policy sets out specific expectations for physicians who offer patients the option of paying for uninsured services by way of a block fee. Expectations for

[4] For a complete list of the common and specific elements of insured services that are considered to be constituent elements of the insured medical services covered by OHIP, see the preamble to the Schedule of Benefits.
[5] Adapted from Section 18(4) paragraph (a) of the *Commitment to the Future of Medicare Act, 2004,* S.O. 2004, c.5 (hereinafter, *CFMA, 2004*).
[6] This does not prevent physicians from calling the fee by another name (i.e., 'Patient Supplemental Plan', 'Block Billing Plan', etc.), provided that it is not misleading.
[7] Most notably, the College's Medical Records and Third Party Reports policies.
[8] This includes, but is not limited to, the *Health Insurance Act*; the *Professional Misconduct*, O. Reg. 856/93 enacted under the *Medicine Act, 1991,* S.O. 1991, C.30 (hereinafter, *Professional Misconduct Regulation*); and the *CFMA, 2004*.

physicians who use a third party to collect payment for uninsured services and/or administer block fees are set out in the final section of the policy.

Charging for Uninsured Services

Charging for Services

Physicians are not permitted to charge for the provision of insured services (including the constituent elements of insured services),[9,10] or to charge any amount in excess to what OHIP has paid or will pay (e.g., extra-billing, user fees).[11] Physicians are also prohibited by regulation from charging for services not performed[12] or for an undertaking to be available to provide services to a patient.[13]

Physicians are entitled to charge patients or third parties[14] for the provision of uninsured services, unless the government has agreed to remunerate physicians for the provision of these services.[15] Uninsured services are those that are not covered by OHIP. They include, but are not limited to, commonplace services such as sick notes and prescription refills over the phone, through to medical procedures that are not covered by OHIP or are only partially covered by OHIP.[16]

Setting Fees that are Reasonable

Physicians must ensure that the fees they charge for uninsured services are reasonable. In accordance with regulation, it is an act of professional misconduct to charge a fee that is excessive in relation to the services provided.[17] This requirement applies to block fees as well.

[9] See the "Constituent and Common Elements of Insured Services" of the Schedule of Benefits and Sections 10(1) and (3) of the *CFMA, 2004*.

[10] A physician may charge patients for services if the physician opted out of OHIP prior to December 23, 2004.

[11] See Sections 10(1) and (3) of the *CFMA, 2004* as well as Sections 18 and 19 of the *Canada Health Act*, R.S.C., 1985, c. C-6.

[12] Section 1(1) paragraph 20 of the *Professional Misconduct Regulation*. Notwithstanding the prohibition on charging for services not performed, physicians are permitted to charge for missed or cancelled appointments in specific circumstances. See Section 1(1) paragraph 20 of the *Professional Misconduct Regulation* and below for more information.

[13] Section 1(1) paragraph 23.2 of the *Professional Misconduct Regulation*.

[14] For example, a representative from an insurance company or a lawyer. For more information see the College's Third Party Reports policy.

[15] For example, while telemedicine is an uninsured service, the government has agreed to remunerate physicians providing telemedicine via the Ontario Telemedicine Network. Similarly, the Ontario Fertility Program remunerates physicians for some fertility services that are uninsured services.

[16] See the Schedule of Benefits, Section 24 of the General R.R.O 1990, Regulation 552 enacted under the *HIA*, as well as the Ontario Medical Association's *Physician's Guide to Uninsured Services* for more information about the specific services that are or are not covered by OHIP.

[17] Section 1(1) paragraph 21 of the *Professional Misconduct Regulation*.

When determining what is reasonable to charge for individual uninsured services, physicians must ensure that the fee is commensurate with the nature of the services provided and their professional costs. As part of making this determination, physicians must consider the recommended fees set out in the Ontario Medical Association's *Physician's Guide to Uninsured Services* ("the OMA Guide")[18] and any recommended fees set out by their professional specialty association(s). While physicians are not obliged to adopt the recommended fees set out in the OMA Guide, in accordance with regulation, it is an act of professional misconduct to charge more than the current recommended fees in the OMA Guide without first notifying the patient of the excess amount that will be charged.[19] Physicians are also advised that in some instances, fees for uninsured services will be prescribed by law or set out in an order of the Information and Privacy Commissioner.[20]

When determining what is reasonable to charge for a block fee, physicians must ensure that the amount charged is reasonable in relation to the services and period of time covered by the block fee.

Additionally, when determining what is reasonable to charge for individual uninsured services or a block fee, physicians must consider the patient's ability to pay.[21] In particular, physicians must consider the financial burden that these fees might place on the patient and consider whether it would be appropriate to reduce, waive, or allow for flexibility with respect to fees based on compassionate grounds.

Communicating Fees

Physicians must ensure that a patient or third party is informed of any fee that will be charged prior to providing an uninsured service, except in the case of emergency care where it is impossible or impractical to do so.

While physicians are ultimately responsible for ensuring that fees are communicated in advance and must be available to offer explanations and/or answer questions, physicians may utilize office staff to inform patients or third parties about fees for uninsured services and to answer any questions they have. Similarly, while posting a general notice listing fees for common uninsured services in a physician's office is recommended and can assist in patient education,

[18] The OMA Guide is typically updated annually, and so physicians must ensure they have reviewed the most recent edition.

[19] Section 1(1) paragraph 22 of the *Professional Misconduct Regulation*.

[20] See Section 37(5) of the *Workplace Safety and Insurance Act, 1997,* S.O. 1997 c.16, Sched. A and Information and Privacy Commissioner orders HO-009 and HO-14. See as well the College's Medical Records and Third Party Reports policies for further information.

[21] The Canadian Medical Association Code of Ethics #16 states that "In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient."

this is not a substitute for directly informing patients of the fees associated with uninsured services prior to providing them. The Patient Information Sheet appended to this policy may also be a helpful resource for patients and physicians are advised to direct patients to this document to further assist with patient education. ~~Additionally, prior to providing an uninsured service, physicians are advised to provide patients with a copy of this policy and/or the appended Patient Information Sheet or provide instructions on how to access these documents, as this will assist in patient education.~~

Combining Insured and Uninsured Services

Physicians sometimes propose or provide insured and uninsured services together or offer uninsured services as an alternative or adjunct to insured services. These situations are ripe for confusion and patients are particularly reliant on the honesty and integrity of their physicians to ensure their needs and interests are being put first, and that they have clear information about their clinical options and any corresponding fees.

As such, in these situations physicians must clearly communicate which services or elements of a service are associated with the fee and which are not and must describe the patient's options in a clear and impartial manner.[22]

Physicians who provide both insured and uninsured services sometimes structure their practice in a manner that leads to different wait times for the insured and uninsured services they provide. If this practice structure also leads to faster access to insured services when combined with uninsured services, physicians must ensure that doing so complies with the *Commitment to the Future of Medicare Act, 2004* prohibition on charging or accepting payment or benefit in exchange for preferential access to insured services.[23] If physicians are unsure of their legal obligations in this regard, the College advises them to obtain independent legal advice.[24]

Physicians are also reminded that they must place the interests of their patients over their own personal interests and manage any real or perceived conflicts of interest that might arise in this context.[25] In particular, physicians must not refer a patient to a facility in which they or a

[22] It is an act of professional misconduct to make a misrepresentation respecting a remedy, treatment or device (Section 1(1) paragraph 13 of the *Professional Misconduct Regulation*) or to make a claim respecting the utility of a remedy, treatment, device or procedure other than a claim which can be supported by reasonable professional opinion (Section 1(1) paragraph 14 of the *Professional Misconduct Regulation*).

[23] Section 17(1) of the *CFMA, 2004*.

[24] For example, from the Canadian Medical Protective Association or other legal counsel.

[25] See *General Regulation*, Part IV, Conflicts of Interest, O. Reg. 114/94 enacted under the *Medicine Act, 1991*, S.O. 1991, C.30. (hereinafter, *Conflict of Interest Regulation*).

member of their family has a financial interest without first disclosing that fact[26] and must not sell or otherwise supply any medical appliance or medical product to a patient at a profit.[27]

Charging for Missed or Cancelled Appointments

In general, physicians are prohibited from charging for services that are not rendered. However, in accordance with regulation, physicians are permitted to charge for a missed appointment or a cancelled appointment where the cancellation is made less than twenty-four hours before the appointment time, or in a psychotherapy practice, in accordance with any reasonable written agreement with the patient.[28]

Physicians who intend to charge patients in these circumstances must have a system in place to facilitate the cancellation process, and ensure that the patient was informed of the cancellation policy and associated fees in advance, and they must have been available to see the patient at the time of the appointment.

When determining what is reasonable to charge for missed appointments or cancelled appointments without the required notice, physicians must consider a variety of factors. This will include, but may not be limited to, considering what amount would constitute reasonable cost recovery,[29] as well as what amount would act as a reasonable deterrent to patients, recognizing the lost opportunity costs to other patients when appointments are missed or cancelled without the required notice. Physicians must also consider the patient's ability to pay the fee, as well as the circumstances that led to the missed or cancelled appointment, and consider granting exceptions where it is reasonable to do so (e.g., first or isolated incident, intervening circumstances, etc.) or on compassionate grounds.

Providing an Invoice

Physicians are advised to always provide an itemized invoice[30] for any uninsured services that are provided and for which fees are paid.[31] Furthermore, physicians must provide an invoice whenever they are asked for one. In accordance with regulation, failure to provide an itemized invoice when asked is an act of professional misconduct.[32]

[26] Section 17(1) of the *Conflict of Interest Regulation.*
[27] Section 16(d) of *Conflict of Interest Regulation.*
[28] Section 1(1) paragraph 20 of the *Professional Misconduct Regulation*.
[29] This could include, for example, any lost opportunity to bill OHIP, as well as any costs incurred by the physician as a result of the missed or cancelled appointment.
[30] Physicians must not charge for the production of an itemized invoice.
[31] This would include any fees charged for missed or cancelled appointments and fees that are charged to patients who have chosen to pay a block fee, but where the fees for some services are merely reduced as a result.
[32] Section 1(1) paragraph 24 of the *Professional Misconduct Regulation*.

Collecting Fees and Outstanding Balances

Sometimes patients may accrue a balance owing for uninsured services received. Physicians may take action[33] to collect any fees owed to them, but must always do so in a professional manner and in accordance with privacy legislation.[34] In so doing, physicians must consider the patient's ability to pay the outstanding balance and consider whether it would be appropriate to reduce, waive, or allow for flexibility in the amount owed based on compassionate grounds. Physicians who are considering ending the physician-patient relationship due to an outstanding balance must comply with the expectations set out in the Ending the Physician Patient Relationship policy.

Offering a Block Fee

Assessing Whether a Block Fee is Appropriate

Physicians who charge for uninsured services may, but are not required to, offer patients the option of paying for uninsured services by way of a block fee.[35]

A block fee may be a more convenient and/or economical way for patients to pay for uninsured services, and for physicians to administer fees for these services. However, a block fee may not be appropriate in all practice settings where uninsured services are provided. Appropriateness will depend on a number of factors, including but not necessarily limited to, the nature of the physician's practice and specialty. It is not permissible to charge a block fee in order to cover administrative or overhead costs associated with providing insured services;[36] rather, a block fee is merely a way of facilitating payment for uninsured services.

Physicians offering a block fee must ensure the fee covers a period of not less than three months and not more than 12 months.

[33] This may include physicians or their office staff contacting patients or hiring a third party (i.e., collection agency) to assist in the process.

[34] This includes, for example, the *Personal Health Information Protection Act, 2004*, S.O. 2004, c.3, Sched. A. (hereinafter *PHIPA, 2004).*

[35] Although section 1(1) paragraph 23 of the *Professional Misconduct Regulation* lists "charging a block fee" as an act of professional misconduct, physicians are able to charge a block fee as this provision has been struck down by the courts in *Szmuilowicz v. Ontario(Minister of Health),* 1995 CanLII 10676 (ON SC) and is therefore not in effect.

[36] See the "Constituent and Common Elements of Insured Services" of the Schedule of Benefits, read in conjunction with section 37.1 (1) of R.R.O 1990, Reg. 552 General, enacted under the *Health Insurance Act* and Section 10 of the *CFMA, 2004*.

Ensuring Patient Choice and Access to Care

Physicians who offer the option of payment for uninsured services by way of a block fee must always provide patients with the alternative of paying for each service at the time that it is provided.

Moreover, patient decisions regarding whether to pay for uninsured services as they are provided or by way of a block fee must not affect their ability, or the ability of other patients in the physician's practice, to access health care services. Physicians must not:

- Require that patients pay a block fee before accessing an insured or uninsured service;[37]
- Treat or offer to treat patients preferentially because they agree to pay a block fee; or
- Terminate a patient[38] or refuse to accept a new patient[39] because that individual chooses not to pay a block fee.[40]

To ensure patients are able to make fully informed choices regarding payment for uninsured services, physicians who choose to offer a block fee must:

1. Offer a block fee in writing.[41] In doing so, physicians must:
    - Indicate that payment of a block fee is optional and that patients may choose to pay for uninsured services as they are provided;
    - Indicate that the patient's decision to pay for uninsured services as they are provided or through a block fee will not affect their ability to access health care services;
    - Identify those services that are covered by the block fee, provide a list of fees that will be charged for each service should the block fee option not be selected, provide examples of those services (if any) that are not covered, and indicate for which services (if any) the fee is simply reduced if the block fee option is selected; [42]

[37] Section 18(2) of the *CFMA, 2004*.
[38] For more specific guidance on ending the physician-patient relationship, refer to the College's Ending the Physician-Patient Relationship policy.
[39] For more specific guidance on accepting new patients, refer to the College's Accepting New Patients policy.
[40] Section 18(2) of the *CFMA, 2004*.
[41] This can include e-communication; however, physicians must provide information to patients by other means (i.e., mailed letter) if their patient(s) do not have access to the internet. Physicians are reminded of the inherent risks in using e-communication with patients and are advised to refer to relevant privacy legislation, policies and guidelines for further direction.
[42] Some uninsured services are particularly time consuming (e.g. complex medical reports). Physicians may choose to provide a discounted fee for these services to those patients who elect to pay a block fee.

- Use plain language and give consideration as to how to address language and/or communication barriers that may impede patients' ability to understand what is being offered;[43]
- Refrain from using language that is or could be perceived as coercive or which suggests that without payment of the block fee, services will be limited or reduced, or that quality of care provided in the physician's practice may suffer;
- Invite patients to consider whether payment of a block fee is in their best interest given their needs or usage of uninsured services; and
- Direct ~~Provide~~ patients ~~with a copy of this policy and/or~~to the appended Patient Information Sheet~~ or provide instructions on how to access these documents~~.[44]

2. Ensure that patient questions about the block fee are answered, ensure that help is available to patients to determine if the block fee is in their best interest, and be available to answer questions or provide assistance upon request. ~~Be available to answer any questions patients have about the physician's billing policy and about any charges the patient does not understand.~~
3. ~~Be available to help patients assess whether payment of a block fee is in their best interest given their needs or usage of uninsured services.~~
4. ~~3.~~ Obtain written confirmation if the block fee option is chosen and maintain it as part of the patient's medical record.[45]

Refunding a Block Fee

Patients must be given the opportunity to rescind the decision to pay a block fee within a week of their original decision. Where a patient rescinds their decision to pay a block fee, physicians must refund the amount charged for the block fee and can then charge the patient for any uninsured services already provided.

Additionally, when a physician ends the physician-patient relationship or ceases to practice, or when a patient leaves a practice, physicians are advised to consider whether it would be reasonable to refund a portion of the block fee, taking into account, both the time remaining in the block fee and the services that have been provided to date.

Use of Third Party Companies

Physicians may find it helpful to utilize the services of a third party company to assist them in administering and managing block fees or payment for uninsured services more generally. Any

[43] See the College's Consent to Treatment policy and Frequently Asked Questions document for guidance on addressing language and/or communication barriers.

[44] For example, physicians can direct patients to the College's website or refer patients to the College's Public Advisory Service (1-800-268-7096 ext. 603)

[45] For more specific guidance on medical records requirements, refer to the College's Medical Records policy.

256 communication between the third party company and patients must identify the third party by
257 name and indicate that they are acting on the physician's behalf.

258 Third parties who administer block fees or manage payment for uninsured services are acting
259 on the physician's behalf. As such, physicians are responsible for ensuring these companies
260 adhere to the same standards required of physicians, as outlined in this policy, other relevant
261 College policies,[46] and applicable legislation.[47]

[46] This includes, but it not limited to, the policies listed in Footnote 7.
[47] This includes, but is not limited to, the legislation listed in Footnote 8 and *PHIPA, 2004*.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

November 30, 2017

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the November 30th meeting of Council, **Dr. Kenneth P. Fung** of Toronto, Ontario will receive the Council Award.

BACKGROUND:

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

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

CURRENT STATUS:

Council member Dr. Marc Gabel will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: November 9, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

November 30, 2017

TOPIC: 2018 COUNCIL AWARD RECIPIENTS

FOR INFORMATION

ISSUE:

To inform Council of the four 2018 Council Award recipients.

BACKGROUND:

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

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

CURRENT STATUS:

The following four physicians have been chosen by the Council Award Committee to receive the 2018 Award:

- Dr. Raymond Anderson, Comber
- Dr. Jason Malinowski, Barry's Bay
- Dr. Sarah Reid, Ottawa
- Dr. Bill Wong, Mississauga

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: November 9, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

November/December 2017

TOPIC: Report of the Finance Committee

FOR DECISION

ISSUE:

Activities of the Finance Committee since the last meeting of Council including decisions for the following items:

- Finance Committee Terms of Reference and Name Change
- Safe Disclosure Policy
- Physician Compensation Working Group Survey of Committee and Council Members
- 2018 Budget

BACKGROUND:

The Finance Committee met on October 11, 2017. At that meeting the following motions were made:

It was moved by Mr. Peter Pielsticker, seconded by Dr. Thomas Bertoia, and **CARRIED.**

*That the Finance Committee recommends to Council that the name of Finance Committee be changed to the **Finance and Audit Committee** to accurately reflect the current responsibilities of the Committee.*

It was moved by Dr. David Rouselle, seconded by Dr. Thomas Bertoia, and **CARRIED.**

That the Finance Committee recommends to Council that the Safe Disclosure Policy be accepted as presented.

It was moved by Mr. Harry Erlichman, seconded by Dr. Steven Bodley, and **CARRIED.**

That the Finance Committee recommends to Council that the budget for 2018 be approved as presented.

It was moved by Mr. Harry Erlichman, seconded by Dr. David Rouselle, and **CARRIED.**

That the Finance Committee recommends to Council that the per diem rates be increased by 2% effective January 1, 2018.

It was moved by Mr. Harry Erlichman, seconded by Dr. Thomas Bertoia, and **CARRIED.**

That the Finance Committee recommends to Council that the membership fee for an independent practice licence be $1,725 effective June 1, 2018.

DECISIONFOR COUNCIL:

Does Council approve the motions as detailed above.

Contact: Pierre Giroux, Chair Finance Committee
Douglas Anderson, Corporate Services Officer, ext. 607
Leslee Frampton, Manager Finance & Business Services

Date: November 7, 2017

Attachments:

Appendix A: Terms of Reference for the Finance and Audit Committee

Appendix B: General By-law Changes

Appendix C: Safe Disclosure Policy

Appendix D: Physician Compensation Working Group Terms of Reference

Appendix E: Survey

Appendix F: 2018 Budget Material

Appendix G: Additional Background Information – 2018 Budget

Appendix A

FINANCE AND AUDIT COMMITTEE TERMS OF REFERENCE

A. PURPOSE

The Finance and Audit Committee (the "Committee") is appointed by, and reports to, the Council of the College of Physicians and Surgeons of Ontario (the "College"). The Committee monitors, evaluates, advises and makes recommendations, in accordance with these terms of reference, on the financial affairs and position of the College, including the annual budget, investment policy, banking of College funds, external audit, risk management, internal control functions, pension plans and the financial reporting and accounting control policies and practices of the College, and is to perform such other duties as the Council may delegate or direct from time to time. As the College is a high volume, low risk transactional environment, and the accounting policies under lying significant judgement and estimates are not complex, the Finance Committee also acts as the Audit Committee.

B. MEMBERSHIP QUALIFICATIONS

Committee members shall have:

1. Knowledge of the primary activities of the College;
2. The ability to read and understand fundamental not-for-profit financial statements, including a statement of financial position, and the statement of operations and changes in net assets; and
3. The ability to understand key operational and financial risks, related controls and control processes.

Committee members shall also have the responsibilities and the desirable behavioural competencies set out in the Governance Process Manual.

C. MEMBERSHIP & ATTENDANCE AT MEETINGS

The Committee members shall be appointed annually by the Council based on recommendations of the Governance Committee, and will include one or more members of the Executive Committee, other Council members, including physician and public members, and may include physician members who are not Council members.

The Committee shall meet at least three times per year, with authority to convene additional meetings, as circumstances require. While one meeting may be dedicated to the orientation of the Committee, each meeting should involve the appropriate orientation of any new Committee member as well as continuous education of all members. All Committee members are expected to attend each meeting, in person or by teleconference.

Attendance by invitation at all or a portion of Committee meetings is determined by the Chair of the Committee or its members, and would normally include the appropriate officers of the College, representatives of the external auditors, and such support staff as may be deemed appropriate. In

addition, any member of the Council is welcome to attend any meeting of the Committee and, in particular, the meeting where the annual budget is tabled. All matters dealt with by the Committee shall be treated as being confidential, subject to reporting to the Executive Committee or the Council or as the subject matter otherwise requires.

D. DUTIES AND RESPONSIBILITIES

1. Financial Statements

    a) Review, and recommend to the Council for approval, the annual audited financial statements of the College.
    b) Review, and recommend to the Council for approval, the financial content of the annual report and all other reports of a financial nature which require approval by the Council prior to the release thereof.
    c) Review and assess, in conjunction with management and the external auditor:
        i. The appropriateness of accounting policies and financial reporting practices used by the College, including alternative treatments that are available for consideration;
        ii. Any significant proposed changes in financial reporting and accounting policies and practices to be adopted by the College;
        iii. Any new or pending developments in accounting and reporting standards that may affect or impact on the College; and
        iv. The key estimates and judgments of management that may be material to the financial reporting of the College.
    d) Review any litigation, claim or other contingency that could have a material effect upon the financial position or operating results of the College, and the manner in which these matters have been disclosed in the financial statements.
    e) Review with management on an annual basis, the College's obligations pursuant to guarantees that have been issued and material obligations that have been entered into, and the manner in which these guarantees and obligations have been, or should be, disclosed in the financial statements.

2. External Auditor

    a) Assess the performance and consider the annual appointment of external auditors, for recommendation appointment by the Council.
    b) When there is to be a change in the external auditor, review all issues related to the change and assume the leadership in the selection process, for recommendation for appointment by the Council.
    c) Review, approve and execute the annual engagement letter with the external auditor, and ensure there is a clear understanding between the Council, the Committee, the external auditor, and the management that the external auditor reports to the Council through the Committee in accordance with its legal and professional duties. The terms of the engagement letter should include matters relating to staffing, objectives and scope of the external audit work, materiality limits, audit reports required, areas of audit risk, timetable, and the proposed fees.

d) Obtain and review a report from the external auditor at least annually regarding the auditor's independence and the profession's or audit firm requirements regarding audit partner rotation.
e) Approve, before the fact, the engagement of the external auditor for all non-audit services requiring a formal written opinion and the fees for such services, and consider the impact on the independence of the external audit work of fees for such non-audit services.
f) Receive and resolve any disagreements between management and the external auditors regarding all aspects of the College's financial reporting.
g) Review with the external auditors the results of the annual audit examination including, but not limited to, the following:
    (i) Any difficulties encountered, or restrictions imposed by management, during the audit;
    (ii) Any significant accounting or financial reporting issues;
    (iii) The auditors' evaluation of the College's system of internal accounting controls, procedures, and documentation, for financial reporting purposes;
    (iv) The post-audit or management letter containing any findings or recommendations of the external auditor including management's response thereto and the subsequent follow-up to any identified internal accounting control weaknesses; and
    (v) Any other matters which the external auditors should bring to the attention of the Committee.
h) Meet with the external auditors, at least annually or as requested by the auditors, without management representatives present, and to meet with management, at least annually, without the external auditors present.

3. Internal Controls and Risk Management

a) Obtain reasonable assurance, by discussions with and reports from management and the external auditors, that the accounting systems are reliable and that the system of internal controls is effectively designed and implemented.
b) At least annually, request the external auditor to provide their views on the quality (not just the acceptability) of the College's annual and interim financial reporting. Such quality assessment should encompass judgments about the appropriateness, aggressiveness or conservatism of estimates and elective accounting principles or methods and judgments about the clarity of disclosures.
c) Review and assess, on an annual basis, the College's risk management framework and policies as prepared by management.
d) Review with management and the auditors, the process and controls in place to mitigate the risk of fraud.
e) Review the internal control and approval policies and practices concerning the expenses of the Council members and officers of the College.
f) Review any claims of indemnification pursuant to the Bylaws of the College.
g) Ensure management has submitted the appropriate tax returns to the government.
h) Ensure management has remitted statutory remittances
i) On an annual basis, review the adequacy of the College's insurance programme.

Other Duties and Responsibilities

a) Engage independent counsel and other advisors as may be deemed or considered necessary, and determine the fees of such counsel and advisors.
b) In accordance with the College's policy established for this purpose, review and determine the disposition of any complaints received from any member of the College, regulatory body, employee or others under this policy.
c) Conduct an assessment, no less than every two years, of the effectiveness of the Committee and provide a report thereon to the Council.
d) Undertake such other budget or finance matters as requested by the Council or management.
e) Request such information and explanations in regard to the accounts of the College as the Committee may consider necessary and appropriate to carry out its duties and responsibilities.
f) Review annually the Terms of Reference for the Committee and to recommend any required changes to the Council.

4. Pension Plans and Investments

a) With respect to the Defined Benefit Pension Plan and the Supplementary Executive Retirement Plan (the "Plans") of the College, as applicable, the Committee shall:
   (i) Receive and review an annual report from management on the operation and financial performance of the Plans including a certificate of compliance that the College has complied with the requirements of the Plans, complied with the requirements of the applicable laws, including the Ontario Pension Benefits Act, and made all required regulatory filings;
   (ii) Review and recommend to the Council for approval:
      - The annual audited financial statements;
      - The appointment of the investment manager(s), the custodian, and the external auditor; and
      - The investment policies and procedures of the Plans' investments.
   (iii) Periodically review the investment performance of the Plans' investments; and
   (iv) Provide an annual summary report regarding the Plans to the Council.
b) On an annual basis, review the adequacy of the College's investment policy and make recommendations thereon to the Council.

5. Budgets

a) Review the draft budget before it is presented to the Council, and report to the Council on:
   (i) The assumptions in the draft budget;
   (ii) The steps taken to maximize efficiency and minimize cost in relation to the quality of goods and level of service; and
   (iii) Any other issue which the Committee considers may affect the financial affairs and position of the College.
b) Review from time to time the expenditures of the College in relation to the budget.

Appendix B

General By-law Changes

1. Subsections 2(1), 4(1)(d), 4(3)(b)(ii) and 6(7)(a) of the General By-law are amended by deleting the references to "finance committee" and substituting them with "finance and audit committee"

2. (1) Funds of the College that are not immediately required may be invested by an investment dealer selected by, and acting in accordance with criteria or parameters given by, the ~~finance committee~~finance and audit committee, only in,

4. (1) Goods may be purchased or leased, and services may be obtained, for the benefit of the College if the purchase, lease or obtaining of services is authorized by,

…

(d) one of the registrar, deputy registrar or corporate services officer and one of the president or vice-president, after conferring with the chair of the ~~finance committee~~finance and audit committee, if the resulting obligation exceeds $75,000 and the expenditure is not authorized by the College budget; or

4. (3) Without derogating from the authority under subsection (1) to obtain legal services, legal advice or representation may be obtained for the benefit of the College,

…

(b) that is not authorized by the College budget, by the administrative head of the College's legal office with the concurrence of,

…

(ii) one of the president or the vice-president after conferral with the ~~finance committee~~finance and audit committee.

Audit

6. (1) In this section, "auditor" means the person or people appointed under clause 28(4)(b).

….

(7) The auditor shall report,

(a) in person to the ~~finance committee~~finance and audit committee on the financial statements and related matters as soon as possible after the financial statements are prepared and as long as possible before the annual financial meeting, and

2. Section 41 of the General By-Law is amended by revoking "3 Finance Committee" and substituting it with "3 Finance and Audit Committee".

Establishment

1. The following committees are the standing committees.
   - 1 Council Award Selection Committee
   - 2 Education Committee
   - 3 ~~Finance Committee~~Finance and Audit Committee
   - 3a Governance Committee
   - 4 Methadone Committee
   - 5 Nominating Committee *[repealed: May 2003]*
   - 6 Outreach Committee
   - 7 Premises Inspection Committee
   - 8 Compensation Committee *[repealed: May 2017]*

3. Section 43 of the General By-Law is amended:

(a) by deleting all references in that section to "finance committee" and substituting them with "finance and audit committee"; and

(b) by deleting the title "Finance Committee" and substituting it with the title "Finance and Audit Committee".

~~Finance Committee~~Finance and Audit Committee

43. (1) The ~~finance committee~~finance and audit committee shall review and report to the council regarding the financial affairs and position of the College.

(2) In order to fulfil its duty under subsection (1), the ~~finance committee~~finance and audit committee shall,

(a) meet with the auditor each year,

(i) before the audit to review the timing and extent of the audit and to bring to the attention of the auditor any matters to which it considers the auditor should pay attention; and

(ii) as shortly before the annual financial meeting as practical in order to review and discuss with the auditor the financial statements, the auditor's report and the management letter;

(b) review the draft budget before it is presented to the executive committee, and report to the executive committee and the council arising from its review of,

(i) the assumptions in the draft budget;

(ii) the steps taken to maximize efficiency and minimize cost in relation to the quality of goods and level of service; and

(iii) any other issue which the committee considers may affect the financial affairs and position of the College; and

(c) review from time to time,

(i) the expenditures of the College in relation to the budget;

(ii) the performance and administration of the College's pension plans;

(iii) the investment strategies and performance of the College's non-pension investments; and

(iv) the security of the College's assets generally.

(3) Except where the council or the executive committee directs otherwise by resolution, no significant expenditure shall be made that is not authorized by the budget without an opportunity for the ~~finance committee~~finance and audit committee to consider the implications of the unbudgeted expenditure and provide to the executive committee a revised budget.

Appendix C

The College of Physicians and Surgeons of Ontario

Human Resources Policies and Procedures

Subject: **Safe Disclosure Policy**

Related Policies: ***HR-Protection from Violence and Harassment***
HR – Code of Conduct

Date: **Revised July 2017** **Policy Number: HR-645**

Safe Disclosure Incidents

The purpose of this Policy is to facilitate the disclosure and investigation of significant and serious incidents at the College involving unlawful, unethical, or unprofessional conduct of other employees, contractors or any stakeholder working on behalf of the College, while creating and maintaining a culture of trust and respect at the College, where employees, contractors or any College stakeholder feel empowered to make good faith reports of such incidents based on reasonable grounds.

An incident reportable under this Policy includes, but is not limited to, the following:

- Fraud or deliberate error in preparing, evaluating, reviewing or auditing financial statements;
- Fraudulent recording or reporting of financial records;
- Fraudulent classification of assets and/or liabilities or any deviation from full and fair reporting of the company's financial condition or results;
- Deliberate, unauthorized manipulation of documents or records;
- Deliberate misuse of the College's funds;
- Unlawful conduct;
- Unprofessional or unethical conduct or business practices that result in violation of College internal policies such as the Code of Conduct; and
- Concealment of any of the above.

Reporting and Investigation Processes

An employee, contractor or other College stakeholder who has reasonable grounds to believe that another employee, contractor or stakeholder working on behalf of the College has committed or is about to commit an incident should promptly report the incident. All incidents should be reported directly to the Associate Director of Human Resources (ADHR) or the Corporate Services Officer (CSO). If the individual does not feel comfortable reporting this information to the ADHR or the CSO, the individual should report it to the Registrar, Deputy

Registrar or the Chair of the Finance Committee. If the incident is regarding the Deputy Registrar, the individual should report it to the Registrar, if the incident is regarding the Registrar; the individual should report it to the President or the Chair of the Finance Committee.

The incident report should include the following:

- Reporter's full name;
- Reporter's contact information (whether at work or at home)
- The name of the College employee, contractor or stakeholder alleged to be involved in the incident;
- A description of the alleged conduct with as much detail as possible including any witnesses, locations and dates; and,
- Reporter's signature.

Although anonymous reports may be investigated by the College, reporting individuals should be aware that maintaining anonymity may limit the College's ability to adequately investigate the report and confirm good faith by the reporter.

The reporter is not required to prove the truth of the allegation but is required to make the report on reasonable grounds and to act in good faith in making the report.

The reporter will not be subject to reprisal or retribution (including termination, demotion, suspension, threats, harassment or other discrimination) as a result of making a report of one or more incidents on reasonable grounds and in good faith. If a College employee, contractor or stakeholder is found to be engaging in acts of reprisal or retribution against the reporter in violation of this Policy, the College may take action against such person, including termination of employment.

The CSO, Registrar or President, in consultation with the ADHR, (the Designated Officers) (excluding any of these persons if they are the subject of the report or involved in the alleged incident) will assess whether the report discloses a matter that is covered under this Policy. If it does, then the Designated Officers will review the information provided and either investigate the report or designate an appropriate internal or external investigator to conduct the investigation. The College will endeavour to complete each investigation in a timely manner, will conduct each investigation on an impartial basis, and monitor investigations on an ongoing basis. The employee, contractor or stakeholder against whom the report is made will be informed of the allegations (but not necessarily the identification of the reporter – see Confidentiality below) and have the right to respond.

If it is determined after the investigation that a College employee, contractor or other stakeholder working on behalf of the College engaged in, or threatened to engage in, an incident, the Designated Officers may approve the following actions, depending on who is the subject of the report:

- Education and training for the individual involved;
- Disciplinary action up to and including dismissal in the case of employees, and termination of the engagement or appointment or other appropriate action in the case of contractors or other stakeholders;
- Other appropriate remedial steps or action in respect of the conduct of the individual involved; and
- If required, notification of appropriate law enforcement authorities or other regulatory entities.

In determining the appropriate action, the College will consider all the relevant circumstances, including the nature and seriousness of the conduct, any relevant history or record of the individual involved, the actual or potential impact of the conduct, and any mitigating circumstances.

Once any investigation has been completed, the Designated Officers will prepare an investigation report. The Designated Officers will notify the reporting individual of the results of the investigation and any action taken as a result, subject to privacy and other legal obligations.

Confidentiality

All complaints under this Policy will be regarded as confidential to the extent possible. The College will protect the identity of the reporting individual unless s/he consents to being identified. Identification will only be revealed if it is required by law, the reporting individual is required to be a witness, or it is necessary in order for the College to effectively investigate or respond to the report or matters disclosed in the investigation. Depending on the nature of the complaint, the College may be required to report the matter to law enforcement officials, which may require a disclosure of the reporting individual's identity. The College will take reasonable steps to protect the reporter from harm if the reporter's identification is revealed. If an incident is also covered by another College policy (for example, Protection from Violence and Harassment Policy and Harassment and Discrimination Policy),the investigation may be conducted in accordance with that other policy and in accordance with the terms of that policy.

Appendix D

PHYSICIAN COMPENSATION WORKING GROUP
TERMS OF REFERENCE

Purpose:

The cost for physician participation in the College is significant and involves Council, Committee members and individuals that serve in expert roles (eg. assessors). In 2016, the expenses for these roles in the College were approximately 17% of our 64M budget. These expenses consist of per diems, hotel meal, and travel expenses as well as other out of pocket expenses. Another contributing factor to these expenses is the number of members that sit on committees and panels. The costs of assessors also contribute to this expense. Over the past number of years there have been changes in the physician compensation area in order to attract Council/Committee members and assessors. The Finance Committee is establishing a working group to review physician compensation and the number of physician members who sit on the committee/panel. This group will:

- Define, review and propose recommendations regarding the honorarium/per diems (rates and rules) for Committees of the College
- Review and propose recommendations regarding remuneration practices for the President and Vice President
- Review and propose recommendations about differential per diems for different College roles (e.g. Committee members, assessors, etc.)
- Review and propose recommendations for reimbursement for cancelled activities
- Define, review and propose recommendations for travel expenses and out of pocket expenses
- Consult with appropriate areas regarding the appropriate number of Committee/Panel members and the appropriate use of Panels

Participants:

- Chair of the Finance Committee – Pierre Giroux
- Immediate Past President – Joel Kirsh
- Former Member of Council – Preston Zuliani

Staff Support

- Registrar or Deputy Registrar – Rocco Gerace or Dan Faulkner
- Corporate Services Officer – Douglas Anderson
- Governance Committee – Louise Verity
- Manager, Finance and Business Services – Leslee Frampton
- Corporate Services Administrator – Greg Neild
- Committee Support Management
- Other areas as necessary

Appendix E

Council and Committee Physician Member Survey

The following survey has been developed to support the Finance Committee in developing a sustainable compensation model for physician members of committees and Council. This effort is part of the College's commitment to ensure that as our activity levels increase, we always look at ways to better understand and control the major cost drivers of the College (such as staff compensation plans that were re-structured in 2016 and Committee costs) to manage both current costs and real and anticipated growth. The College is interested in understanding why physicians choose to contribute to Council and Committee work and how compensation plays a role in this decision. Reimbursement for all reasonable travel expenses will continue, and this review will not include public member compensation as it requires legislative change that is already actively under consideration.

Please complete this short survey about your contribution to the CPSO. All responses are anonymous. The results of this survey will be used to help inform decisions about future compensation policies.

Survey Questions:

Please tell us about your clinical practice:

1. Specialty: (*drop down list of specialty groups)*
2. Practice status:
    a. Full-time clinical practice
    b. Full-time non-clinical practice
        i. Please specify:
    c. Part-time clinical practice (reduced work hours, semi-retired, or involved in other non-clinical work) Please specify
    d. Fully retired from clinical practice
        i. If so, how long have you been retired?
    e. Other
        i. Please specify:
3. How long have you been or were you in clinical practice?
    a. Less than 10 years in practice
    b. 10-19 years in practice
    c. 20-29 years in practice
    d. 30 years or more in practice

4. Main source of remuneration: *(will only appear if respondents indicate they are not retired in question 2)*
    a. Fee-for-service
    b. Alternate Payment Plan (for example, a department of an academic hospital)
    c. Salary (for example, a department head)
    d. Capitation or Blended payment (for example, a primary care model)
    e. Sessional fees
    f. Other
        i. Please specify:

Please tell us about your involvement with the CPSO:

5. How many years were you involved in CPSO work prior to becoming a Council or Committee member, if any?
    a. Enter number
6. How many years have you been a Council or Committee member?
    b. Enter number

Please tell us about your motivation for engaging in CPSO work:

7. Given that there are a number of professional organizations that you could contribute your time to, what are the main reasons you have chosen the CPSO?
    a. Open text field

Please tell us about how remuneration influences your decision to contribute to College work:

8. When you attend a meeting at the CPSO, does this affect the remuneration you receive for your clinical and/or non-clinical practice?
    a. Yes
    b. No
9. If yes, how so? (check all that apply)
    a. I am unable to bill for patient care
    b. I am responsible for overhead expenses (e.g., office space, administrative staff)
    c. Other
        i. Please specify:
10. When you attend a meeting at the CPSO, please select the option(s) that best describe your situation:
    a. I close my office for the day(s) that I am away
    b. I keep my office open and make alternate arrangements for my patients

c. I arrange to see patients at a different time
d. I have expenses that I must pay for when I am doing work for the College

11. Which statement most reflects your opinion about compensation for College work?
    a. Compensation is the primary reason why I contribute to the College. Receiving the highest possible pay is important to me.
    b. Compensation is a secondary reason why I contribute to the College. Receiving reasonable pay is important to me.
    c. Compensation is not a prominent reason why I contribute to the College. Receiving some pay is important to me, but the amount will not be a factor in my decision to contribute to the College.

If respondent indicated they are in part-time clinical practice or fully retired:

12. You indicated that you are currently working part time or retired. If you were in full time practice, would you still find time to contribute to College committees/council, even if it meant some impact on your clinical remuneration?
    a. Yes
    b. No

13. We recognize that each specialty has unique scheduling challenges and remuneration rates. Does your specialty affect your ability (e.g., nature of clinical practice, time available) to participate in CPSO Council or Committee work?
    a. Yes
        i. Please describe:
    b. No

14. When considering your involvement with Council and Committee work at the College, how important are the following types of compensation to you?

	Not important	Somewhat important	Very important
a. Payment for time spent in attendance at the College	❍	❍	❍
b. Payment for time travelling to and from the College	❍	❍	❍
c. Payment for time spent preparing for meetings	❍	❍	❍

15. The CPSO is considering alternative compensation models and is interested in your feedback about potential options. How much would each of the following scenarios impact your willingness to contribute to the College?

	Minimal impact on my willingness to contribute (I would continue to contribute the same amount of time)	Moderate impact on my willingness to contribute (I would consider reducing the amount of time I contribute)	Significant impact on my willingness to contribute (I would consider no longer contributing to the College)
a. If payment for travel time was reduced	❍	❍	❍
b. If payment for travel time was eliminated	❍	❍	❍
c. If payment for travel time was eliminated but the per diem was increased	❍	❍	❍
d. If payment for preparation time was reduced	❍	❍	❍
e. If payment for preparation time was eliminated	❍	❍	❍
f. If there was a standard time allotted for preparation (e.g., 1 hour) for Council meetings	❍	❍	❍
g. If there was a standard time allotted for preparation (e.g., 3 hours) for Committee meetings	❍	❍	❍
h. If compensation was provided on a per-meeting basis, based on type of meeting, rather than a per-hour or per-diem basis	❍	❍	❍

16. Please provide any other comments related to compensation by the College that have not been adequately addressed in the above questions.
    a. *Open text field*

Appendix F

BUDGET

2018

CPSO
Budget 2018

	2017 BUDGET	2018 BUDGET	% CHANGE	Increase in Membership Fee required to balance budget
BASE BUDGET				
Total Revenue (net of CRCC's)	67,257,363	67,083,858	-0.3%	
Total Expenses (net of CRCC's)	67,122,511	65,748,613	-2.0%	
Surplus/(Deficit)	134,852	1,335,245	-$	67.54
CAPITAL		76,156	-$	63.69
OTHER NEW REQUESTS - OPERATING		3,105,913	$	93.42
OTHER NEW REQUESTS - CAPITAL		130,093	$	100.00
Surplus/(Deficit)		- 1,976,916		
Potential $100 fee increase		1,976,917	$	0.00
Surplus/(Deficit)		**0**		

Income Statement - Alternative

	ACCOUNT NUMBERS	ACTUALS 2014	ACTUALS 2015	ACTUAL 2016	BUDGET 2017	Numbers	Fee	BUDGET 2018	% Increase Over 2017 Budget
REVENUES NET OF CRCC'S									
MEMBERSHIP FEES									
Independent Practice									
RIPL (Renewal) - First 5 months	3110	48,602,117	50,049,503	51,491,946	53,759,750	33,497	$ 1,625	22,680,260	1.9%
RIPL (Renewal) - Last 7 months	3110					33,890	$ 1,625	32,124,896	
NIPL (New)	3111	2,630,106	2,660,466	2,925,616	3,030,500	1,913	$ 1,625	3,108,625	2.6%
Suspended	3112	12,560	12,560	15,950	-				
Credit Card Service Charge	3465	- 1,183,030	- 1,204,105	- 1,253,249	- 1,251,151			- 1,276,870	2.1%
Renewal Post Graduate	3120	1,266,066	1,356,707	1,565,894	1,363,725	2,975	$ 325	966,875	-29.1%
New Post Graduate	3121	671,184	666,347	719,839	848,540	1,324	$ 325	430,300	-49.3%
Penalty Fee	3198	395,001	371,501	348,906	348,307			355,866	2.2%
TOTAL MEMBERSHIP FEES		52,394,004	53,912,980	55,814,902	58,099,671			58,389,952	0.5%
APPLICATION FEES									
General									
Independent Practice	3210	1,550,158	1,633,303	1,655,975	1,947,800	1,913	$ 980	1,874,740	-3.8%
Short Duration	3280	6,687	3,828	6,146	3,828			6,305	
Expedited Review Fee	3245 + 3255				89,719			95,912	
Post Graduate Educational	3220 + 3230	444,762	483,348	535,664	1,039,188	1,324	$ 406	537,875	-48.2%
Expedited Review Fee	3250				29,906			96,415	
Certificates of Professional Conduct	3325 + 3326	404,910	419,800	387,075	600,000	8,000	$ 75	600,000	0.0%
Certificates of Incorporation									
New	3340	573,950	571,150	515,500	640,000	1,400	$ 400	560,000	-12.5%
Renewals	3341	2,094,370	2,165,025	2,383,375	3,325,000	19,647	$ 175	3,438,225	3.4%
TOTAL APPLICATION FEES		5,074,837	5,276,453	5,483,734	7,675,441			7,209,472	-6.1%
OTHER									
Miscellaneous Services									
Embassy Letters	3305	24,516	27,190	22,560	26,000	450	$ 40	18,000	
Wall Diplomas	3310	21,000	23,695	18,975	26,250	275	$ 75	20,625	
Other	3990+	25,730	17,708	26,228	10,000			22,921	129.2%
Prior Year Items	3880	248,282	133,881	14,216	-				
OHPIP Application and Affiliation Fees	3370 + 3385	47,850	44,200	36,400	33,037			35,921	8.7%
OHPIP and IHF Penalty Fees	3197 + 3199	86,343	34,419	35,285	36,106			27,825	-22.9%
Survivor Fund Charge Backs	3825		45,620	20,418	7,851			29,563	
Legal Charge Backs	3835	12,500	15,000		15,139				
Discipline Charge Backs	3830	268,671	442,488	374,551	238,400			261,092	9.5%
Investment Income									
Short Term Investments	3510	7,278	646	-	-				
Portfolio Investments	3520	1,505,996	991,919	613,405	651,000			676,000	3.8%
Treasury Account	3530	510,301	436,367	401,600	438,468			392,489	-10.5%
TOTAL OTHER		2,758,468	2,213,134	1,563,638	1,482,251			1,484,435	0.1%
TOTAL REVENUE (BEFORE CRCC'S)		**60,227,309**	**61,402,567**	**62,862,274**	**67,257,363**			**67,083,858**	**-0.3%**
EXPENSES NET OF CRCC'S									
Executive		2,893,996	2,948,457	3,146,782	3,264,692			3,123,372	-4.3%
Information Technology		3,534,581	3,786,597	4,498,282	5,122,144			5,221,466	1.9%
Research and Evaluation		1,020,462	1,170,039	1,588,278	1,614,930			1,550,274	-4.0%
Policy and Communications		4,170,717	4,833,262	5,168,000	5,509,187			5,388,210	-2.2%
Legal Services		3,736,969	3,965,469	4,320,300	4,926,611			4,638,842	-5.8%
Corporate Services		7,162,362	7,248,162	8,061,714	8,133,813			8,021,622	-1.4%
Quality Management		12,031,364	12,569,552	13,819,123	15,073,297			14,253,655	-5.4%
Investigations and Resolutions		18,950,806	21,176,453	23,176,820	23,477,837			23,551,171	0.3%
TOTAL EXPENSES BEFORE CRCC'S		**53,501,257**	**57,697,992**	**63,779,300**	**67,122,511**			**65,748,613**	**-2.0%**
EXCESS REVENUE OVER EXPENSES (BEFORE CRCC'S)		**6,726,052**	**3,704,575**	**- 917,025**	**134,852**			**1,335,245**	**890.2%**
COST RECOVERY COST CENTRES									
OHPIP Annual Fees and Reassessments - R	3375+3380	767,869	1,053,301	1,215,732	-			-	
OHPIP Annual Fees and Reassessments - E		- 767,040	- 1,053,301	- 1,215,732	-			-	
IHF Annual Fees and Reassessments - R	3344+3845	729,398	1,198,421	1,078,327	-			-	
IHF Annual Fees and Reassessments - E		- 729,571	- 1,198,421	- 1,078,327	-			-	
Reg. Comm. and I & R Reassessment Fees - R	3342+3343	1,155,200	1,102,501	1,057,331	-			-	
Reg. Comm. and I & R Reassessment Fees - E		- 1,162,020	- 1,160,291	- 1,058,571	-			-	
Other Cost Recoveries - R	3612+3660+3760+3630+ 3780+3785+3790	196,765	255,620	386,303	-			-	
Other Cost Recoveries - E		- 264,626	- 279,107	- 350,566	-			-	
TOTAL NET COST RECOVERIES		**- 74,025**	**- 81,278**	**34,497**	**-**			**-**	
EXCESS OF REVENUE OVER EXPENSES (AFTER CRCC'S)		**6,652,027**	**3,623,297**	**- 882,528**	**134,852**			**1,335,245**	**890.2%**
Increase in Membership Fee (i.e. seven months at the increased rate)						33,890	$ 100	1,976,917	
EXCESS OF REVENUE OVER EXPENSES AFTER THE INCREASE IN MEMBERSHIP FEE								**3,312,162**	
CAPITAL AND NEW REQUESTS									
Per diem rate increase - Operating								190,991	
HST increase (Due to per diem rate increase) - Operating								11,173	
Salary increase at Jan. 1 - Operating								561,624	
Salary increase at Nov. 1 - Operating								23,725	
Benefit increase due to change in salaries - Operating								81,949	
Pension increase (Due to salary increase) - Operating								53,852	
Strategic Planning Project (Executive Division)								100,263	
New Requests - Operating								2,082,335	
New Requests - Capital Fund								130,093	
Transfer to/(from) Capital Fund		2,678,978	70,659	- 245,089	287,898			46,800	
Depreciation on new Capital items above								29,356	
Transfer to/(from) Building Fund		6,195,391	3,552,638	- 637,440	-				
Unrealized (Gain)/Loss on Portfolio Investment		- 2,222,342	-	-	-			-	
TOTAL CAPITAL AND NEW REQUESTS								**3,312,162**	
TOTAL NET SURPLUS/(DEFICIT)		**- 0**	**- 0**	**0**	**- 153,046**			**0**	**-100.0%**

FURNITURE & EQUIPMENT (ACCOUNT 1800)			
Item	Number	Cost Centre	Cost
Fridge/cooler staff room	1	1800	5,000
HR Office furniture	1	7050	5,000
Furniture for retrofitted meeting room to office for 4 people	4	Team 4	15,000
Desk chair	1	7200	700
Desk chairs	6	7400	4,200
Desk chairs	6	7430	4,200
Desk chairs	3	7405	2,100
Desk chair	1	7000	700
Desk chairs	6	7430	4,200
Total			$ 46,800

CAPITAL COSTS NET OF LEASES **$ 46,800**

LEASED EQUIPMENT (ACCOUNT 1822)			
Item	Number	Cost Centre	Cost
Core switches		7270	125,000
9 laptops		7400	22,500
1 Laptop		7000	2,500
1 Laptop		7940	2,500
Fortigate 50 D Firewall For Guests and Employee Wi-Fi		7270	2,260
Extra access points for new wi-fi		7270	5,000
To be paid for in 2018			162,260
Carried forward from 2017			
Total			$ 162,260

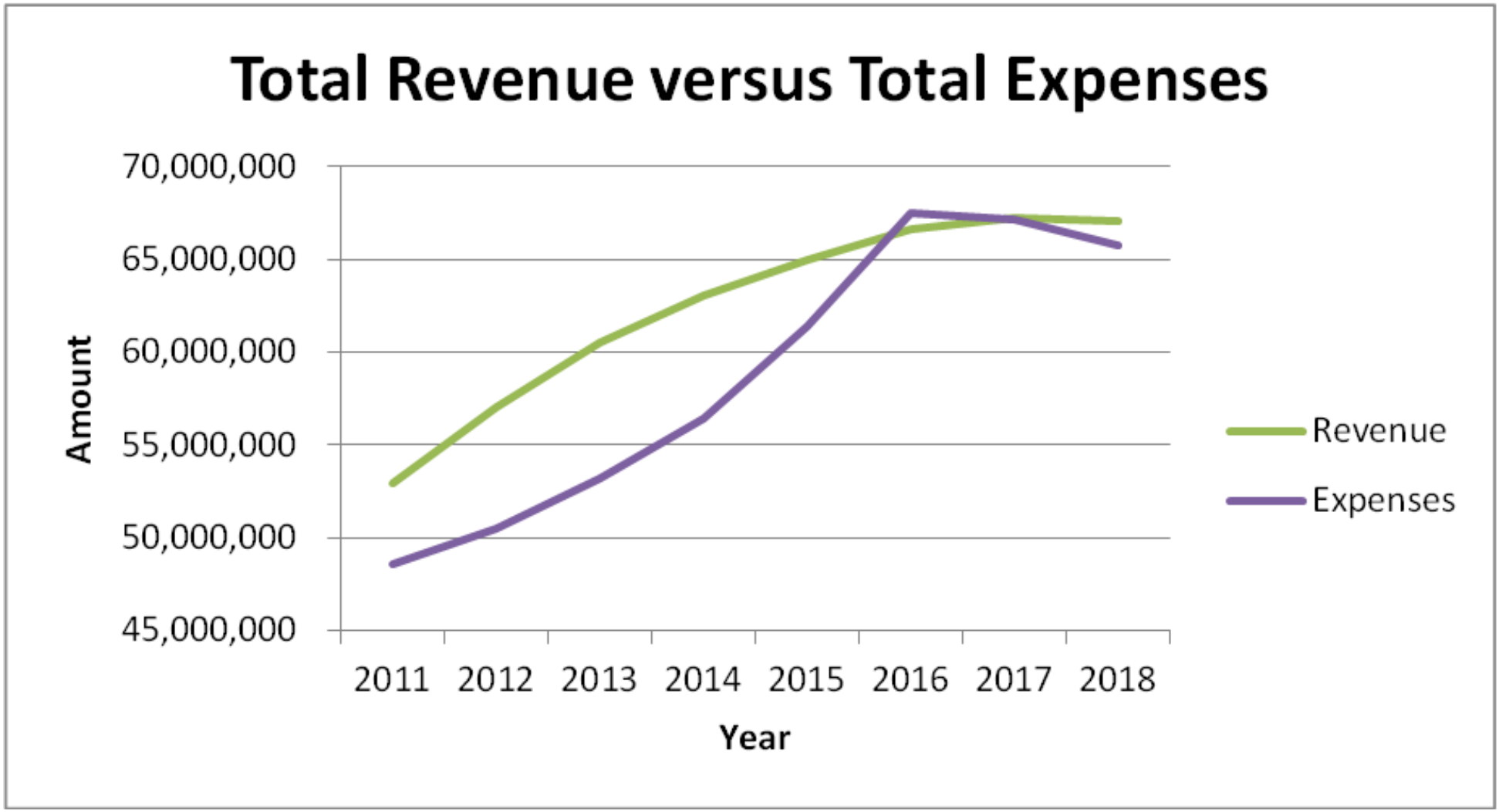
Depreciation using 1/2 year rule		
	Building	-
	Furniture & Fixtrues	2,340
	Telephones	-
	Computer Hardware	-
	Leased Equipment	27,016
	Website	-
	Total	29,356

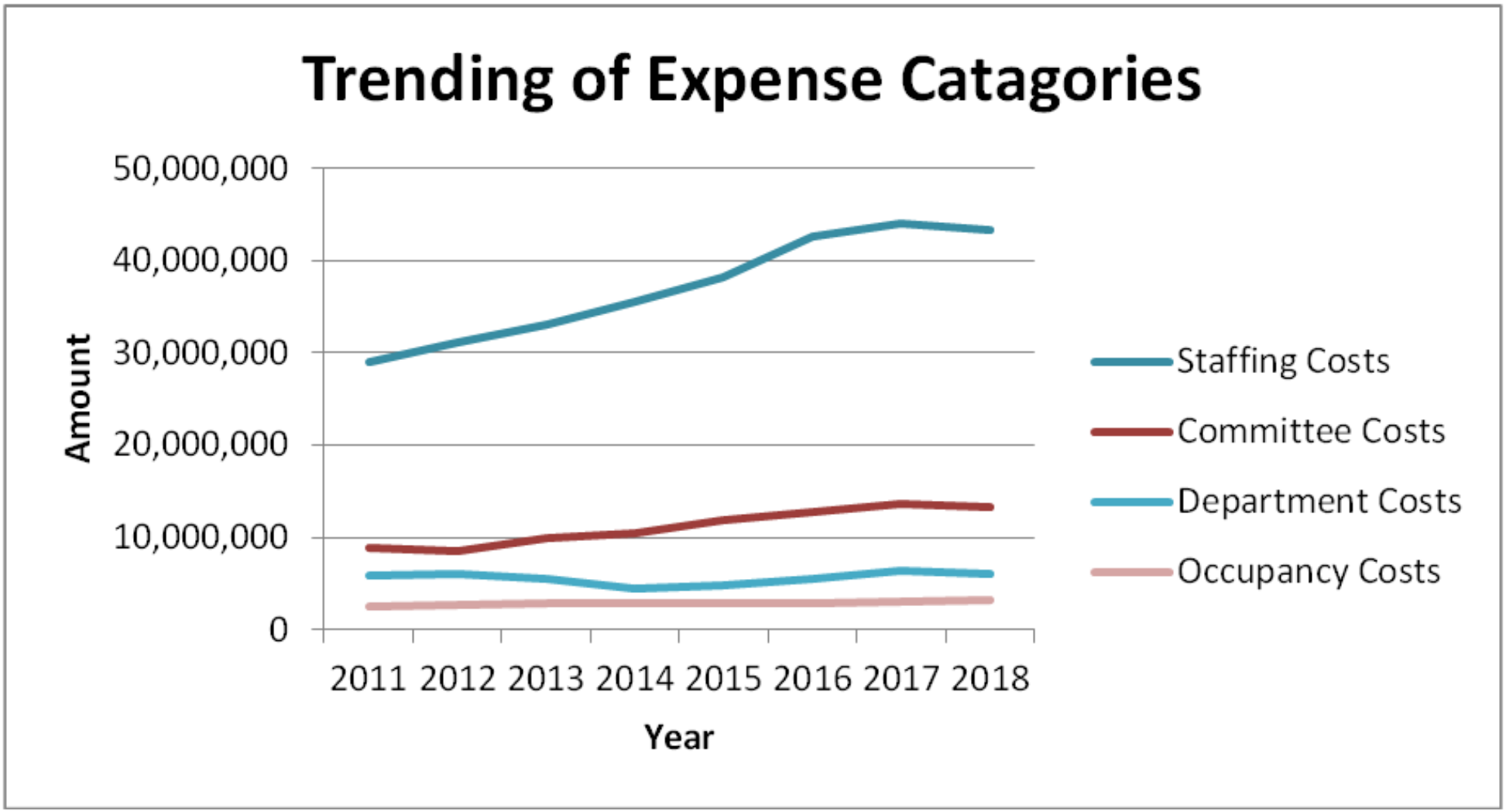
Exp by Cost Centre (ex CRCC)

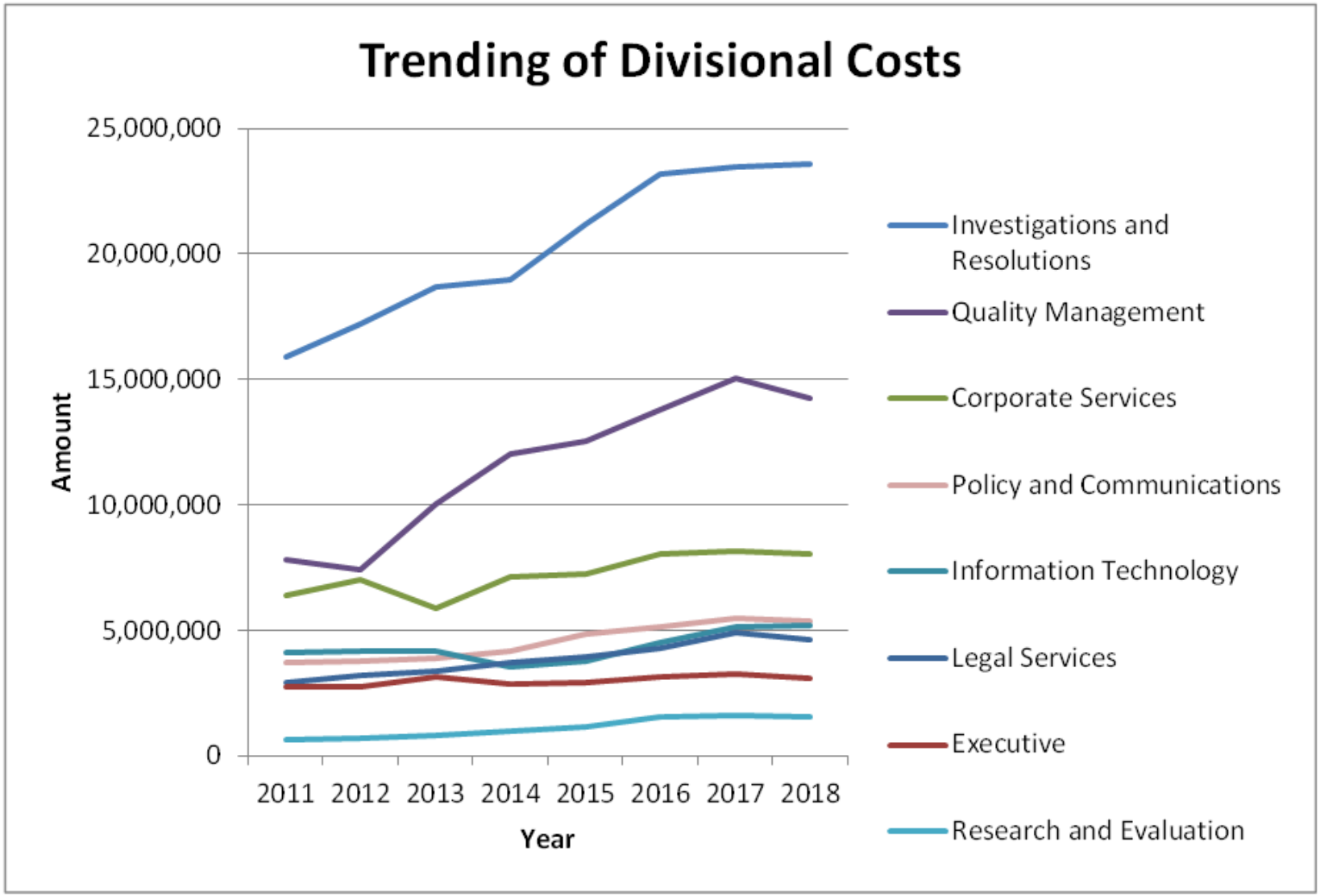
	ACTUALS 2014	ACTUALS 2015	ACTUAL 2016	BUDGET 2017	BUDGET 2018	CHANGE $	CHANGE %	
Executive Division								
4100 Council	577,886	524,946	545,471	519,785	484,021	- 35,764		
4101 Strategic Planning Project (Not used in F's 15, 16 or 17)	547	-	-	-	-	-		
4200 Executive Committee	61,975	65,378	83,029	90,835	83,745	- 7,090		
4201 President's Expenses	96,462	108,062	101,165	85,788	79,299	- 6,489		
4204 FMRAC	475,053	489,933	497,641	537,512	433,900	- 103,612		
5301 Physician Resource Task Force (Not used in F'15)	1,449	-	-	-	-	-		
7000 Executive Department	1,680,623	1,760,139	1,919,476	2,030,772	2,042,408	11,636		
Total	2,893,996	2,948,457	3,146,782	3,264,692	3,123,372	- 141,320	-4.3%	
Information Technology Division								
7250 IT Department	3,030,553	3,175,378	3,616,351	3,957,479	3,693,775	- 263,704		
7270 Infrastructure	504,028	611,219	881,931	1,164,665	1,527,691	363,026		Software Costs
Total	3,534,581	3,786,597	4,498,282	5,122,144	5,221,466	99,322	1.9%	
Research and Evaluation Division								
5710 Research & Evaluation Projects	161,065	158,538	273,340	273,280	204,767	- 68,513		
5705 Educational Program Development	32,254	33,133	70,076	107,500	83,500	- 24,000		
7840 Research & Evaluation Department	827,143	978,368	1,244,863	1,234,150	1,262,007	27,857		
Total	1,020,462	1,170,039	1,588,278	1,614,930	1,550,274	- 64,656	-4.0%	
Policy and Communications Division								
4103 Governance Committee	48,600	32,037	32,083	55,588	44,795	- 10,793		
4115 Outreach Program	59,821	65,468	45,748	65,842	41,076	- 24,766		
4110 District Elections	29,101	9,721	5,385	15,747	7,847	- 7,900		
7020 Communications Department	1,866,491	2,247,134	2,491,426	2,589,169	2,526,916	- 62,253		
7080 Advisory Services Department	1,156,835	1,295,000	1,341,158	1,405,759	1,419,371	13,612		
4220 Policy Working Group	119,842	78,253	76,386	142,323	101,474	- 40,849		
4260 Patient Relations Program	13,155	110,240	134,427	127,595	127,764	169		
7010 Policy Department	876,872	995,410	1,041,386	1,107,164	1,118,968	11,804		
Total	4,170,717	4,833,262	5,168,000	5,509,187	5,388,210	- 120,977	-2.2%	
Legal Services Division								
7550 Legal Services Department	3,736,969	3,965,469	4,320,300	4,926,611	4,638,842	- 287,769	-5.8%	
Corporate Services Division								
7050 Human Resources Department	674,391	823,415	1,140,737	1,022,092	874,084	- 148,008		
5500 Finance Committee	133,057	55,215	53,133	68,872	64,815	- 4,057		
7200 Finance Department	1,754,831	1,780,836	2,027,614	2,050,810	1,813,179	- 237,631		
7190 Business Services	202,089	197,425	248,385	254,610	255,312	702		
7170 Records Management	791,199	897,020	905,324	967,948	966,089	- 1,859		
7110 Facility Services	801,633	838,982	923,249	885,987	936,444	50,457		
8000 Occupancy Costs	2,346,209	2,207,524	2,331,520	2,172,314	2,380,066	207,752		Depreciation
8007 800 Bay	458,954	447,746	431,753	711,180	731,634	20,454		
Total	7,162,362	7,248,162	8,061,714	8,133,813	8,021,622	- 112,191	-1.4%	
Quality Management Division								
5720 Quality Assurance Committee	850,687	937,099	954,740	1,215,331	1,026,451	- 188,880		
6210 Peer Assessment Program	3,088,873	2,865,054	2,964,399	2,522,329	2,129,287	- 393,042		
6215 Peer Redesign Assessment	-	-	-	846,642	1,269,726	423,084		Attendance, Travel Time, HST, Meals and Accommodations, Travel Expenses
6218 Assessor Training	54,750	88,701	39,935	150,812	147,137	- 3,675		
7860 Quality Assurance Progam	2,441,646	2,638,168	3,077,774	3,081,139	2,905,676	- 175,463		
7684 Methadone Committee	56,078	98,236	95,088	130,142	-	- 130,142		No longer in use as of 2018. See CC 5720
6219 Assessor Networks	8,030	63,194	68,873	110,331	123,916	13,585		
6216 Assessor Bi-Annual Meeting	135,483	14,947	167,225	-	183,638	183,638		Active year
5100 Education Committee	66,564	39,438	45,815	68,468	50,187	- 18,281		
5101 Changing Scope Practice Working Group	-	3,873	22,556	160,837	41,048	- 119,789		
5102 Registration Pathway Evaluation	231,356	248,906	119,923	100,000	96,000	- 4,000		
7850 QMD - Administration Department	928,307	1,122,268	1,419,668	1,540,319	1,533,976	- 6,343		
5300 Registration Committee	186,793	231,206	229,084	322,645	231,727	- 90,918		
7940 Applications & Credentials	2,359,943	2,559,862	2,802,790	2,869,373	2,842,103	- 27,270		
7180 Annual Membership Survey	86,834	53,338	52,071	56,200	44,800	- 11,400		
7970 Membership Department	710,717	677,278	769,168	810,041	661,592	- 148,449		
7990 Corporations Department	825,305	927,983	990,013	1,088,688	966,391	- 122,297		
Total	12,031,364	12,569,552	13,819,123	15,073,297	14,253,655	- 819,642	-5.4%	
Investigations and Resolutions Division								
7400 I&R Administration	2,035,959	2,158,843	1,994,330	2,211,893	2,301,987	90,094		Training and Conferences
7430 Public Complaints Resolutions	905,069	1,005,948	1,164,434	1,224,929	1,215,857	- 9,072		
7440 Sexual Impropriety Investigations	806,325	971,347	1,326,293	1,173,367	1,237,743	64,376		
7450 Public Complaints Investigations	3,925,671	4,103,162	4,550,766	4,462,008	4,296,333	- 165,675		
7465 Registrar's Investigations	2,758,620	2,893,241	2,991,145	2,878,826	2,746,969	- 131,857		
7480 Incapacity Investigations	396,041	315,516	453,298	365,454	569,435	203,981		Increases in accounts which they have no control over
4905 Peer Opinions (IOs)	348,946	353,519	288,393	344,859	185,738	- 159,122		
4900 Medical Assessors (Mis)	873,252	1,136,847	1,155,815	837,506	1,054,410	216,904		Attendance and HST
4650 Health Assessments	123,153	140,491	94,835	105,350	81,887	- 23,463		
7405 ICR Committee Support	1,526,160	1,799,139	2,000,790	2,118,632	2,034,974	- 83,658		
7406 Compliance Monitoring	1,254,220	1,446,292	1,484,007	1,500,222	1,553,749	53,527		
4402 Caution Panels	88,231	103,825	87,994	102,171	103,486	1,315		
4403 Business, Leadership, Training and Orientation	184,412	236,397	193,847	261,515	216,474	- 45,041		
4410 General, Fast & Medium Track and Teleconference Panels	929,345	973,615	1,208,014	1,188,956	1,274,831	85,875		Preparation Time, HST and Travel Expenses
4411 ICRC-Specialty Panels	695,201	784,783	882,279	845,241	969,031	123,790		Preparation Time, HST and Travel Expenses
4412 ICRC-Health Inquiry Panels	118,286	104,897	114,028	114,411	88,952	- 25,459		
4415 Training - Non-Staff (Not used in F'16)	17,973	36,322	-	25,000	12,500	- 12,500		
7500 Hearings Office	549,266	520,951	585,506	661,862	640,226	- 21,636		
4501 Discipline Committee Case Management Processes	124,173	146,205	235,282	209,457	264,902	55,445		
4500 Discipline Committee Hearings	1,046,362	1,698,344	2,080,129	2,477,136	2,363,600	- 113,536		
4504 Discipline Committee Policy/Training	217,615	220,058	235,330	281,557	255,625	- 25,932		
4600 Fitness to Practise Committee	26,526	26,714	50,306	87,485	82,460	- 5,025		
Total	18,950,806	21,176,453	23,176,820	23,477,837	23,551,171	73,334	0.3%	
Total	**53,501,257**	**57,697,992**	**63,779,300**	**67,122,511**	**65,748,613**	**- 1,373,898**	-2.0%	

SUMMARY - BY ACCOUNT (Before CRCC's)

ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ACTUALS 2014	ACTUALS 2015	ACTUAL 2016	BUDGET 2017	BUDGET 2018	CHANGE $	CHANGE %	
	COMMITTEE COSTS								
9030 + 9031	Attendance	2,444,928	2,894,007	3,156,669	3,819,349	3,346,892	- 472,457		
9040	Preparation Time	2,183,507	2,390,553	2,612,977	2,975,189	2,880,404	- 94,785		
9041	Decision Writing	692,942	647,788	712,767	564,601	125,200	- 439,401		
9045	Expert/Peer Opinions	1,361,742	1,569,749	1,480,952	1,267,495	1,190,000	- 77,495		
9046	Assessors	457	932	3,419	-	-	-		
9050	Travel Time	1,451,259	1,344,157	1,349,543	1,458,256	2,007,050	548,794		CC's 6210 & 6215
9160	HST on Per Diems	323,560	416,301	500,780	511,304	524,397	13,093		
9070	Legal Fees	707,669	1,397,637	1,498,452	1,509,511	1,572,792	63,281		
9080	Audit Fees	62,506	35,719	38,092	45,000	40,000	- 5,000		
9090	Sustenance	255,377	233,342	311,518	282,350	344,075	61,725		
9120	Meals and Accommodations	295,440	273,255	326,015	431,283	457,304	26,021		
9130 + 9132	Travel Expenses	677,950	624,838	683,977	742,768	722,025	- 20,743		
9150	Witness Expenses	60,421	55,800	30,300	70,100	66,600	- 3,500		
	TOTAL COMMITTEE COSTS	10,517,757	11,884,078	12,705,462	13,677,206	13,276,739	- 400,467	-2.9%	
	STAFFING COSTS								
9210 + 9212	Salaries	28,328,520	30,457,669	33,697,575	34,152,028	33,672,690	- 479,338		
9211	Internal Charges - S & B	-	- 106,645	- 74,065	-	- 100,000	- 100,000		
9220	Part Time Help	259,302	361,979	231,089	240,000	415,940	175,940		
9230	College Paid Benefits	3,480,834	3,768,466	4,464,739	4,859,686	4,794,177	- 65,509		
9250	College Pension	2,503,366	2,656,200	2,889,942	3,103,437	3,097,888	- 5,549		
9260	Defined Benefit Plan	242,413	213,496	210,407	325,000	215,000	- 110,000		
9240	Personnel Consultants	110,963	270,292	336,164	240,000	238,135	- 1,865		
9270	Placement	60,349	59,546	255,354	115,000	107,839	- 7,161		
9280	Training and Conferences	405,124	377,426	437,204	778,186	593,035	- 185,151		
9290	Employee Engagement	179,112	178,861	227,680	228,881	243,346	14,465		
	TOTAL STAFFING COSTS	35,569,982	38,237,290	42,676,088	44,042,218	43,278,050	- 764,168	-1.7%	
	DEPARTMENT COSTS								
9060 + 9222	Consultant Fees	853,855	784,591	1,066,481	1,516,650	1,427,340	- 89,310		
9223	IT Projects - External Partners	188,543	154,106	424,475	325,000	190,000	- 135,000		
9310	Software Costs	154,051	162,793	265,693	603,207	770,000	166,793		CC 7270
9320	Equipment Leasing	98,960	71,554	110,894	21,250	26,480	5,230		
9330	Equipment Maintenance	98,226	104,295	39,937	66,250	48,500	- 17,750		
9400	Miscellaneous	108,735	92,690	118,862	349,076	235,800	- 113,276		
9480	Internal Charges	- 275,708	- 365,627	- 311,463	- 355,908	- 318,913	36,995		
9410	Photocopying	469,420	414,910	356,565	322,974	248,500	- 74,474		
9420	Printing	58,917	52,637	37,341	41,850	32,300	- 9,550		
9430	Postage	299,303	296,108	288,440	310,055	280,370	- 29,685		
9440	Courier	114,471	117,743	111,448	100,766	70,050	- 30,716		
9421	Members Dialogue - Printing	181,743	279,092	233,913	365,000	420,000	55,000		CC 7020
9431	Members Dialogue - Postage	78,520	120,173	146,384	105,000	-	- 105,000		
9450	Telephone	297,371	265,557	310,443	334,218	305,916	- 28,302		
9460	Office Supplies	254,216	336,480	331,191	347,878	343,735	- 4,143		
9470	Reporting and Transcripts	182,629	255,864	353,184	374,520	297,212	- 77,308		
9500	Professional Fees - Staff	80,668	92,002	82,039	116,817	135,261	18,444		
9501	Professional Fees - FMRAC	458,280	469,860	471,000	505,500	433,900	- 71,600		
9510	Publications and Subscriptions	159,395	200,710	191,780	223,245	184,023	- 39,222		
9530	Travel and Other	337,537	367,678	437,610	324,035	397,750	73,715		CC 4900
9830	Offsite Storage Costs	158,027	201,296	203,143	205,000	215,000	10,000		
9590	Grants	139,500	74,000	74,000	125,000	125,000	-		
9591	Survivors Fund	-	87,517	107,017	90,000	90,000	-		
9595	Bad Debt Expense	-	108,590	5,742	-	-	-		
	TOTAL DEPARTMENT COSTS	4,496,658	4,744,619	5,456,117	6,417,383	5,958,224	- 459,159	-7.2%	
	OCCUPANCY COSTS								
9610	Electrical	20,475	42,610	48,079	55,650	50,200	- 5,450		
9620	Plumbing	30,104	16,170	43,765	66,000	53,400	- 12,600		
9630	Building Consultants	17,149	34,560	49,836	29,700	23,400	- 6,300		
9640	Mechanical	99,403	72,724	78,440	128,700	83,000	- 45,700		
9710	Housekeeping	207,142	209,680	209,930	217,000	204,000	- 13,000		
9818	Offsite Leasing	358,550	371,917	384,653	687,400	692,000	4,600		
9605 + 9820	Other Building Costs	32,925	50,478	35,143	48,000	45,000	- 3,000		
9650 + 9660	Depreciation Expense	1,419,696	1,289,327	1,270,931	893,754	1,257,099	363,345		CC 8000
9840	Insurance	453,559	449,721	496,566	535,000	500,000	- 35,000		
9860	Realty Taxes	78,624	78,486	78,236	80,000	80,000	-		
9870	Hydro Electricity	164,529	181,392	214,015	199,500	212,000	12,500		
9880	Natural Gas	19,679	15,789	13,190	25,000	15,000	- 10,000		
9890	Water and Other Utilities	15,025	19,151	18,850	20,000	20,500	500		
	TOTAL OCCUPANCY COSTS	2,916,859	2,832,005	2,941,633	2,985,704	3,235,599	249,895	8.4%	
	TOTAL COSTS	**53,501,257**	**57,697,992**	**63,779,300**	**67,122,511**	**65,748,613**	**- 1,373,898**	-2.0%	


Total Revenue versus Total Expenses
70,000,000
65,000,000
60,000,000
55,000,000
50,000,000
45,000,000
Amount
2011
2012
2013
2014
2015
2016
2017
2018
Year
Revenue
Expenses


Trending of Expense Catagories
50,000,000
40,000,000
30,000,000
20,000,000
10,000,000
0
Amount
2011 2012 2013 2014 2015 2016 2017 2018
Year
Staffing Costs
Committee Costs
Department Costs
Occupancy Costs


Trending of Divisional Costs
25,000,000
20,000,000
15,000,000
10,000,000
5,000,000
0
Amount
2011
2012
2013
2014
2015
2016
2017
2018
Year
Investigations and Resolutions
Quality Management
Corporate Services
Policy and Communications
Information Technology
Legal Services
Executive
Research and Evaluation

CPSO
Fee Proposal 2018

The scenarios presented below are based on the following:
1. There are basic operational requirements that need to be met (eg. staff, COL, HST, capital, etc.) which have been accomodated in the Base Buc
2. All contract re-justifications should be maintained; conversions and upgrades can be evaluated on an individual basis. These were approved in
3. All departments have submitted staffing requests (new, contract renewals) that will address specific needs (service, effectiveness, etc)
4. I&R and Legal have been identified as two areas that require additional resources in 2018 to manage growing and unsustainable volume and c

Increase in Per Diems	
Increase in HST	
Increase in Salaries (2.5%)	
Benefit and Pension Increase	
Strategic Planning Project	
Capital Expenditures & Depreciation	
Sub-Total	$1,099,734

Conversions/Contracts - Extensions & New/Upgrades			**# of Positions**	**Space Required**
NFT - New Position, FT - Conversion from Contract to Full Time, CE - Contract Extension, NC - New Contract, U -Upgrade				
Compliance Department Assistant	I&R	CE	1	
I&R Department Assistant	I&R	CE	0.5	
Finance Assistant	Corporate Services	FT	1	
Purchasing Coordinator	Corporate Services	FT	1	
Talent Acquisition Specialist	Corporate Services	FT	1	
Decision Administrator	I&R	FT	1	
EO Project Manager	Executive	NC	1	*
Medical Analyst	I&R	NC	1	*
Law Clerk	Legal	NC	1	*
Legal Assistant	Legal	NC	1	*
Legal Counsel	Legal	NC	2	*
Compliance Case Manager	I&R	NFT	2	*
Decision Administrator	I&R	NFT	2	*
Investigator	I&R	NFT	2	*
Investigator (Two FT positions to be hired in July)	I&R	NFT	1	*
Legal Assistant	Legal	NFT	1	*
Governance Analyst	Policy & Communications	NFT	1	*
Supervisor, Meeting & Events	Corporate Services	U		
Publications Counsel	I&R	U		
Statistician (to Manager)	I&R	U		
Legal Assistant	Legal	U		
EA/Government Relations Coordinator	Policy & Communications	U		
Policy & Program Coordinator	Policy & Communications	U		

Sub-Total	$ 2,212,428
Total request	$ 3,312,162

Annual Membership Fees			
Year	Fee	Increase	%
2017	$1,625.00	$30.00	1.88
2016	$1,595.00	$25.00	1.59
2015	$1,570.00	$0.00	0
2014	$1,570.00	$20.00	1.29
2013	$1,550.00	$20.00	1.31
2012	$1,530.00	$45.00	3.03
2011	$1,485.00	$75.00	5.32
2010	$1,410.00	$110.00	8.46
2009	$1,300.00	$100.00	8.33
2008	$1,200.00	$150.00	14.29
2007	$1,050.00	$65.00	6.6
2006	$985.00	$0.00	0
2005	$985.00	$50.00	5.35
2004	$935.00	$55.00	6.25
2003	$880.00	$25.00	2.92
2002	$855.00	$35.00	4.27
2001	$820.00	$131.00	19.01
2000	$689.00	$9.00	1.32
1999	$680.00	$8.00	1.19
1998	$672.00	$17.00	2.6
1997	$655.00	$0.00	0
1996	$655.00	$0.00	0
1995	$655.00	$80.00	13.91
1994	$575.00	$0.00	0
1993	$575.00		

MEDICAL REGULATORY AUTHORITIES

Licensure / Renewal Fees

	2016	2017	2018
CPSA	$1,960[a]	$1,960	$1,960
CPSPEI	1,900	1,900	1,900*
CPSS	1,880	1,880	1,880
CPSNS	1,750	1,750	1,850
CPSNL	1,750	1,750	1,850
CPSM	1,700	1,780	1,780
CPSO	1,595	1,625	1,725*
CPSBC	1,625	1,670	1,680*
CMQ[b]	1,420	1,520	1,520
CPSNB	600	600	600

(a) Included a $150 fee for a building fund
(b) Effective 1 July each year
*Referred to Council

Report of the Finance Committee

Appendix G

Additional Background Information

2018 Budget

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Context: External Environment

- Closely scrutinized - high profile work
- Considerable changes underway in regulatory environment
  - Work associated with change “the new normal”
  - Several reviews
    - Sex abuse, Goudge, Facilities, Transparency
  - Legislative change – high volume
    - Bill 87
    - MAID
    - Community clinics legislation
    - More to come via regulations
- Governance modernization coming

Context: Internal Environment

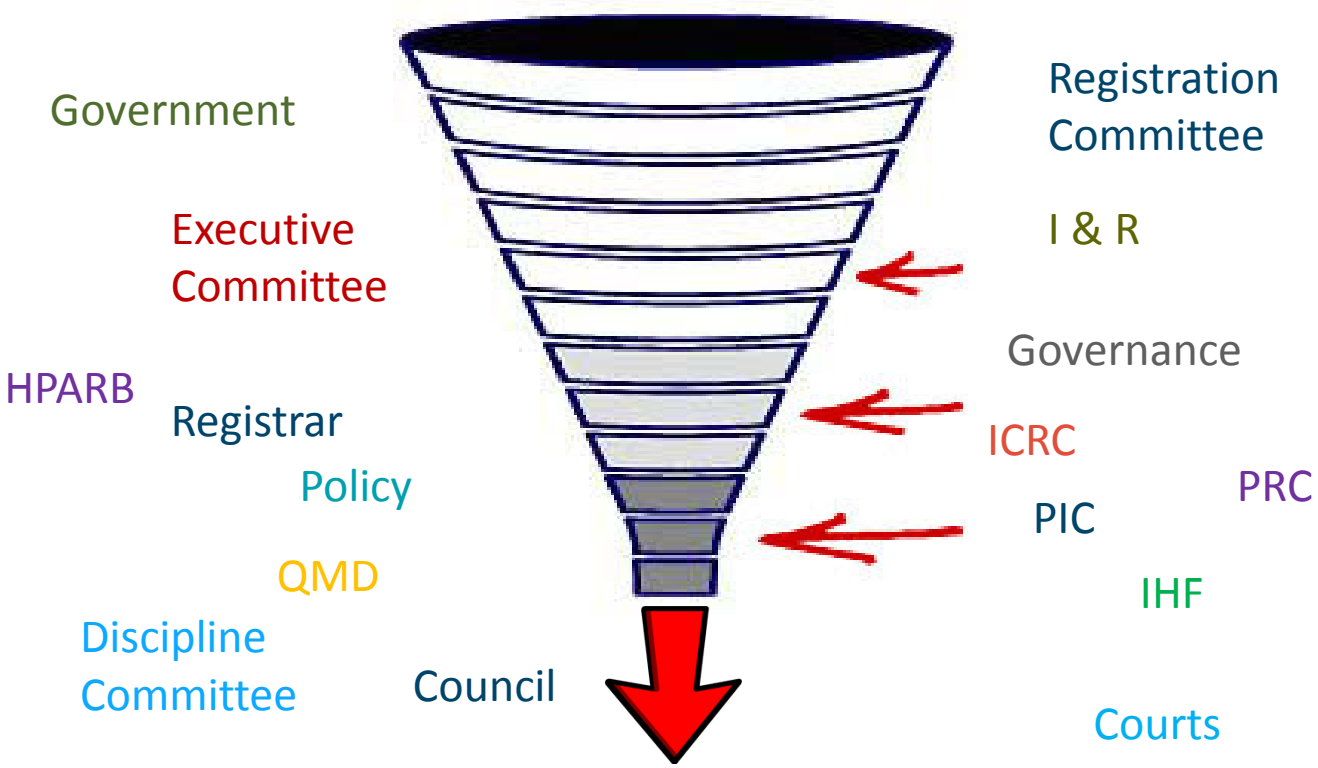
- Workloads are up
  - Number of investigations steadily climbing
  - Number of open discipline matters – unprecedented
    - Stress and strain on I &R and legal
    - Stress and strain on Council and DC/ICR committees
  - Important projects (i.e., opioids)
  - Legislative change – workload implications
  - Workload associated with implementation of Bills 87 and 160 and potentially dozens of regulations…
  - No slowdown in sight

Current Situation - Legal

- Dual function of in-house legal department
  - A partner
    - Provides legal advice and services to all areas of College
    - Helps institution achieve goals while minimizing risk to acceptable level
  - A guardian
    - Guards corporate integrity and ensures regulatory compliance

Current Situation - Legal

- Where does legal work come from?

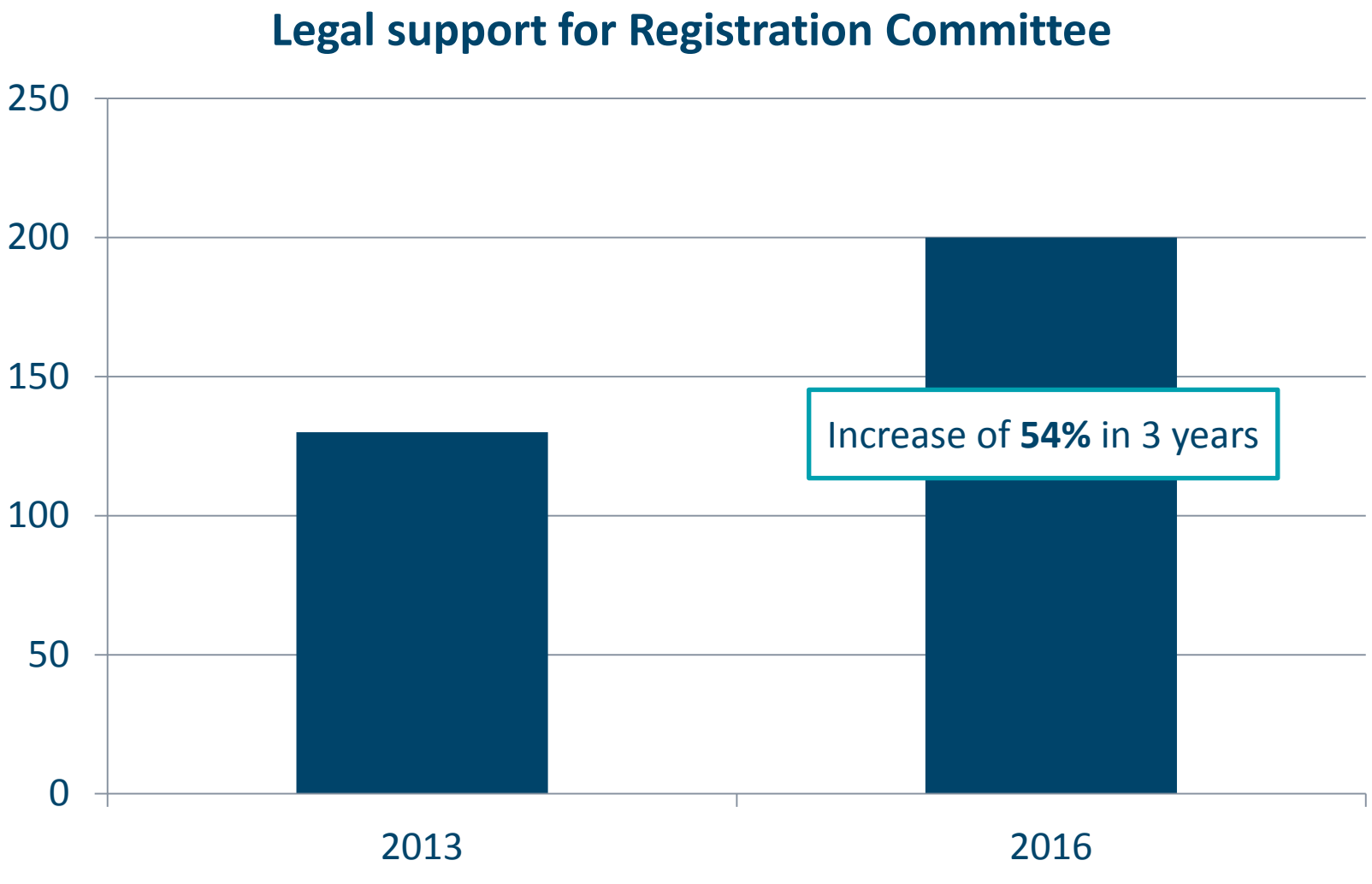


Legal Work Required

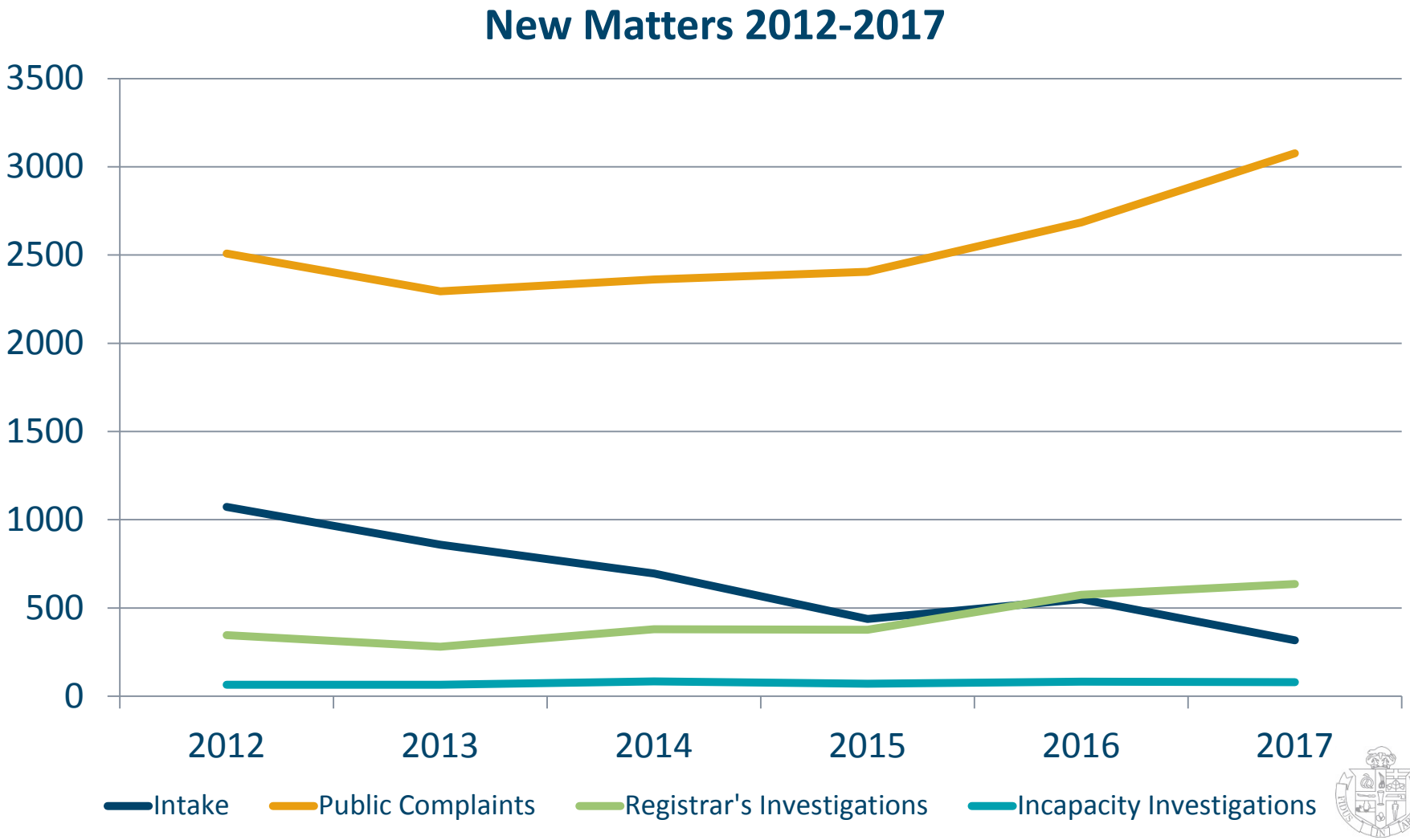
Current Workload - Environment

- CMPA data: ‘massive’ increase in volume
- “College matters brought to CMPA have ***almost doubled since 2006 to more than 4000 new cases annually***…Ontario and Quebec have seen the greatest increases in college complaints”

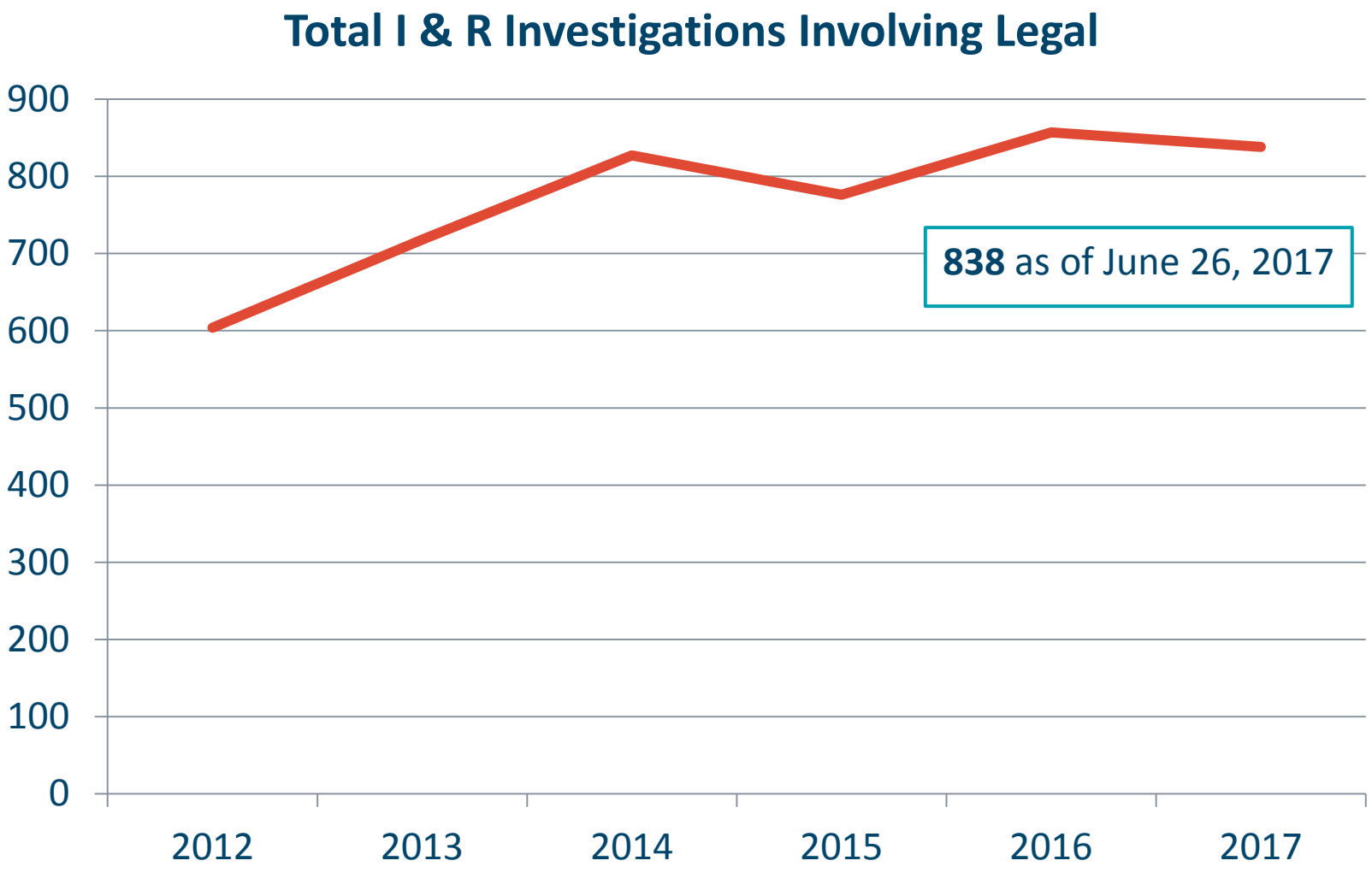
Current Workload – Registration Support



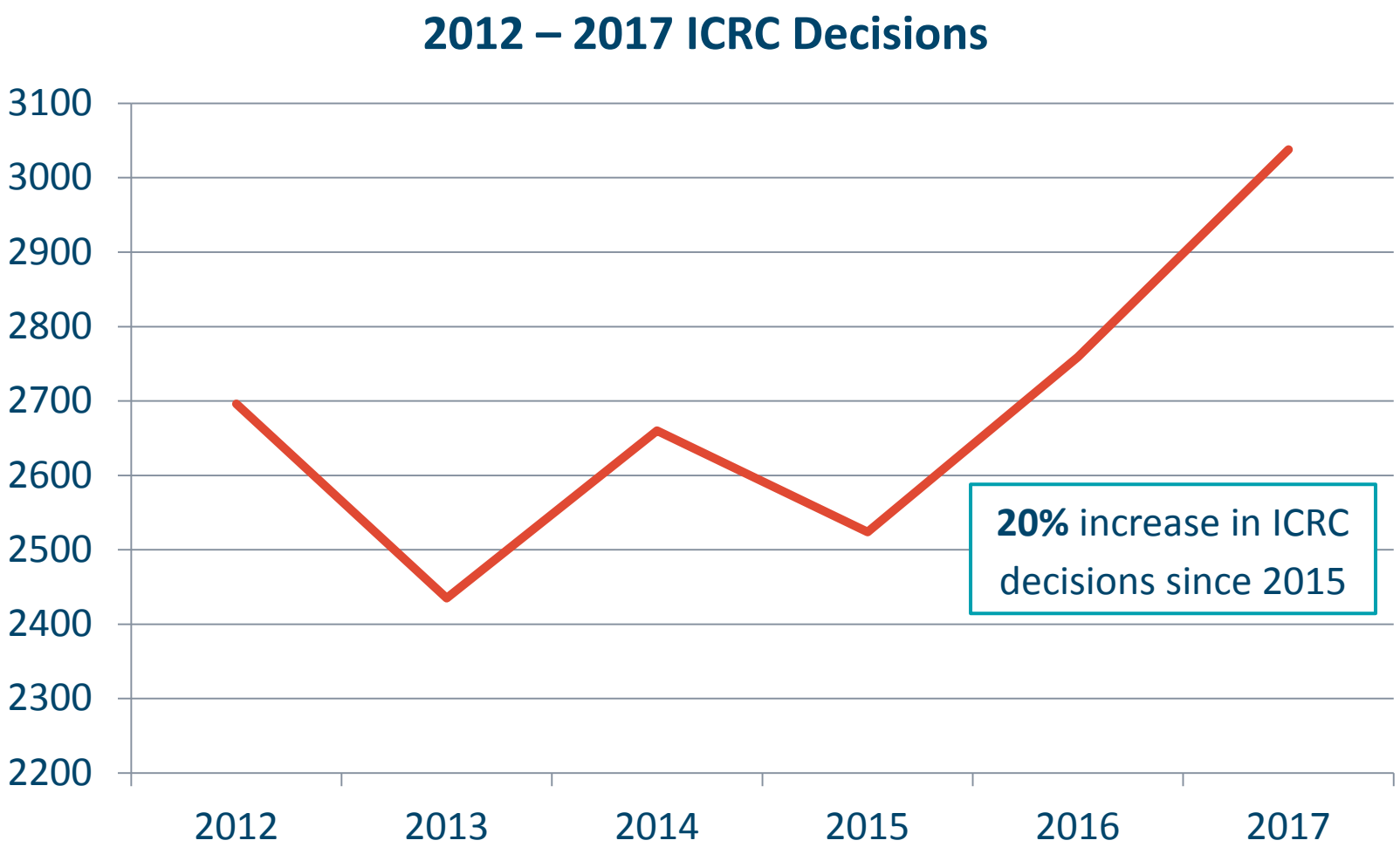
Current Workload - Investigations



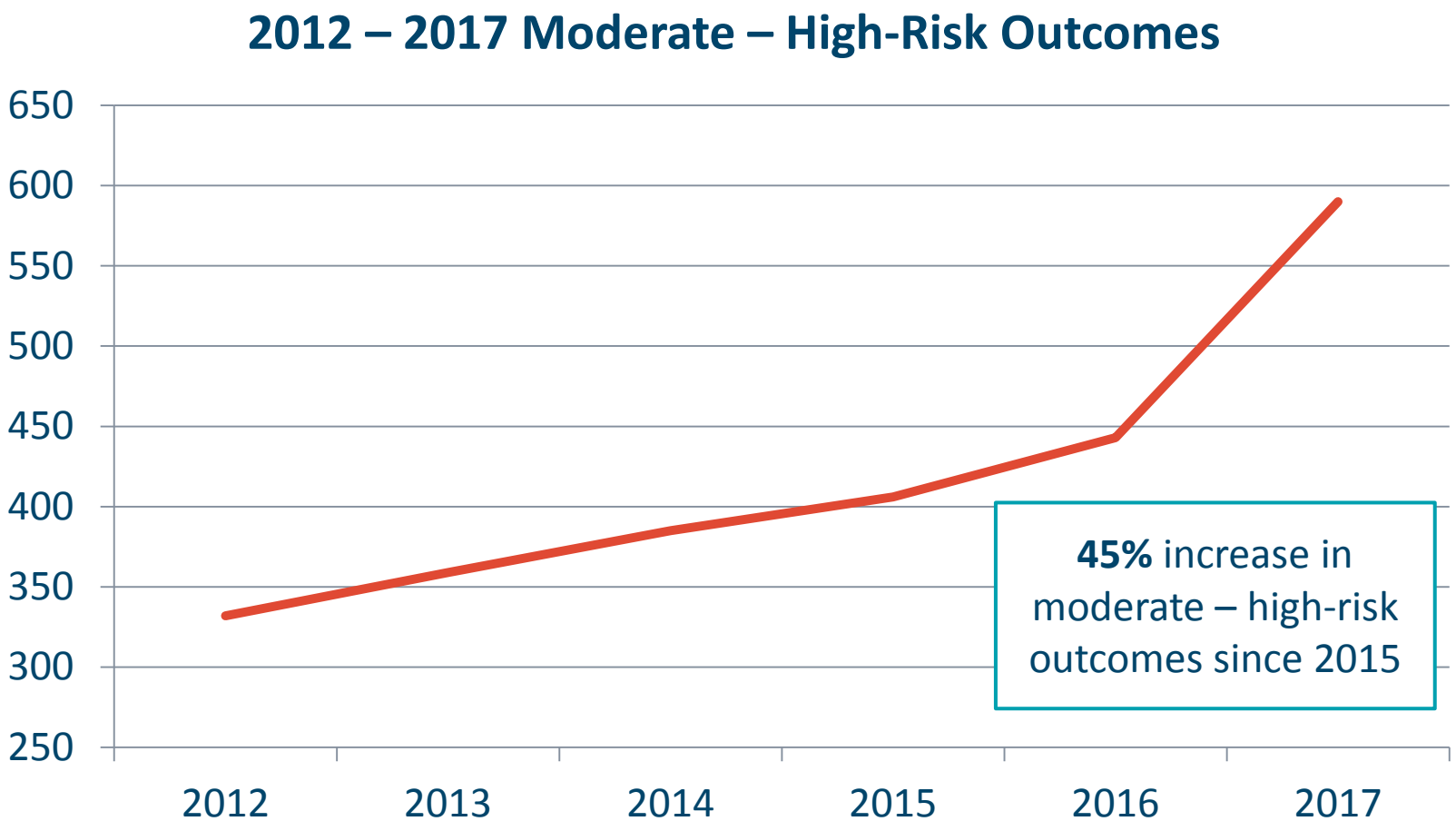
Current Workload – I & R Support



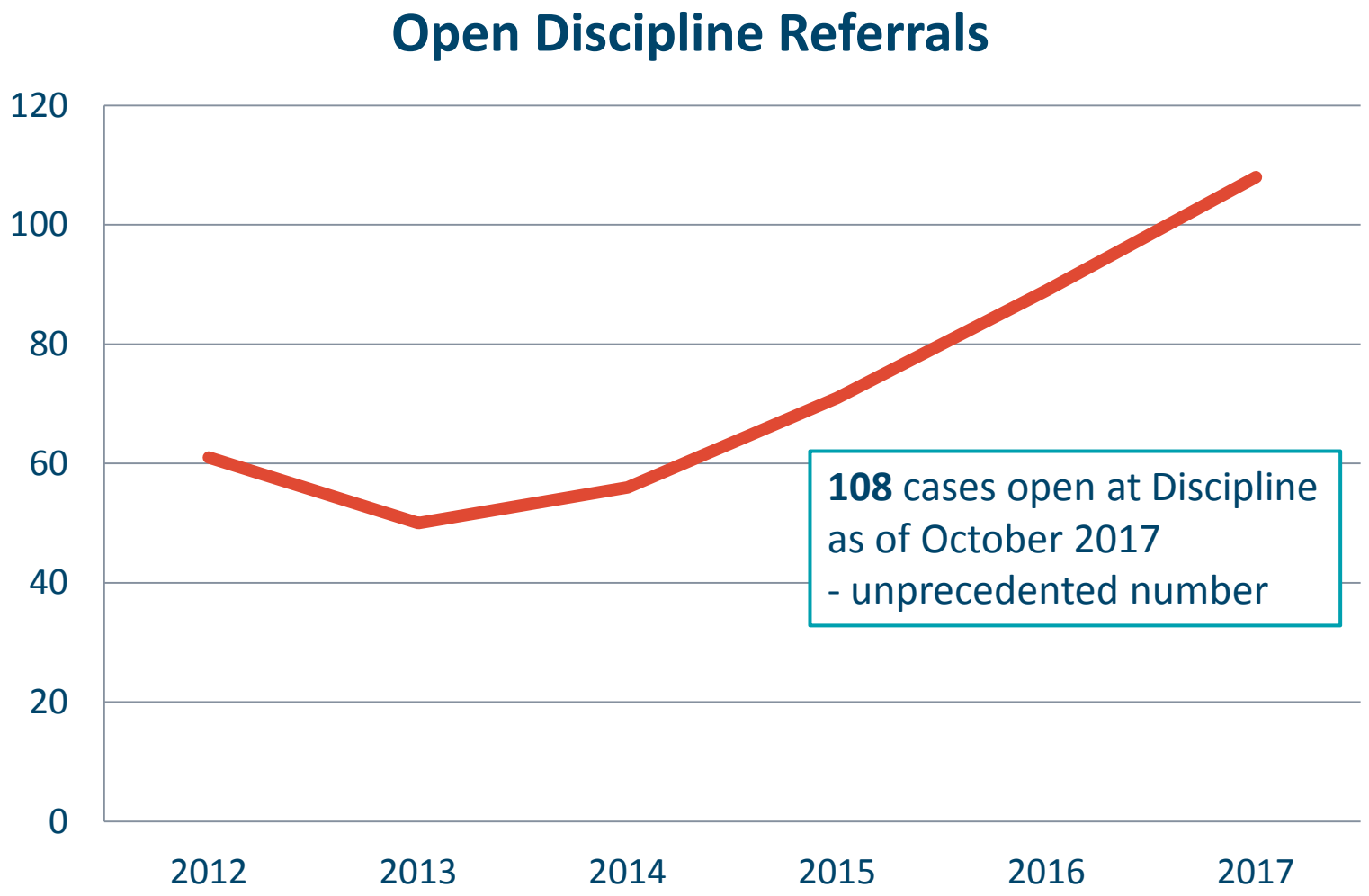
Current Workload – ICRC Decisions



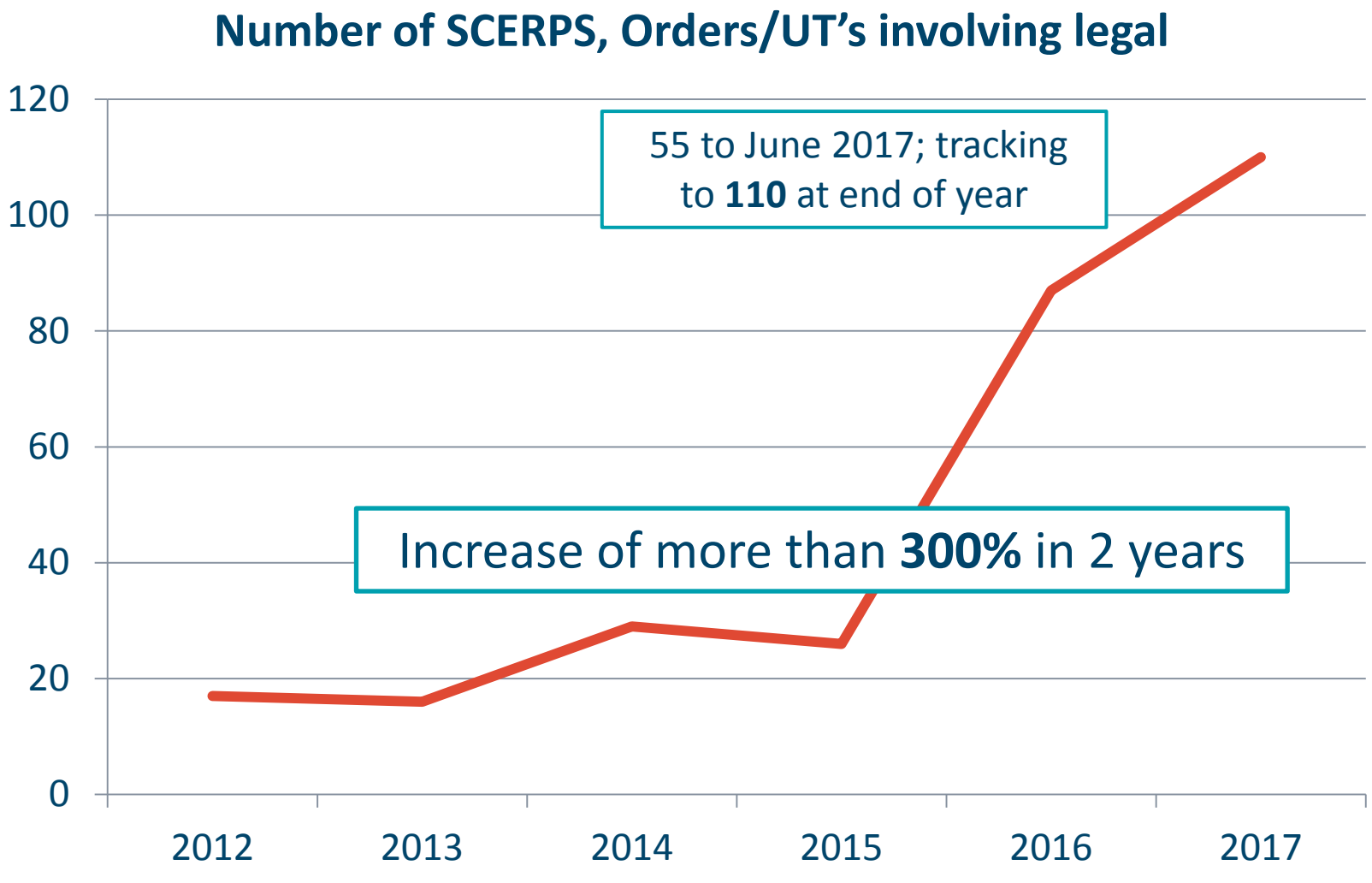
Current Workload – ICRC Outcomes



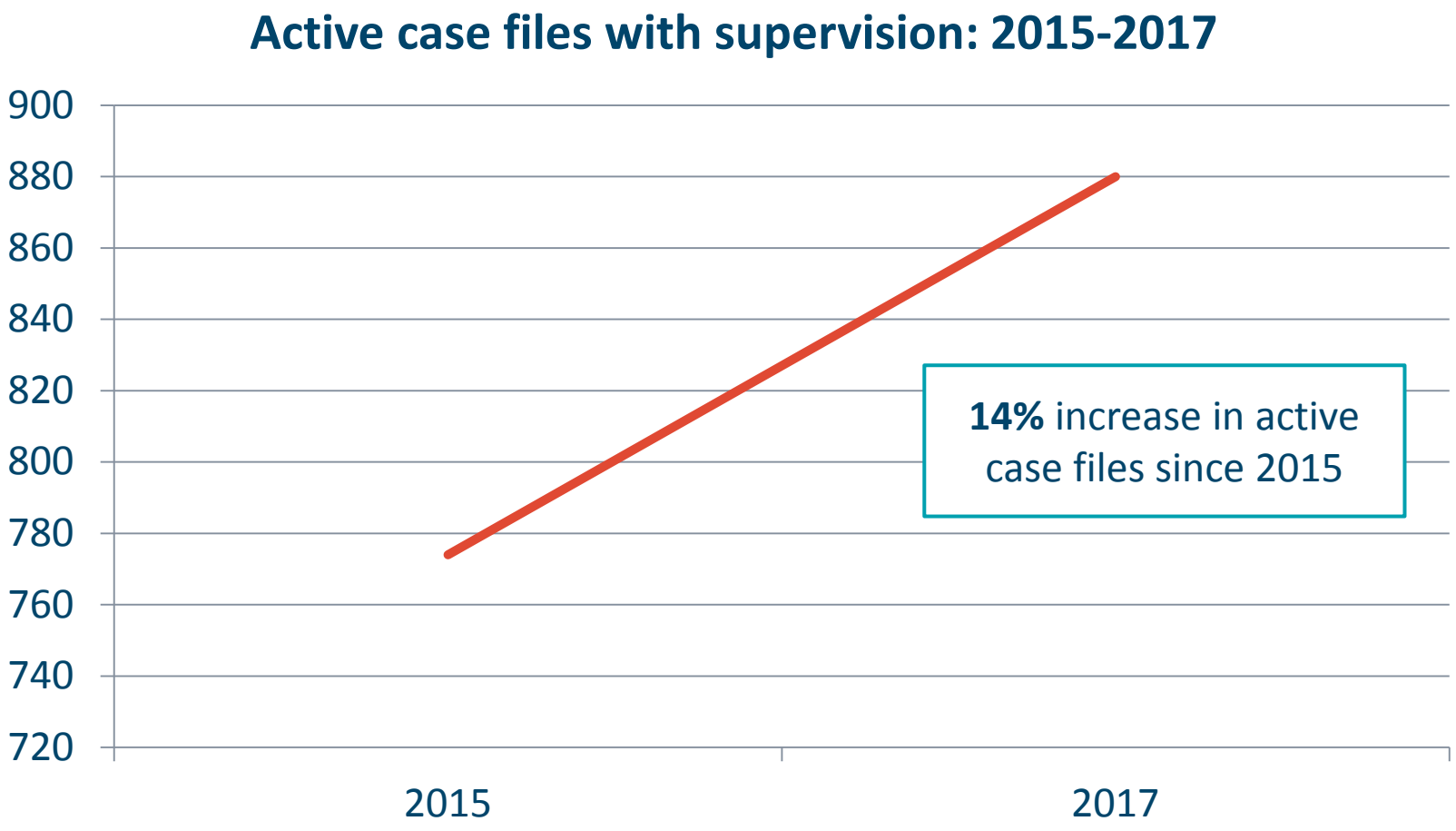
Current Workload – Discipline



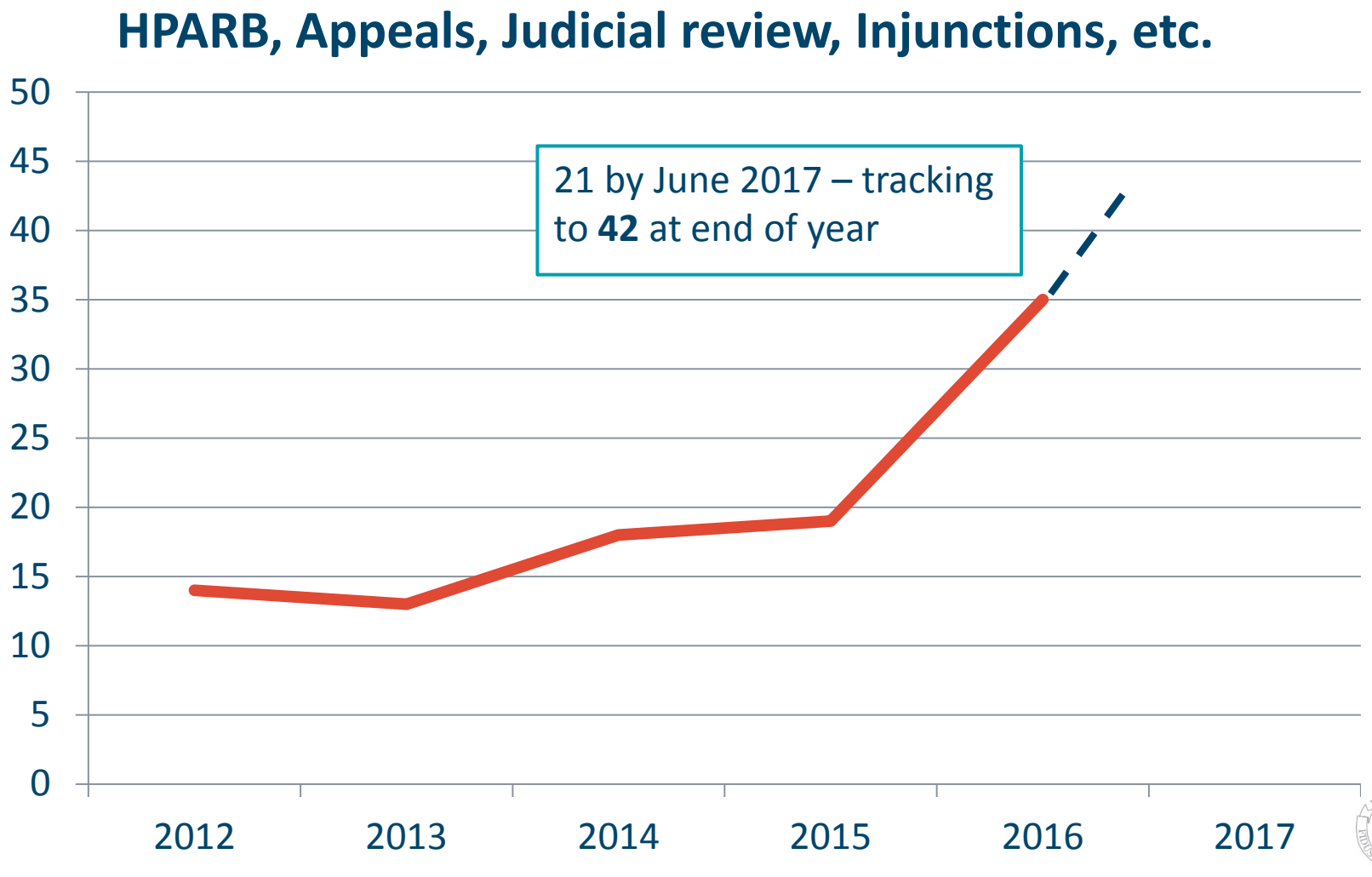
Current Workload – QA Support



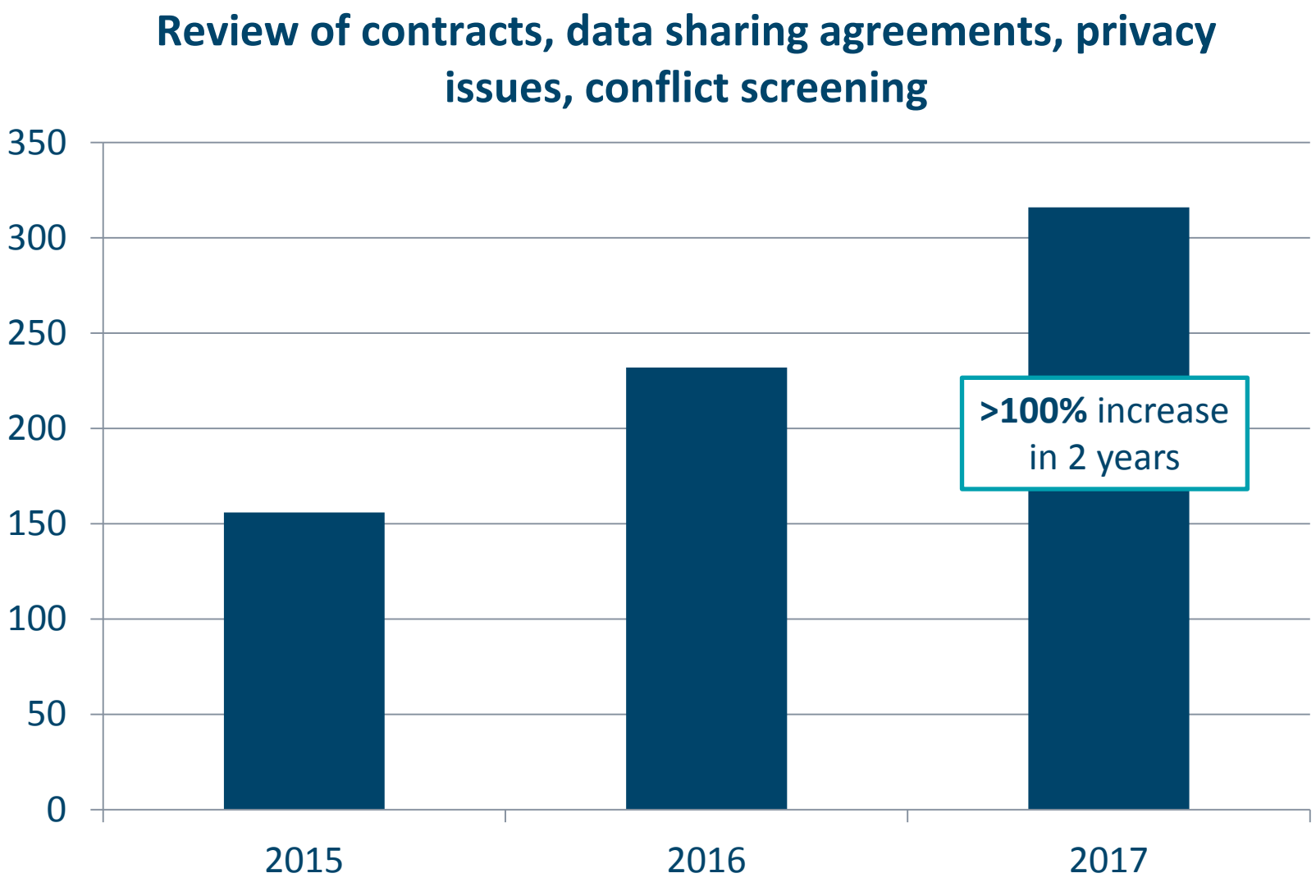
Current Workload – Compliance Monitoring



Current Workload – Civil Litigation



Current Workload – Corporate Matters



Current Workload – Legal Dept.

- Approximately 1200 open matters
- 2016: legal office disclosed over 211,500 individual images
  - Each page sorted, prepared, copied, coded, & redacted for privilege, confidential info.
- Average of 25 new legal requests every week
- High outside counsel costs to support volume

Current Workload – I & R

- Investigators (51.5): average 60 cases each
  - Industry Standard: 25
- Decision Administrators (9): average 320 decisions+
- Compliance Case Managers (6.5): average 108 files each
  - Target is 60 files

What has been done – Legal Dept.

- Electronic litigation software and litigation support clerk
- Hired 1st year lawyer and reassigned work where possible
- Tried to reduce scope of work in “low value” areas or non-urgent matters
- Where sufficient volume, assigned single or multiple lawyers to provide specialized support to program areas

What has been done – Legal Dept.

- Hired dedicated in-house corporate counsel
- Implemented duty counsel system
- Hired part-time / emergency support staff
- Secondment of assistant from I & R
- Negotiated reduced rate for outside counsel (corporate and litigation)

What has been done – Legal Dept.

- Legal has retained a process improvement consultant to provide advice within the legal department on:
  - Efficiencies
  - Staffing
  - Technology
  - Process improvements

What has been done – I & R

- Regression Analysis on historical data from 2012 -2016
  - Identified trends in investigation steps
  - Identified contributing factors to timelines
  - Revised protocols
  - Revised assessment screen

What has been done – I & R

- Model for ideal investigator caseload
- Standardized Investigator/CCM training
- Restructured Decision/Reason Template
- Improved IEP process
- Commitment to electronic files
- PPAS management of administrative cases

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Finance
Annual Committee Report 2017

REPORT OF THE FINANCE COMMITTEE

The Finance Committee convened three times in 2017. They met: January 18, 2017 (Orientation/Education), April 4, 2017 and October 11, 2017.

At each meeting of the Finance Committee, the conflict of interest policy (based on the "Not-for-Profit Corporation Act, 2010") was reviewed and any conflicts were declared. Furthermore, the Finance Committee reviewed its work plan to ensure that it remains appropriate and on target; statements and variance analysis to confirm budget tracking; space planning for future growth; and any educational needs for the Committee:

In addition, the Committee reviewed the following topics:

- January 18, 2017
    - Audit Engagement and Planning Letter
    - Insurance and Risk
    - Cost Efficiencies
    - TD Visa Agreement
    - Space

- April 4, 2017
    - Auditor's Report and Year-end Financial Statement
    - Internal Controls
    - Appointment of Auditor
    - Finance Committee Terms of Reference
    - In-Camera Session with the Auditor
    - Physician Compensation Working Group
    - Administrative Purchasing Practices Review Group
    - Budget Objectives for 2018

Council was provided with a more detailed account of these topics at the May Council meeting.

The October 11, 2017 Finance Committee focused on the following items:

- Audit Engagement and Planning Letter for 2018
- Finance Committee Terms of Reference and Name Change
- Finance Committee Work Plan for 2017
- Safe Disclosure Policy
- Statement Analysis (August 31, 2017)
- 2016 Financial Statements for both the closed Defined Benefit Pension Plan and the Defined Contribution Pension Plan
- Physician Compensation Working Group

- The College's Compensation Plan
- 2018 Budget

Further details on a number of these items follow.

Finance Committee Terms of Reference and Name Change

In conjunction with the College's external auditor, the Finance Committee has developed a more robust set of terms of reference. The attached Terms of Reference document clearly sets out the responsibilities of the Finance Committee including the annual budget, investment policy, banking of College funds, external audit, risk management, internal control functions, pension plans and the financial reporting and accounting policies and practices of the College.
As the Finance Committee also serves in the capacity of an audit committee, the Committee is recommending to Council that the name of the Committee be changed to the Finance and Audit Committee. In order to do this, an amendment to s.43 of the by-law (the Finance Committee provision) would be required to change the name of the Committee. The by-law would not have to be circulated. Section 43 also sets out the mandate and duties of the Finance Committee, as does the Governance Process Manual.

The Finance Committee approved the following motion:

It was moved by Mr. Peter Pielsticker, seconded by Dr. Thomas Bertoia, and **CARRIED**.

That the Finance Committee recommends to Council that the name of Finance Committee be changed to the Finance and Audit Committee to accurately reflect the current responsibilities of the Committee.

Safe Disclosure Policy

The College has an obligation to have a policy that clearly facilitates the disclosure and investigation of significant and serious incidents at the College involving unlawful, unethical, or unprofessional conduct of other employees, contractors or any stakeholder working on behalf of the College, while creating and maintaining a culture of trust and respect at the College, where employees, contractors or any College stakeholder feels empowered to make good faith reports of such incidents based on reasonable grounds.

The College had a "Whistleblower Policy" but a review of the policy determined that it needed to be more robust and deal with a more comprehensive set of incidents. It was also thought that the term "Whistleblower" carried a negative connotation so the policy was renamed to "Safe Disclosure".

This policy clearly defines the nature of a reportable incident and a reporting and investigation process. It also deals with the issue of confidentiality. The policy has been reviewed and approved by the Senior Management Team, Human Resources, and the College's in-house legal counsel.

The Finance Committee approved the following motion:

It was moved by Dr. David Rouselle, seconded by Dr. Thomas Bertoia, and **CARRIED**.

That the Finance Committee recommends to Council that the Safe Disclosure Policy be accepted as presented.

Physician Compensation Working Group

The Physician Compensation Working Group (PCWG) is a subgroup of the Finance Committee, charged with responsibility to review and develop recommendations for a sustainable compensation model *for physician members* of committees and Council. The terms of reference are attached. The mandate of this group does not address public member compensation. A separate process and communications with the Government of Ontario are being managed through the Policy and Communications area.

The PCWG has met twice since June 2017 (the PCWG was approved by the Finance Committee in April 2017). Costing and member data continues to be reviewed in order to develop specific compensation recommendations that address cost management for the consideration of the Finance Committee, and ultimately recommendations to Council.

The system of compensating physicians on College committees and Council has not been reviewed in many years. The compensation approach was originally established more than 25 years ago to cover the costs of a physician's office overhead while performing work for the College, respecting the predominant fee-for-service model of physician remuneration. The Finance Committee will explore the modernization of the College's approach to physician compensation.

The PCWG believes that additional information is needed to better understand:

- the practice circumstances of current Council and Committee members,
- the reasons physicians participate in professional regulation and
- their views on compensation

To that end, the PCWG directed the development of a survey for all physician committee and council members to ascertain the above.

The Finance Committee is overseeing the distribution and analysis of a survey to all Committee and Council physician members in December and January. Council members are provided with the draft survey.
The results of the survey will inform the recommendations for compensation with respect to physician participation on Committees and Council.

2018 Budget

Overview

The College is accountable for a $67M budget and takes its responsibility of managing resources in a prudent and responsible manner.

Steps are taken as part of the College's routine processes to ensure regular demonstration of fiscal accountability, optimal resource use and the delivery of effective and efficient programs. This is accomplished through detailed reports and oversight by the Finance Committee, regular reporting to Council, and of review of College expenditures by an independent auditor. The College's financial statements are publicly available in our annual reports.
The development of the 2018 budget has been particularly challenging.

Workloads are up across many departments. The College is facing an unprecedented volume of cases and an increase in the number of complex and time-consuming investigations. Over the last several years, the number of investigations has been steadily climbing. In the last year alone there was a 13% increase in the total caseload. As of October, there were more than 108 open discipline matters – an unprecedented number.

The College is mindful of the increased financial challenges currently facing physicians, yet despite our understanding of these pressures, the College has a statutory duty to govern in the interest of the public.

In recognition of these challenges and as part of ongoing work to find efficiencies, work has been ongoing over many months to find savings, make process enhancements and make best use of resources. At the direction of the registrar, senior staff have cut more than $1,3 million from the existing base budget.

A $100 fee increase is recommended to renew an independent practice certificate of regulation in order to ensure that the College has the necessary resources to fulfill its statutory obligations. This would bring the membership fee for an independent practice license to $1,725, representing an average increase per year over the past five years of 2.25%.

The College has a mandate to protect the public and this includes registering qualified physicians, investigating complaints against doctors and ensuring physicians are providing quality care to their patients.

While there are considerable workload pressures across the organization, the Investigations & Resolutions and Legal Office are two areas that require dedicated new resources in 2018 to address growing caseloads.

Development of the 2018 Budget

This year, the 2018 budget process consisted of the following:

- In Q2 and Q 3, the management team reviewed the 2017 corporate plan and considered program, project and staffing needs into 2018. Some key issues were:
    - Focus on activity trends and resource needs for the entire investigative process, compliance, hearings and the associated needs for legal support (both in-house and external counsel). The respective Directors were asked to prepare a comprehensive review of current activity, trends and the impact of maintaining the status quo for staffing levels.
    - Identification of discretionary work activity could be stopped or deferred in order to manage the work-related activities of existing staff in all areas, but specifically in investigations and legal support.
    - A direction from the Registrar for all Divisions to cut more than $1.3 million from the existing base budget. A direction from the Registrar for all Directors to prepare efficiency plans for 2018.
- From May - August, development by all departments of specific resource needs for staff, Committees, programs and capital costs.

- From August – September, preparation of budget scenarios to support and manage growing caseloads consider various levels of increased staffing in I&R and Legal to meet our statutory obligations and benchmarks.

Key features of the 2018 budget preparation include:

- The College's budget is largely determined by:
  - Statutory obligations – the College has no choice but to comply with the required programs and, in many cases, prescribed processes and timelines. Staff is always looking for ways to be efficient and effective within the legislative parameters.
  - External drivers – Numerous issues arrive at the College and require – based on risk, public safety, stakeholder relationships or direction by Government – concentrated work efforts which sometime involves numerous departments and staff (e.g. Bill 87 implementation and the opioid strategy require significant resources).
  - Strategic priorities – This encompasses priorities determined by Council and other issues that are deemed to be important for the long term sustainability of programs. While these are discretionary decisions, they are not always easy to contain or stop, because of the commitment to the protection of the public on the part of Council, Committees and/or staff. The senior management team is becoming more rigorous in its approach to planning and budgeting.
  - Emerging issues (currently not included in the 2018 budget) – there are always issues that may strain the College's resources, but we have little or no information about what, if any, impact the College will experience. This year we are carefully monitoring a number of issues that could impact our budget but for which we have little information in order to take definitive action.
    - Physician Assistants – the Minister of Health and Long Term Care has asked us to consider oversight models for PAs in collaboration with Ministry staff
    - Potential incorporation changes under consideration by the Canadian government could impact whether physicians apply for, or renew existing, incorporation status.
    - Patient sexual abuse therapy fund – Bill 87 amended the RHPA in a variety of ways, including changes to the criteria to access patient funding for treatment and therapy related to sexual abuse. The relevant sections have not yet been proclaimed and the associated financial impact is unknown.
    - Public member compensation – Legislative change and political will are required, and it is difficult to assess when or if this may transpire.

The Finance Committee heard from various budget requesters, including detailed presentations of the current activities, trends and needs identified by the Investigations & Resolutions Division and the Legal Department. Background information on College volumes and longitudinal trends is attached to this report.

- The nature and volume of the work in both Legal and I&R is not always predictable; external issues can change the volume or intensity of the work (high risk, urgency). For example:

    - Estimates are made of the probable number of annual complaints and investigations, but certain unknown events have dramatically changed the numbers and complexity of cases (for example, the number of referrals to the Discipline Committee in 2017, and the number of opioid investigations and their intensity)
    - The Legal Department provides legal advice and services to the entire College and is responsible for the corporate integrity and regulatory compliance of the College. The nature of the work spans the entire College and includes case management and support for all statutory activities, as well as external litigation, policy and program support, and many corporate issues. External legislation, media and public issues also can consume considerable legal resources while the case volume continues to climb (eg. Bill 87, Sexual abuse, MAID, Community Clinic Legislation, etc.).
- In both areas, on a per staff basis, individuals have carriage of case file volumes that are well above previous years. Trending in the investigations and legal functions shows growth in activity that is not stabilizing or decreasing. This applies to number of investigations, ICRC decisions, compliance cases, discipline referrals, and open hearings.
- The complexity of cases is also changing, with a greater proportion of cases requiring immediate attention based on potential patient and public safety issues. This also translates into added need for Legal advice and services with respect to outcomes like hearings, restrictions and undertakings.
- Timelines cannot improve without additional staff resources to manage the increasing volumes and complexities.
- The impact to the College is experienced in many ways: inability to reduce timelines for public and physicians, negative impact on staff, and a need for more costly external legal counsel.
- Several approaches have been taken to address the above indicators, some of which are described in the attached background material.
- Notwithstanding the ongoing changes being adopted, there is an urgent need for additional staff to support and manage the case load growth faced by the I&R and the Legal Departments. These details are provided in the attached budget – new staff requests.

The Finance Committee recommends to Council a fee increase of $100 per member. This will move the membership fee for an independent practice license from $1,625 to $1,725.

The Finance Committee recommends this fee increase of $100 per member to support a growing and unsustainable workload in the Investigations and Resolutions area and Legal area, specifically in support of additional staff as described in the accompanying documents.

The budget can be summarized as follows:

	2018 – Base	2018 – New	2018 - Total
Total Revenues	$67,083,858		$67,083,858
Base Budget	$65,746,913		$65,746,913
New Initiatives Requested			
Per Diem Increase (2%)		$190,991	$190,991
HST Increase		$11,173	$11,173
Salary Increase (2.5%)		$721,150	$721,150
Strategic Planning Project		$100,263	$100,263
Conversion/Contract Extension, Upgrades and New Positions		$2,212,428	$2,212,428
Capital and depreciation		$206,249	$206,249
Building Reserve		$0	$0
Sub-total		$3,312,161	
Total Expenditures	$65,746,913		$69,059,074
New Revenue from $100 fee increase		$1,976,917	$1,976,917
Surplus	$1,336,945		$0

The Finance Committee approved the following motions and Council will be asked to consider related motions with respect to the 2018 proposed budget and fee increase:

It was moved by Mr. Harry Erlichman, seconded by Dr. Steven Bodley, and **CARRIED**.

That the Finance Committee recommends to Council that the budget for 2018 be approved as presented.

It was moved by Mr. Harry Erlichman, seconded by Dr. David Rouselle, and **CARRIED**.

That the Finance Committee recommends to Council that the per diem rates be increased by 2% effective January 1, 2018.

It was moved by Mr. Harry Erlichman, seconded by Dr. Thomas Bertoia, and **CARRIED**.

That the Finance Committee recommends to Council that the membership fee for an independent practice licence be $1,725 effective June 1, 2018.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: Bill 160, Schedule 9 *Oversight of Health Facilities and Devices Act, 2017*

FOR INFORMATION

ISSUE:

- *Bill 160, Strengthening Quality and Accountability for Patients Act, 2017* was introduced on September 27, 2017 and it passed second reading on October 26.

- Bill 160 has been referred to the Standing Committee on General Government. At the time this note was written, the College had expressed interest in presenting at the public hearings, occurring on November 15, 16, 20, and 22, but had not yet received confirmation of the date of our presentation.

- The Bill is expected to pass prior to the Legislature rising on December 14. However, proclamation will not occur until a later date.

- Bill 160 is a large omnibus health bill containing ten schedules. Schedule 9 *Oversight of Health Facilities and Devices Act, 2017* contains the government's plan for a single legislative framework for the Independent Health Facilities Program (IHFP), the Out-of-Hospital Premises Inspection Program (OHPIP) and energy applying and detecting medical devices (EADMDs). It is this schedule of the Bill that is of particular interest to the College and the focus of this note.

- Council is provided with an overview of Bill 160, Schedule 9 *Oversight of Health Facilities and Devices Act (OHFDA*) and a summary of the College's concerns with the *OHFDA.* The College's submission to the Standing Committee, approved by the Executive Committee, can be found on the College's website.

- This briefing note only addresses Schedule 9 of Bill 160. Council is provided with an overview of the other schedules of Bill 160 in the Government Relations Report.

BACKGROUND:

- Council has previously been provided with information regarding the history and context of the proposed consolidation of the quality oversight regimes for the IHF and the OHPIP.

- Briefly, in the fall of 2014 the Minister of Health and Long-Term Care requested Health Quality Ontario (HQO) to undertake a review of out of hospital facilities regulation in Ontario, including the oversight programs in place for Independent Health Facilities (IHFs) and Out-of-Hospital Premises (OHPs).

- In February 2015, the College made a submission to HQO that detailed the College's involvement and experience with the current regulatory systems and our recommendations for a consolidated regulatory system.

- In May 2016, HQO released its report, *Building an Integrated System for Quality Oversight in Ontario's Non-Hospital Medical Clinics*. HQO's recommendations were generally consistent with the College's submission.

- *The OHFDA* contains the legislative changes that, once passed and enacted, will bring forward a consolidated regime for facility oversight in Ontario.

Summary of the *Oversight of Health Facilities and Devices Act*

What facilities will be captured?

- The *OHFDA* will, if passed, establish a single legislative framework for:
    - community health facilities (including Independent Health Facilities (IHFs), Out-of-Hospital Premises (OHPs), private hospitals, and other facilities prescribed in regulation, and
    - energy applying and detecting medical devices (EADMDs) (e.g. conventional X-rays, CTs and fluoroscopy, MRIs, ultrasounds, nuclear or molecular imaging devices).

- In the legislation, a "community health facility" is defined as
    a) a place or a collection of places where one or more services prescribed in regulations made by the Minister are provided, and includes any part of such a place, and
    b) a place or collection of places prescribed in regulations made by the Minister.

- Given that the services that will be the trigger for a community health facility (CHF) coming under the regime will have to be prescribed in regulations made by the Minister; we cannot definitively list the facilities that will be captured by the new regime. However, we understand the Bill's repeal of certain acts[1] and the government's communications, that the following facilities are intended to be captured:
    - Independent Health Facilities (IHFs);
    - Out-of-Hospital Premises (OHPs);
    - Private hospitals;

[1] The OHFDA would repeal the *Independent Health Facilities Act*, *Private Hospitals Act* and *Healing Arts Radiation Protection Act*.

- Energy Applying and Detecting Medical Devices (EADMD);
- Birthing centres; and
- Other facilities or services as prescribed in regulations made by the Minister.

Key Roles and Responsibilities in the new Regime

- The roles and responsibilities proposed in the new regime include, but are not limited to, the Executive Officer (EO), the Inspecting Body (IB) and Inspectors.

- The EO would be a Lieutenant Governor in Council (LGIC) appointment. The EO would accept applications to operate a CHF (both funded and non-funded) or an EADMD. In considering such applications the EO will consider whether the applicant has met certain conditions and whether or not, in the case of CHFs, the facility seeks to provide services that are needed in Ontario. The EO will be able to suspend, revoke or refuse to renew a license for factors including the management of the health care system. The Act contains a prohibition on a person operating a CHF without a licence.

- The EO will be responsible for licensing facilities, funding and capacity planning. This would include making decisions regarding the renewal, cessation, suspension and revocation of licenses. The EO will be able to appoint CHF supervisors.

- Regulations will designate one or more organizations as inspecting bodies of CHFs. We understand that the College will be designated as an Inspecting Body (IB). There will be authority for the EO to appoint other Inspecting Bodies.

- The responsibilities of an IB will include:
    - Developing safety and quality standards for the CHFs, and updating existing standards, either as the IB considers appropriate, or as requested by the EO.
    - Establishing schedules for the regular inspection of the CHFs.
    - Providing for the inspection of CHFs as the IB considers advisable or as requested by the EO.
    - Appointing Inspectors to carry out responsibilities designated under this Act and any subsequent regulations.
    - Submitting reports of inspections and other information, which may include personally identifiable information, to the EO, and to other persons or entities as required by the EO.
    - Making inspection reports in the form specified by the EO, which shall not include personal information, available to the public.

- Making orders provided for in this Act.

- Establishing committees to carry out any functions of the IB, or any function required by the EO.

- Establishing and collecting fees from the operators of CHFs in respect of the administration of quality assurance programs, the administration of inspection systems and the performance of inspections.

- Inspectors and/or the IB will have significant new powers to impose orders related to the operation of the facilities. The IB or an inspector can make compliance or cessation orders. The Act outlines the grounds for issuing a cessation or compliance order, restrictions, process, notification, and recourse that a licensee will have for review.

Other Provisions in the *OHFDA*

- Subject to minor exceptions, existing independent health facility licenses and out-of-hospital premises would transition to the *OHFDA*.

- The *OHFDA* will require CHF licensees to have a quality advisor and quality committee that comply with the requirements of the Act. The quality advisor must be a member of a regulated health College, be approved by the EO, and must not be a licensee or prospective licensee.

- The *OHFDA* also requires every CHF to have a complaints process to receive and respond to complaints from patients and service providers as well as an incident review process. There is authority to make regulations to set out the requirements for both the complaints and incident review processes.

- The Act will restrict the ability of CHFs to charge, obtain or accept a benefit for providing an insured person with access to an insured service at a community health centre facility.

- The purpose of the new regime with regards to EADMDs is to expand legislation applicable to X-rays and X-ray machines and equipment. This addition in the legislation is meant to replace the existing *Healing Arts Radiation Protection Act* (HARPA) that was also the subject of a government review. If enacted, no person will be permitted to operate a device for diagnosis, treatment, mitigation or prevention of disease or for detection of radiation unless duly licensed, and licensees would be required to have a safety officer. The EO will have the authority under the Act to appoint inspectors to inspect premises at which an EADMD is located. Like a CHF license, an EADMD license can be suspended, revoked or refused for renewal for factors related to the management of the health care system.

CURRENT STATUS:

- College staff have completed a detailed analysis of the *OHFDA*. Overall, the legislation is largely consistent with the College's recommendations for a consolidated regime contained in our 2015 submission to HQO.

- The *OHFDA's* focus on patient safety, transparency, and public reporting are vital changes to a new regulatory system of oversight for community health facilities in Ontario. Specifically, the College is supportive of the legislation as it provides an IB with effective tools to take action to protect the public where quality issues are identified by the IB. The College is also supportive of the potential flexibility that the new legislation possesses to capture a broader range of services that are delivered to patients in the community and that should be subject to quality oversight.

- The CHF program, like the OHPIP, will continue to operate on a cost-recovery basis.

- Much of the details of the new system will only be known once regulations are developed. For example, issues such as the breadth of services or College's ability as an IB, to establish and collect fees from the operators of a CHF will be established in regulation.

- Below is a summary of areas of concern and suggested amendments with regard to the *OHFDA*. The submission to the Standing Committee contains a full list and explanation of the concerns and suggested amendments.

Areas of Concern and Suggested Amendments

General

- As currently drafted, the Bill provides that a community health facility is "a place or a collection of places where one or more services prescribed in regulations made by the Minister are provided". The approach of regulating "services" to be set out in a regulation poses certain problems. First and foremost, regulating services rather than locations and persons practicing within those locations creates potential gaps in oversight. For example, there may be services delivered at a particular physical location (e.g. a clinic) that are not prescribed services for the purposes of the *OHFDA* and over which the IB would have no authority. This distinction is unlikely to be apparent to patients or the public, who will assume that the entire physical location is subject to regulatory oversight.

- Similarly, the approach of regulating "services" raises the possibility that, depending on the services delivered by the particular licensee at a particular physical location, there might be multiple inspecting bodies responsible for the development of standards and for inspections. This overlapping responsibility has the potential to lead to confusion on the part of patients and to break-downs in communication and accountability.

- The Act does not specify an enactment date. The *OHFDA*, once enacted, will create an entirely new system of oversight for CHFs and an extraordinary amount of work will be required by the College to prepare for this change. In order for this new system to meet its goals of patient protection and transparency, it is essential that the enactment date is, at minimum, a year in the future. A small selection of the preparatory work the College will have to complete is highlighted below in the "CONSIDERATIONS" section of the briefing note.

- The College has significant concerns with the ownership structure contemplated by the *OHFDA*. The Act contains no obligation for the licensee of a CHF to be a physician or a member of a regulated health College. The College's experience with facility regulation in the IHF and OHP context has underscored the challenges of overseeing facilities with non-physician owners. We have urged government to consider the consequences and limitations of allowing individuals who are not regulated health professionals to be licensees of a CHF.

Quality Advisor

- Currently, only the EO can approve the appointment of a quality advisor. However, there will be circumstances where the IB has information about a proposed quality advisor as a member of the College that might speak to suitability. An amendment is proposed so that both the IB and the EO must approve the appointment of a QA.

- There is concern that the quality advisor must only "advise the licensee on the quality and standards of services" provided in the CHF. The College believes that framing the quality advisor's primary responsibility as providing "advice" to the licensee poses a number of challenges. We urge the government to strengthen and more clearly define the quality advisor's primary responsibilities and to specify the quality advisor's responsibility if he or she has reasonable grounds to believe that the licensee has not followed the quality advisor's advice.

- Further, the QA must not only advise about the quality and standards of services but also about the **safety** of services provided in a CHF.

- There is a lack of clarity regarding the respective accountabilities and relationship between the quality advisor, the quality committee, and the licensee – these must be clarified. Additionally, as the QA will be an employee of the licensee, there is an apparent conflict of interest that must be addressed.

Assessment Fees

- The Act relies on IBs to perform the critical task of ensuring the safety and quality of services delivered at CHFs. However, there is nothing in the Act with respect to enforcement mechanisms where there has been a failure by the licensee to pay a fee established by the IB. A number of amendments are required to ensure that the payment of fees is a condition for the issuance, transfer, or renewal of a CHF license.

Adverse Event Reporting

- The Act is silent on adverse event reporting. Currently, physicians practicing in OHPs and the OHP's medical directors are required to report Tier 1 and Tier 2 adverse events to the College. These requirements will no longer be in force with the repeal of the Regulation establishing OHPs as CHFs and accordingly must be independently established in the *OHFDA*. Amendments are required in order to obligate CHFs to report adverse events to the IB.

Inspection Reports and Orders

- The College believes that transparency must be a defining principle of the *OHFDA*. The Act has a number of gaps with regards to the regime of reports, compliance, and cessation orders. Amendments are required in order to address these gaps, including:
    - Requiring the licensee (or prospective licensee) to post all cessation and compliance orders while these are in effect;
    - Requiring the IB to not only post the CHF's inspection report but also post any compliance or cessation orders;
    - Clarify that it is personal health information that must not be made public rather than personally identifiable information; and
    - Ensure that the IB is able to effectively serve notice of an order on the licensee.

Non-Compellability of IB

- The College, as an IB, requires that its staff, agents and members of its governance structures including Council and Committees, be able to perform their duties without the threat of being compelled to provide evidence in civil proceedings, and that these persons be afforded immunity with respect to their activities. Currently, the *OHFDA* contemplates only non-compellability with respect to an inspector or a person accompanying an inspector. Amendments are required so that employees, agents, committee members, and Council members are not compellable in civil suits or any proceeding.

CONSIDERATIONS:

- It is anticipated that the implementation of the proposed legislation will have a significant impact on the operations of the College, including the composition of a new committee.

- There is significant preparatory work required in order for the College to function as an IB. This preparatory work includes but is not limited to:

    - Developing quality standards for each of the prescribed "services" for which the College is responsible as an IB. This is a significant body of work and will require convening Working Groups comprised of experts in the area of the particular service or services; consulting with and receiving feedback from stakeholders including licensees; approval of the standards by a Committee or Council; consultation, communication and publication of the standards to the relevant parties; development of tools for inspectors to ensure consistency in evaluating compliance with the quality standards.

    - Recruiting, appointing and training inspectors: inspectors in the new legislation have significantly greater responsibilities and powers than assessors under the IHFA or OHP regulation. The persons who will act as inspectors must be recruited and trained with respect to the new legislative regime and their responsibilities and powers, and trained with respect to the new standards and tools.

    - Creating, recruiting and appointing members of a College Committee to approve standards, appoint Inspectors, review cessation orders and issue decisions.

    - A review of current staffing and recruitment to address the increase in job requirements.

    - Creating internal processes and training staff to run the new inspection program set out in the legislation, including processes related to compliance and cessation orders.

    - Developing the necessary information technology systems to allow for the results of inspections and for orders to be made available to the public as required by the legislation.

    - Developing an assessment fee model that reflects the services for which the College is responsible as an IB.

    - Developing the necessary finance and invoicing systems associated with assessment fees to be prescribed in regulation.

- The development of regulations will be essential in clarifying the College's role and powers and understanding the details of the new system.

NEXT STEPS:

- It is anticipated that Bill 160 will pass third reading by December 14.

This item is for information

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Shandelle Johnson, Ext. 401
Jessica Amey, Ext. 749
Miriam Barna, Ext. 557

Date: November 10, 2017

Council Briefing Note

November/December 2017

TOPIC: Corporate Report and Dashboard – 2017 Q3

FOR INFORMATION

ISSUE:

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

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

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

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

The 2017 Corporate Plan guides the College's strategic and operational activities. Progress towards the goals set out in both the Strategic and Corporate Plans is reflected in the Corporate Report and Dashboard for Q3, attached at Appendix B.

Work is underway to finalize the 2018 Corporate Plan, which will provide a foundation for strategic discussions in 2018.

DECISION FOR COUNCIL: For information only

Contact: Rocco Gerace
Maureen Boon, ext. 276

Date: November 9, 2017

Attachments:

Appendix A: Strategic Framework
Appendix B: Corporate Report and Dashboard – Q3

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

Appendix B

Corporate Report – 2017 – Q3

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

Regulatory Initiatives	Objective(s)	Status
Facilities/Premises	Improved facilities oversight	Oversight of Health Facilities and Devices Act, 2017 (Schedule 9 of Bill 160) introduced September 27, 2017. Submissions to be made mid-November.
Investigations/Hearings/Monitoring	Process improvements Monitoring of Goudge recommendations & SATF response	Process improvements underway Protecting Patients Act (Bill 87) implementation underway
Registration	Modernization of registration regulation, including integration of pathways	Work on hold due to competing priorities.
Assessments	Every doctor assessed every 10 years (EDEX) Peer assessment redesign implementation	Initial assessments underway in some scopes for peer assessment redesign implementation. Linked to physician factors work.
RHPA Review (Protecting Patients Act)	To work with government to achieve best possible legislation relating to sexual abuse, transparency and committee structure	Protecting Patients Act (Bill 87) passed May 30, 2017. Implementation underway for sections currently in force. Regulations in development.

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

Dashboard – 2017 – Q3

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Comments
Optimize Registration	Meets processing time for Registration Applicants	90% of applicants meet processing time of a) 3 wks b) 4 wks				Credentials Applications 4,022 of 4,023 applications is 99% Registration Committee Applications 900 of 928 applications is 96%
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2600 assessments/year **NOTE**: this target has been adjusted to 2475 to redirect resources to peer redesign.				Assessments completed Q3 YTD 770, tracking to 1598. 65% of adjusted target of 2475.
	Quality Management Partnership implementation: physicians receive information about quality	% of physicians in each program receiving quality reports 1 colonoscopy 2 mammography 3 pathology				Data not yet available Initial reports will be provided to physicians later in 2017
	Increase input in policy	130 responses/policy				Four consultations since September: • Medical Records (48 responses) • Maintaining Appropriate Boundaries and Preventing Sexual Abuse (31 responses) • Physician Services During Health Emergencies and Disasters (33 responses) • Ensuring Competence (30 responses).

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Comments
						The average number of responses is 36. Results current to November 3; consultations open to November 14.
	Existing policies[1] current/relevant	80% of policies have been reviewed within 5 years				80% of are either current (have been reviewed in the last 5 years) or under review.[2] Some policy reviews have been deferred to enable the Policy Department to respond to urgent or competing priorities of the College.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days.				January 1st – September 30th, 2017: 90% of high risk investigations were completed in an average of 180 days, (69 investigations involving 43 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year				January 1 – September 30, 2017: 90% of hearings (34) began on average, 373.0 days (12.3 months) from the NOH date
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u>				January 1 – September 30, 2017: 90% of uncontested decisions (20) were released , 37.7 days (1.2 months) from the last hearing date
		<u>6 months for contested (C)</u>				January 1 – September 30, 2017: 90% of contested decisions (17) were released , 135.4 days (4.5 months) from the last hearing date

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

Strategic Priority	Objective	Measure/Target	Q1	Q2	Q3	Comments
Operational Excellence	Improve service level targets	85% live answer (PPAS, A&C)				A&C 23,004 of 27,784 = 82% live answer PPAS 37,455 of 41,604 = 90% live answer Combined 86% = live answer
	Improve service level targets	10% call abandonment				A&C 1,277 calls abandoned = 5% PPAS 2,655 calls abandoned = 6% Combined calls abandoned = 6%
	Media coverage	80-100% positive or neutral				In the third quarter, media interest in the CPSO remained high with 289 stories measured. The tone of the coverage was very good with 90% of stories either positive or neutral in tone. The breakdown was 19% positive (55 stories); 71% neutral (205 stories); and 10% negative (29 stories).

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 **NOTE**: target has been adjusted to 2475 for Q3 and Q4.	Tracking to >= 2475	Tracking to 2300-2474	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 <=***243d*.**	90% High Risk investigations done ***244-256 d***.	90% High Risk investigations done in ***257d+***.
	Schedule discipline hearings more quickly	Time from referral (notice of hearing) to hearing date	Hearings begin within 1 year	90% began within 365 days (1 yr)	90% began w/i 366-457 days (12-15 mos)	90% began more than 457 days (15 mos)
	Reduce discipline decision release times	Time from hearing date to decision release date	Uncontested (UC): 2 months Contested (C): 6 months	90% released <= 2 mos (UC) <= 6 mos (C)	90% released 2-4 mos (UC) 6-8 mos (C)	90% released > 4 mos (UC) > 6 mos (C)
Operational Excellence	Improve service level targets	Live answer for PPAS and A&C	85% live answer	85% or greater	75-85%	Less than 75%
	Improve service level targets	Call abandonment rate	10% call abandonment	10% or less	11-15%	Greater than 15%
	Media coverage	Positive or neutral media coverage	80% positive/neutral media coverage	80-100%	60-80%	<60%

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: Registration Pathways Program Evaluation

FOR DISCUSSION

ISSUE:

- The Registration Pathways Program Evaluation is a multi-year evaluation designed to understand the effectiveness of the College's registration processes. Specifically, this evaluation focused on understanding the effectiveness of *alternative* registration pathways and policies, implemented as part of a system-wide strategy to increase physician supply in Ontario from the early 2000's onward.
- The evaluation sought to determine if performance differences exist between practicing physicians who were registered through alternative routes to registration and those who were registered through the traditional route (i.e., physicians fully trained in Canadian residency and qualified in Canadian examinations).
- This was established as a long term evaluation and was approved by Council in 2012. The Registration Committee commissioned the study and was a principal contributor to recommendations based on the findings. The Quality Assurance Committee (QAC) oversaw the component of the project requiring use of the College's QA assessment infrastructure (e.g. Peer Assessment).
- This note provides background and context for the evaluation, an overview of key findings, and potential implications of this work based on consultations with multiple stakeholder groups.

BACKGROUND:

- In the 2000's, the CPSO contributed to a system-wide approach to address physician supply issues in Ontario. Registration policies were changed and added to complement provincial recruitment of physicians, increases to undergraduate and postgraduate medical training positions, and other provincial strategies. Please see the following CPSO paper for a discussion of the policy context https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5342883/

- This evaluation sought to determine what, if any, differences exist in the practice performance outcomes of physicians who achieve Ontario registration through alternative and traditional routes (ARPs and TRPs respectively) (Appendix A).
- Physicians who access alternative registration routes are those applicants who do not meet CPSO's regulation requirements for registration (under the Medicine Act, 1991) but instead meet an alternative set of qualifications approved by the CPSO Council (in the form of policies and pathways) or meet the requirements of the federal/ provincial/territorial Agreement on Internal Trade that was codified in the Regulated Health Professions Act in 2009. The CPSO has implemented many alternative licensure routes but the current evaluation focuses on the following broad pathways and policies:
    - Agreement on Internal Trade (AIT) – This is a federal-provincial-territorial agreement to enable professions' mobility from a Canadian jurisdiction in which they have a license, to gain licensure in another Canadian jurisdiction (note: under the provisions of the RHPA and its regulations, physicians achieving registration/licensure in Ontario may be reviewed by the Registration Committee or may receive their certificate of registration without a Committee review. This AIT cohort includes both sets of physicians)
    - Routes for physicians with residency training in the United States (who either received supervision in Ontario (Pathways 3 and 4) or were eligible for examinations by the RCPSC or CFPC (USA Exam Eligible)
    - Routes for physicians with residency training in Canada but did not immediately pass Canadian licensing examinations (requiring supervised practice)
    - Exam eligibility routes for physicians with practice experience and/or training in another Canadian jurisdiction (e.g. Physician is licensed under another province's rules and subsequently becomes eligible to challenge the CFPC certification examination based on two years of Canadian practice)
    - Exam eligibility routes for physicians who have completed training in one of 29 Royal College approved training systems that have been deemed by the RCPSC to be comparable to Canadian residency programs.
    - Routes for internationally trained specialists who completed practice assessments in Ontario (i.e. programs formerly run by the Ministry of Health and Long Term Care and known by a variety of names/acronyms such as APIMG).

- The objectives of the evaluation approved in 2012 are to:
    - Determine whether the CPSO's registration pathways and policies are meeting their intended purpose of licensing equivalently qualified physicians;
    - Gain insight into the ways in which the alternative registration processes may need to be updated to meet the needs of those who access them; and
    - Understand the educational needs of different physician subgroups to enable the development of appropriate quality improvement initiatives.

- The performance of traditionally and alternatively registered physicians (TRPs and ARPs respectively) was measured using multiple data sources:
    - The outcomes of the College's Peer Assessment program (chart audit and physician interview),
    - The results of a 360-evaluation tool called Multi-Source Feedback (MSF), and,
    - Primary care quality indicators developed and analyzed at the Institute for Clinical Evaluative Sciences (ICES).
- An analysis of CPSO complaints was also originally intended to be included as a fourth data source in this evaluation. In the latter part of the evaluation, it was determined that there is not an adequate number of ARPs with a representative complaints sample in the study period. An analysis of the complaints data will be considered as part of the ongoing registration quality assurance processes, and when a sufficient sample is available.
- Examining multiple data sources allowed for a comprehensive assessment of physician performance and for a rigorous investigation of potential differences between ARPs and TRPs. It is important to note that each data source has strengths and limitations, thus the triangulation of multiple measures of performance bolsters the study design.
- As indicated in the Council briefing note from 2012, the evaluation has also been designed to provide information on how the College may continuously improve its assessment infrastructure. The evaluation of alternative routes to registration yielded valuable information about how physicians are selected for assessment and the potential use of MSF to assess communication, collaboration and professionalism (Appendix A).

CURRENT STATUS:

- Data collection and analyses for all performance measures were completed in 2017. The following description briefly outlines the evaluation design, data collected and analytical processes:
    - Between 2013 and 2017, 1633 physicians received a Quality Assurance assessment that included both a Peer Assessment and MSF assessment (481 were ARPs and 1152 were TRPs).
    - All ARP and TRP primary care physicians (i.e. Family doctors) registered by the CPSO between 2000 and 2012 who had complete OHIP billing data in 2014 were included in the ICES component of the project (377 ARPs and 11,127 TRPs were included).
    - Statistical analyses were conducted on assessment data and ICES data to compare the performance of ARPs and TRPs.
- Data analysis has concluded and several key findings are summarized in this briefing note. In September and October of 2017, interpretation of study findings was discussed with Medical

Advisors, Education Committee, Quality Assurance Committee, Registration Committee, Executive Committee, as well as multiple staff groups.

KEY EVALUATION FINDINGS:

Overall, the evaluation supports the CPSO's alternative registration framework in that the pathways and policies are registering qualified physicians. ARPs and TRPs performed similarly on the three measures of practice performance described above and potential areas for quality improvement were identified for some subgroups. A summary of study findings is provided as follows:

Peer Assessment

- Very few QAC decisions resulted in significant outcomes (<1% of decisions for ARPs and TRPs combined). Significant outcomes include interviews with the Committee, Specified Continuing Education and Remediation Plan (SCERPs), Peer and Practice Reassessment Comprehensives (PPRC), or Terms, Conditions and Limitations (TCLs). There were no differences between ARPs and TRPs on these outcomes.
- There were no differences in peer assessment performance for 4 of the 7 pathways and policies included in the evaluation.
- In 3 of the pathways and policies, ARPs were more likely than TRPs to receive decisions of reassessment, indicating record keeping or minor care concerns that can be addressed educationally. These pathways included ARPs utilizing AIT, Pathways 3&4 (American trained who were supervised for one or more years in an Ontario practice setting) and those who obtained eligibility for their CFPC examination by practicing in another Canadian jurisdiction (and subsequently became eligible for registration in Ontario).

Multi-Source Feedback

- Analyses revealed no meaningful differences between ARPs and TRPs on MSF scores (mean scores for both groups were high across all stakeholder groups, including communication, collaboration and professionalism).

Primary Care Quality Indicators

- ICES primary care indicators, derived from OHIP billing and other administrative data, were developed and validated by the Institute for Clinical Evaluative Sciences (ICES). ICES routinely uses a variety of administrative data to evaluate and monitor the effectiveness of the health care system in Ontario. These indicators reflect whether a physician billed for a particular type of care and serve as a proxy of whether the care was provided to patients.

- Analyses revealed that ARPs were similar to TRPs on the majority of primary care quality indicators including diabetic care, cancer screenings, mammography rates, and hospital readmission rates.
- Some differences were found in certain ARP subgroups. Most notably, the billing rates of physicians entering Ontario from another Canadian province (either through AIT or through the exam eligibility route for those with practice experience in another Canadian jurisdiction) were different than TRPs in preventive pediatric care, as measured by billing for well-baby visits, 18-month assessments, and immunizations. Differences in relative rates between ARPs and TRPs were deemed to be statistically and clinically significant by stakeholder groups during the consultation process (clinical significance is the practical significance of a finding).
- For some ARP groups, statistically significant respiratory care differences were evident using OHIP claims for spirometry and on a measure of all-cause emergency department visits of chronic condition patients. These differences were small and not deemed to be clinically significant.

CONCLUSIONS AND POTENTIAL IMPLICATIONS:

- Based on three measures, the evaluation supports the CPSO's alternative registration framework in that the pathways and policies are registering qualified physicians. The findings suggest that ARPs and TRPs performed similarly on most primary care quality indicators and on MSF assessments during the study time period. However, some ARP subgroups were more likely to receive reassessment on Peer Assessments submitted fewer billing claims for preventative pediatric care based on OHIP data. Overall, the College is meeting its mandate to ensure patient safety and public protection by registering qualified physicians.
- Potential areas for quality improvement were identified for some ARP subgroups. The delivery of educational opportunities may reside within the *system* for these subgroups of physicians. For instance, the current evaluation findings point to early education needs in medical record keeping, and potentially, preventive pediatric care. Education and QI opportunities could be coordinated by multiple organizations in the system, and may include such things as billing practices and understanding primary care expectations that differ across the country.
- The evaluation of CPSO's registration policy and pathway framework represents a rigorous approach to understanding regulatory outcomes. It is likely the only study of this breath in Canada, and potentially internationally. The study and its findings serve to move the College toward its goals of accountability, transparency and evidence-informed regulation.
- In addition to understanding the effectiveness of the CPSO's registration pathways and policies, this evaluation also contributed knowledge to regulatory assessment activities of the future:

- The use of targeted (or focused) assessment methods was used for 1633 physicians (physicians who obtained registration through an alternative pathway were selected for assessment and were informed of their reason for selection). This serves as valuable information for the administration and communication of future focused assessments.
- The evaluation informs the potential use of MSF as an assessment tool in our Quality Assurance assessments. Appendix B includes a full evaluation of the findings of our use of MSF as well as preliminary issues for consideration in the potential use and integration of MSF into existing assessment processes at the College.
- Future assessment directions will consider how the evidence about practice risk and support factors can be used to assign appropriate assessment levels based on physician need (Appendix C). Consultations with various College Committees will be held in 2018, with respect to:
  - Assessing physicians based on particular needs at important career stages (i.e. Early, middle, late career)
  - Triaging physicians to an appropriate level of assessment, allowing the College to focus limited resources on physicians who may be more at risk of practice deficiencies
  - Using the appropriate assessment processes and tools to assess various aspects of practice (e.g. Clinical expert, communication, professionalism)

- Staff will seek publication of the registration pathways and policies evaluation, providing additional technical detail related to the findings. Further communications external to the College will inform organizations like medical regulatory authorities in Canada, certification bodies (i.e. College of Family Physicians of Canada, Royal College), and international medical graduate assessment programs.

DECISION FOR COUNCIL:

This item will be presented and is for discussion at Council.

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Date: December 1, 2017

Attachments:

Appendix A: Council briefing note on the pathways project (February 2012)
Appendix B: Council briefing note on evaluation of Multi-Source Feedback (May 2017)
Appendix C: Council briefing note on Physician Factors (December 2015)

COUNCIL BRIEFING NOTE

TOPIC: Registration Program Evaluation

ISSUE:

- This project is a key part of the Council's strategic priority to "Optimize the Registration System."
- The purpose of the project is to design and implement a program evaluation to understand the effectiveness of registration pathways and policies.
- The evaluation will focus on learning what, if any, differences exist between practising physicians who achieved registration through alternative routes to registration and the traditional route to registration.
- The Registration Committee is overseeing the project in its entirety (e.g. coordination with other Committees, design, recommendations based on findings) and the Quality Assurance Committee (QAC) is overseeing a significant component of the project requiring the College's assessment expertise and infrastructure.
- Council is being provided with an update on the strategic project and a proposal to use the assessment infrastructure in the College. Council is also asked to provide direction on the project as it will inform two very important issues for the College's consideration in the future: (1) the testing and use of multisource feedback to obtain information on dimensions of performance not currently obtained, such as communication and collaboration; and (2) the consideration of indicators to direct focused selection for peer assessment (ie. Selection based on specified indicators).

BACKGROUND:

Program Evaluation

- The objectives of the program evaluation in registration are:
  - Contribute to the validation of alternative routes to ensure that pathways and policies are meeting their intended purpose;
  - Gain insight into the ways in which alternative route process changes may be useful, and
  - Better understand the educational needs of different physician subgroups to enable the development of appropriate quality improvement indicators.
- This project, directed by Council, will determine what, if any, differences exist in the practice/performance outcomes of physicians who achieve Ontario registration through alternative and traditional routes.
- Information learned from the evaluation will be valuable for several reasons:
  - The Registration Committee and Council will better understand the outcomes of their current policies and it will help to inform future policy

development;
- The Quality Assurance Committee will understand more about the specific quality improvement needs of certain physician groups;
- The results will contribute to the Quality Assurance Committee and Council's understanding of multisource feedback as one component of an assessment program in order to make future program decisions; and
- The results will contribute to the Quality Assurance Committee and Council's understanding of the pros and cons of focused selections for peer assessment (i.e. Selections that are not random but based on studied indicators that are associated with performance).

Registration Pathways, Policies and AIT

- In 2010, the Quality Assurance Committee considered how it could play a role in using quality assurance/improvement tools as one method to look at the quality of care and performance by physicians who enter Ontario through alternative registration routes.
- In June 2010 the QAC discussed the various registration routes, including physician mobility based on new legislative provisions in 2009. The QAC agreed in principle to consider selecting physicians for peer assessment using methods other than random and age-based criteria. This included consideration of all entry routes, such as the now-complete Registration Through Practice Assessment Program, pathways approved in 2008, other registration policies, and those entering through enhanced pan-Canadian physician mobility.
- The QAC agreed to receive more direction from the Registration Committee before proceeding on its agreement in principle.

A Plan for the Program Evaluation Using Existing Programs

- Throughout 2011, the Registration Committee and the QAC have been involved in the development of the program evaluation. It includes both a retrospective analysis of data that exists in the College and a prospective use of the assessment authority of the QAC to **assess** specifically identified physicians.
- The prospective component of the evaluation will look at somewhere between 500 to 1000 assessments over 2 to 3 years. The exact number will be determined using statistical and practical considerations, but will form part of the QAC's annual allocation of peer assessments (i.e. these will be "real" assessments in addition to the random and age-selected cohorts). The selection cohort will be based on the physician's route of registration and each physician selected will receive an 'enhanced' peer assessment, complemented with the use of tools to gain insight into their communicator and collaborator skills (multisource feedback). Both of these differences are described below.
- On December 15, 2011 the Registration Committee considered the need to conduct an evaluation of registration pathways to inform policy decisions. They requested the Quality Assurance Committee conduct assessments of physicians who have been registered by alternative and traditional pathways as part of the peer assessment selection process.
- The QAC considered the evaluation plan at its October and December 19, 2011 meetings. The evaluation protocol is attached as Appendix 1.
- The QAC is supportive of the program evaluation goals, the use of its assessment infrastructure, and the approach to enhancing the assessment with a multisource feedback model to obtain information that is not possible from the

existing peer assessment tools (CanMEDS roles such as communication and collaboration feedback are not assessed in a medical record review).

- The QAC is satisfied, after a comprehensive review of the risks, benefits, the literature and practical program considerations, that the evaluation protocol:
    - Will be fair to participants;
    - Will be transparent to all as a communication plan will be developed as part of the evaluation process;
    - Will enable the Committee to carry out its mandate and assessment goals with all selected physicians, and allow for the collection of useful data to make assessment decisions and facilitate practice improvements with members of the profession;
    - Will provide internal quality improvement for the Council as information will be used to (a) assist Council in making decisions about the use of multisource feedback within the overall quality improvement enterprise of the College and (b) assist Council in understanding the risks and benefits of selecting specific groups of physicians for focused peer assessments (in addition to the random and age-selected cohorts approach to date).
- Therefore the QAC is recommending the following:
    - That the QAC will select physicians for peer assessment in order to contribute to the program evaluation. Physicians will be selected to represent four alternative registration pathway cohorts (see Appendix 1), and physicians who have been registered by the traditional registration pathway will be selected based on matched characteristics (e.g., gender, age, medical specialty). Physicians in this latter group will be drawn from the larger pool of physicians who are randomly selected each year to undergo a peer assessment. The protocol will likely begin in late 2012 and extend into 2014. To be as transparent as possible, all selected physicians will be informed of the reason for their selection.
    - That the traditional peer assessment for the program evaluation will be augmented by multisource feedback in order to assess additional CanMEDS roles (e.g. Communicator, Collaborator). Note that the traditional peer assessment modules primarily assess the Medical Expert role and the record keeping competency of the Communicator role.
    - That there be a staged implementation of MSF, with the first stage being a pilot project on the 30 - 40 peer assessors who will be recruited as assessors to complete peer assessments based on the specialties seen through alternative registration routes. In stage one, the assessors will test the MSF tools on their own practice and this will form the basis of their subsequent training in the interpretation and use of MSF within a peer assessment. The second stage will involve the same assessors administering an "enhanced peer assessment" to physicians in the specified cohorts.

- On January 17, 2012 the Executive Committee supported the directions of the program evaluation.
- It is important to note that the evaluation protocol was developed to be part of current operations and is not a research study (i.e. the goal is to understand practice using existing applied tools of the College). The Committees agreed that the proposed design will optimize College resources, achieve multiple goals within the design and readily incorporate key lessons into our existing processes.
- The QAC is satisfied that it is using current concepts on how to assess physician

performance and how to effectively promote lifelong learning. Council heard from two Canadian experts in physician assessment and MSF at its November 2011 meeting. These experts presented on the sizable research into MSF and how its utility is enhanced when the feedback is integrated into a structured feedback process (see Appendix 2 for materials from these presentations).

DECISIONS FOR COUNCIL:

1. Council is asked to direct the staff, under the oversight of the Registration Committee and the Quality Assurance Committee, to implement the registration program evaluation by:
    a) selecting physicians who have obtained registration through alternative and traditional pathways to undergo a peer assessment beginning in late 2012 (approximately late Fall);
    b) augmenting the traditional peer assessment with assessment tools that will assess CanMEDS roles other than medical expert (eg. communicator and collaborator roles within multisource feedback (MSF) tools); and
    c) staging the implementation of multisource feedback tools by first conducting a pilot project with 30 - 40 peer assessors, followed by the implementation of an enhanced peer assessment for the physicians identified in (a).

DATE: February 24, 2012

CONTACT: Dr. John Jeffrey, Chair, Registration Committee
Dr. Eric Stanton & Dr. James Watters, Co-Chairs, QAC
Dan Faulkner, Rhoda Reardon, Wade Hillier (QMD)

Appendices

Appendix 1: Literature review and proposed evaluation design
Appendix 2: Presentations to Council on MSF

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Council Briefing Note

TOPIC: CPSO Evaluation of Multi-Source Feedback (a component of the Pathways Evaluation)

DATE: May 25, 2017

Discussion

ISSUE:

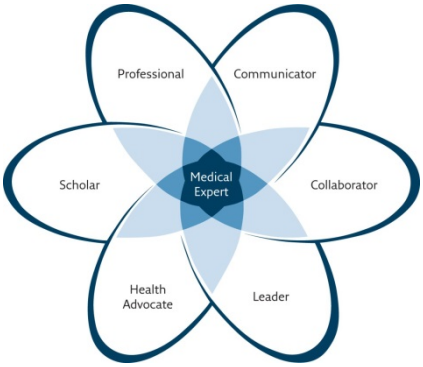
- The CPSO conducted a multi-year evaluation of physician practices based on their route to registration (i.e. a comparison of physicians that were registered by alternative pathways with those registered by traditional pathways – traditional pathways physicians are those who were fully trained in the Canadian context. This project, entitled "the pathways evaluation", included a comprehensive evaluation of Multi-Source Feedback (MSF) as used by the CPSO.
- Over the course of 2017, Council will be provided with information about the evaluation findings, analysis, and recommendations. This note will provide the key findings from the MSF evaluation, and describe several ongoing CPSO and national initiatives. These findings, the current environment for MSF nationally, and Council's response to the evaluation will all contribute to the development of recommendations related to the CPSO's future use of MSF.
- Council directed the pathways and MSF evaluation in 2012. The project team is seeking feedback from Council on evaluation findings.

BACKGROUND:

- A key strategic priority of the CPSO is to "Optimize the Registration Framework". In order to help achieve this, Council approved a project in 2012 to evaluate alternative licensure routes created primarily for internationally trained medical graduates to help fulfill physician shortages across the province **(Appendix A).** The goal of the project is to determine if performance differences exist for those registered via alternative licensure routes and those who were registered by traditional routes.
- As part of the evaluation, performance data was collected prospectively using an enhanced approach that augmented the current Peer Assessment Program (medical record review and assessor interview of physician) with a multisource feedback tool (MSF) licensed from the College of Physicians and Surgeons of Alberta. With approval from Council and under the authority of the Quality Assurance Committee (QAC), a specified number of Peer Assessments over 3.5 years had the MSF component added to it to assess physician roles in addition to the

Medical Expert role as exemplified by the CanMEDS framework (the primary roles assessed in MSF are Communicator, Collaborator, Professional - Figure 1). [1]

Figure 1: CanMEDS Physician Competency Framework



- This initiative is also aligned with the strategic priority to "Assure and Enhance Physician Competence":
  - The CPSO seeks to increase the number of assessments annually, which to date is principally in the form of on-site Peer Assessments and physicians assessed as part of an on-site facility assessment (e.g. Out-of-Hospital Premises Inspection).
  - The strategic priority also seeks to explore assessment options and the potential utility of MSF as a cost-effective screening, self-assessment, or evaluation tool.
- Since the MSF-enhanced Peer Assessments were launched in 2013, two related national collaborations aimed at enhancing physician competence have emerged, with extensive involvement of medical regulatory authorities:
  - The *Pan-Canadian Physician Factors Initiative (2015)* is currently studying the "factors" or characteristics associated with physician practice and performance (factors that may indicate a risk to practice performance and factors that may be protective). It is envisioned that medical regulators will use physician factors to assess physicians based on a common evidence base. Provincial programs to assure and improve physician competence are being developed and a common approach is to route physicians to an assessment with the appropriate level of "intensity" or "need" based on risk characteristics (this approach will necessitate different assessment options).
  - The Medical Council of Canada (in collaboration with medical regulatory authorities, physician organizations, academic partners and hospitals) acquired ownership of the CPSA MSF survey tools (in 2015) and is undertaking an expansive program development to improve and standardize the tools and the program of administering the tools, on a national basis (this initiative is now called *MCC 360*).

[1] The CPSO Council adopted the CanMEDS framework for assessment in May, 2015.

CURRENT STATUS:

- The MSF Evaluation focused on the following three key areas:
  - Implementation and the processes associated with its operation;
  - Outcomes and impact associated with MSF for key stakeholders;
  - Critical factors needed to support potential integration and sustainability of the MSF program.

- Data for the evaluation was collected from three key stakeholder groups: assessed physicians, the Quality Assurance Committee (QAC) and staff in the Practice Assessment & Enhancement (PA&E) department. Data was collected at the beginning, midpoint and at the end of the project through surveys, focus groups and interviews.
- A total of 1721 Peer Assessments that included MSF were initiated between 2013 and 2016. Each were assessments that would have been conducted within the Quality Assurance program to meet annual departmental targets. For each of these assessments, MSF was appended to the regular assessment process to collect data from two data sources.
- Of the 1721 assessments, 474 were administered to alternative registration pathways physicians while 1247 were administered to physicians obtaining licensure through traditional registration routes.

Key findings from the evaluation (discussed in the final report)

Costing information:

- The cost of a Peer Assessment with MSF is $1851.06 with Peer Assessment accounting for 81% of the cost (the average cost for MSF is $346.64).
- The incorporation of MSF also had time implications for the QAC and staff (time increased for both groups).

Feedback from the Quality Assurance Committee (QAC):

- Approximately 90% of the QAC agreed that there is value in assessing extended CanMEDS roles and that MSF adds value to the Peer Assessment process.
- QAC agreed with the use of the tool and were able to reach a combined score based on both data sources for all assessments. However, approximately half of the committee had difficulty making a decision based on two data sources for the following reasons:
  - MSF reports were sometimes hard to interpret without the inclusion of narrative comments.
  - Intervention and reassessment / follow-up options to address issues arising from MSF were limited.
  - Developing educational interventions for intrinsic CanMEDS roles (e.g., Communication, Collaboration, and Professionalism) is inherently more challenging than for the Medical Expert role.

Feedback from assessed physicians:

- 83% of assessed physicians agreed that an assessment including both Peer Assessment and MSF provided a comprehensive picture of their practice, prompted reflection and highlighted areas of success and areas for improvement in their practices.
- Assessed physicians were more motivated to make practice changes based on performance data from the Peer Assessment than MSF.
- Physicians who had the opportunity to speak to a Medical Advisor about their MSF results were more likely to make practice changes.
- Assessed physicians reported making the following practice changes as a result of MSF:
  - Stress management (e.g., attending to work-life balance)
  - Patient education (e.g., providing educational brochures for patients in the waiting room)
  - Communication (e.g., focusing on interactions with colleagues)
  - Practice Management (e.g., implementing regular staff meetings, improving patient flow)
  - Professional Development (e.g., attending local continuing medical education meetings)

Feedback from Practice Assessment & Enhancement (PA&E) staff:

- Staff felt adequately trained to administer Peer Assessments with MSF, but their satisfaction with processes declined throughout the project due to ongoing program development.
- Staff was extensively involved in the assessment administration; their feedback and suggestions (included in the report) provide valuable information for the development and implementation of future large scale projects embedded within routine operations.

Conclusions

- MSF is deemed acceptable among assessed physicians and QAC as a useful quality improvement tool to provide physicians with feedback.
- The utility of the performance data for physicians improves when a physician has a conversation with a Medical Advisor instead of receiving and attempting to use the report independently (this finding is supported by the assessment literature stressing the importance of facilitated feedback).
- Limitations were identified in the MSF tool/process that was used during this evaluation. For example, MSF currently only includes numeric ratings; narrative comments are needed to provide context for scores.
- The MCC 360 initiative is currently developing a comprehensive program that will address a number of current limitations identified in the CPSO evaluation, including the addition of narrative comments.

CONSIDERATIONS:

- None

NEXT STEPS:

- A comprehensive evaluation report is being developed and an Executive Summary has been provided at this time (Appendix B). The findings augment the existing scientific literature on MSF and identify some challenges in using MSF (that have also been identified by others), that will be addressed through the national MCC 360 program.
- Recommendations for the CPSO's use of MSF will be considered in a few months as national initiatives proceed.

DECISION FOR COUNCIL:

For discussion

Contact: Wendy Yen x263; Dan Faulkner x228; Wade Hillier x636

Date: May 25th, 2017

Appendices:

Appendix A: Council Briefing Note for Registration Program Evaluation (Feb 24th, 2012)

Appendix B: MSF Evaluation Report: Executive Summary

December 3 & 4, 2015

COUNCIL
BRIEFING NOTE

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

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ISSUE:

- How can the College "assure and enhance physician competence" on a regular basis?
- This complex question requires the College to use its significant infrastructure of assessment to perform an acceptable number of physician assessments annually, and to continually evaluate the quality and effectiveness of the assessments to achieve their desired purpose.
- It also requires new directions and careful attention to (1) identifying, understanding and using empirically defined factors of practice that support physician performance or that suggest a risk of poor performance; (2) developing and implementing alternative interactions between the College and physicians that serve to "provide feedback to physicians to validate appropriate care and show opportunities for practice improvement"; and, (3) alignment with, and greater physician participation in, local systems and supports that enhance performance for safe and quality patient care.
- A pan-Canadian MRA Steering Committee has been formed to identify, understand and use empirically defined factors.
- This note and presentation will provide an update on the work to date, and also initiate discussions on how these factors can be used by the College to define a broader program of physician performance assurance and enhancement.

BACKGROUND:

- Since the College's strategic plan was approved, the College has:
    - increased the number of annual assessments from 1460 to 2600 in a four year timeframe (from 2008 to 2012, with current assessments remaining at 2600);
    - implemented the out of hospital facility inspection program;
    - addressed assessment quality by:
        - evaluating multisource feedback use;
        - re-designing peer assessment tools with active involvement by Assessor Networks[1]

[1] The Quality Management Division has established over 40 assessor specialty networks consisting of approximately 500 physician assessors. The networks are aligned to specialty of practice (eg.

- developing an enhanced assessment process to better direct physicians to relevant continuing professional development (ie. the unperceived needs).

- In 2011, Council approved the CPSO Assessment Model (Appendix 1) with three levels of assessment, each with a clearly defined purpose.[2]

- Council also re-framed its strategic priority as the assessment of every physician on a ten-year frequency (ie. "every doctor every ten years").

CURRENT STATUS

Challenges to Address

- The College is seen as a leader across the country for its commitment to both the quality and the quantity of physician on-site assessments.

- However, Committees and Council have expressed concerns that the College should not focus solely on using random and age selection criteria for the on-site physician assessment.[3] In addition, there are questions about whether an improvement-focused interaction of peers on a ten-year basis, is satisfactory for public protection and capable of building public trust.

- Some of the related concerns/questions include:

    - Are there empirically-derived factors that can support our selection decisions for physician assessment?
    - Could the frequency of College-physician interaction be determined by the degree of risk and support within each physician's context of practice (eg. demographics, environment, quality supports, etc.)?
    - Could there be a range of proactive interactions between the College and physicians that will include, but not be limited to, the on-site peer assessment?
    - Could the type of interaction be determined by the weighting of risk and support factors?
    - Could the College influence physicians to actively participate in existing local quality systems and supports?
    - How can the College work more effectively with partners to drive further provincial and local development of quality systems and supports?

Cardiology, family medicine) and by area of practice where there may be several specialties involved (eg. Pain management, walk-in clinics, sleep medicine).

[2] The College approved model is derived from the national model of Monitoring and Enhancement of Physician Performance (MEPP), Federation of Medical Regulatory Authorities, 1995.

[3] The Peer Assessment Program has selected physicians on the basis of reaching 70 years of age and every five years thereafter. Other factors have been shown to be predictive of peer assessment outcomes (eg. solo practice, no hospital privileges, no CFPC certification) but have not been implemented as selection criteria.

- Together, the College's existing strategic directions, program results and the identified challenges, have led to the formation of a pan-Canadian Physician Factors Steering Committee.

Pan-Canadian Physician Factors Steering Committee

- Throughout 2014, several organizations were working independently on issues related to competence assurance and physician risk factors. For example, the Federation of Medical Regulatory Authorities of Canada (FMRAC) was working towards the development of a risk framework for physician health and aging. The College of Physicians and Surgeons of Alberta (CPSA) was also strategically focused on using well-studied factors that are predictive of physician performance.

- In the Fall 2014, a coalition began to form of several regulatory bodies with a strategic mandate to use physician performance factors in their quality assurance programs. The organizations contributing to this program development include:

    - College of Physicians and Surgeons of Ontario
    - College of Physicians and Surgeons of Alberta
    - College of Physicians and Surgeons of British Columbia
    - College of Physicians and Surgeons of Nova Scotia
    - Collège des Médicins du Québec
    - College of Physicians and Surgeons of Manitoba (joined in Feb/15)
    - Federation of Medical Regulatory Authorities of Canada

- The Steering Committee has had several teleconferences and two face-to-face meetings in January 2015 (Toronto) and June 2015 (Fredericton).

- The Steering Committee agreed first to work on:
    - Understanding which factors impact physician practice (ie. support factors that increase likelihood of acceptable performance, and risk factors that increase likelihood of unacceptable performance)
    - Understanding the weight of the factor evidence
    - Defining methods for the sustainable collection of data related to identified factors

- To achieve its mandate, the Steering Committee is working with the following researchers:

    - Dr. Susan Glover-Takahashi, University of Toronto, was contracted to conduct a comprehensive literature scoping review of risk and support factors in the professions of medicine, physiotherapy, pharmacy and occupational therapy. Her draft report was presented to the Steering Committee in June

2015 and the Steering Committee continues to work with her and use the product of her review.[4]
  - Dr. Elizabeth Wenghofer, Laurentian University, was recruited to develop an overarching pan-Canadian approach to using the physician factors in a consistent manner, including data collection and program development. Dr. Wenghofer is also conducting similar concept building and analysis with several USA-based assessment programs.
  - The Collège des Médicins du Québec agreed to become a member of the Steering Committee, and is a Canadian front-runner in using risk factors to target physician assessment.

- At the June 2015 Steering Committee meeting, the following projects were launched:

  - *Understanding and testing an existing risk framework*: Several MRAs will use the CMQ's risk framework to further test and validate the performance risk factors against existing assessment program outcomes (eg. peer assessment, multisource feedback).
  - *Understanding risk and support factors beyond the published evidence*: A qualitative research project has been initiated to identify and understand factors that are based on the experience of assessors, committees, and MRA staff members.
  - *Deeper dive into selected factors*: The work of Dr. Glover-Takahashi identified the factors and their frequency of appearance in published literature. Across the country, all MRAs share an interest in learning more about aging and health in respect to performance. The FMRAC Board of Directors also identified this area as a strategic priority and therefore plans are being developed to conduct a more extensive review of the aging literature base.
  - *Defining a common data set*: Applying the factors in future MRA activity requires an accurate picture of a physician's scope of practice (ie. Their actual practice activity and context at a given point in time). This requires a consistent approach to defining scope and effective methods to capture information from individual doctors. There is great diversity in the programs, information systems and data of MRAs. The Steering Committee will work to build consistency in how MRAs define physician scope of practice, what data is necessary to determine scope, and how to create a common national data set. This work will connect to other national partners and discussions have been held between the Registrars of the MRAs and the partner organizations of the National Physician Survey (Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, Canadian Medical Association).

- Each project is led by a regulatory representative with significant CPSO involvement in all projects.

[4] Meta-Epidemiology of the Competence of Four Health Professional Groups, to be submitted for publication in Fall 2015.

How Will This Support CPSO's Strategy and Goals?

- In order to achieve an effective approach to physician competence assurance and enhancement, the College may focus on the following key areas:

    - **A strong empirical base for physician risk and support factors**
        - Significant, national work is emerging in this area
        - There is an articulated evidence base of risk and support factors that will be seen as credible and actionable
        - Further work is being developed to understand how the factors can be used in assessment programs
        - A qualitative study will enable MRAs to go beyond and complement the published literature
        - Mechanisms to identify appropriate data, how it will be collected, and build consistency across the MRAs is also in development
        - MRAs are also committed to the continual collection of data to understand how the factors will be maintained or change over time.
    - **A tool-box of assessment methods**
        - The on-site peer assessment is an important component of our quality assurance program
        - Other forms of assessment should be considered for physicians with low-risk, high support factors
        - A tool-box of assessment methods can be cost-effective and enable interaction with several thousand physicians annually
    - **With partners, ensure physician accessibility to local systems and structures for safety and quality**
        - The College can only have a finite and limited impact on physician practice and improvement through our on-site assessments (low frequency, limited interaction)
        - To meet our mandate of quality assurance, the College will consider how it can influence and support:
            - Availability and access to provincial and local quality systems and supports that can demonstrate patient care improvement; and
            - Greater physician participation in those relevant and effective systems and structures
        - Our increased understanding about supports and risks of physician performance, will enable more local opportunities for physicians to improve their practice.

- This project demonstrates the summative advantage of national collaboration. Ontario is benefiting from other jurisdictional experience, and MRAs are staging program development on a common base. This work also connects to various other national initiatives such as FMRAC's Physician Practice Improvement initiative and building effective CPD programs.

- With the pan-Canadian Physician Factors Project, Ontario may be able to think beyond “every doctor every ten years”. Our goal could be:

    - Reliable data collection, using weighted factors to make assessment decisions (eg. Who is selected for assessment; what type of assessment)
    - For certain physicians (high risk; low support factors), there may be more in-depth (eg. on site peer assessment) and frequent (eg. Every 3 years) assessments conducted
    - For certain physicians (low risk; high support factors), alternative assessment methods (eg. team-based), with lower cost (compared to on-site peer assessment) and greater volumes may be conducted
    - Outside of College assessments, physicians will have daily access to, and will participate in, local quality systems and structures (eg. receiving and using provincially developed clinical data reports; locally driven multisource feedback, etc.)
    - Public protection and confidence can grow with an integrated system of competence assurance and enhancement.

DECISIONS FOR COUNCIL:

This item is for discussion and will be accompanied by a presentation.

The Council is asked to consider:

1. What general suggestions do you have for the mandate and the projects of the Physician Factors Steering Committee?
2. What feedback do you have about the longer term goal of the College:
    a. Create a strong empirical base for physician risk and support factors
    b. Expand our toolbox of assessment methods
    c. Influence through partners, more and better local systems and structures for safety and quality?

CONTACTS: Dan Faulkner (ext. 228), Rhoda Reardon (ext. 767), Wade Hillier (ext. 636), Wendy Yen (ext. 263)

DATE: December 3, 2015

Appendix 1: CPSO Assessment Model

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Physician Health Program - Update

Guest Speaker: Dr. Joy Albuquerque, MD, MA, FRCPC
Medical Director, Physician Health Program
Ontario Medical Association (OMA)

Dr. Albuquerque joined the OMA's physician health program in 2004 to develop its services for doctors with mental health problems and, in 2017, accepted the position of Medical Director. Her role has evolved beyond the management of mental health conditions to expertise in the field of risk management of physicians and their work. Dr. Albuquerque is regularly invited to present on issues related to physician health and well-being. She has written and published on topics of physician health, burnout and resilience.

Dr. Albuquerque is Chair of the Forum for Canadian Physician Health Programs.
Dr. Albuquerque practices at St. Michael's Hospital and is Assistant Professor at the University of Toronto, department of psychiatry.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: Governance Committee Report

FOR DISCUSSION:

1. **2017 Council Performance Assessment Results**
2. **Non-Council Public Members on Committees**

FOR DECISION:

NOMINATIONS:

3. **2017-2018 Governance Committee Election**
4. **Methadone Specialty Panel: Vice Chair Appointment for 2017-2018**
5. **Committee Membership Appointments for 2017-2018**

FOR INFORMATION:

6. **Completion of Annual Declaration of Adherence Form**

FOR DISCUSSION:

1. 2017 Council Performance Assessment Results

Background:

- Council's 2017 performance assessment was distributed with the meeting materials for the September meeting of Council.
- This is the 14th year that the assessment has been conducted and the results were again quite positive.
- The goals of the performance assessment include the following:
  - to gage Council's performance in a number of areas over the past year;
  - to identify areas for improvement;
  - to obtain general feedback, both positive and negative to inform ongoing development.
- Of the 34 questionnaires distributed, 22 were completed, representing a response rate 65%.
- Number of years on Council:
  - 1 year < – 23%
  - 1-2 years – 18%
  - 3-4 years – 23%
  - 5-6 years – 13%
  - >7 years – 23%

A. VISION AND MANDATE

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. I understand the vision and the mandate of the College.	**100%**[1]			
2. The Council formally reviews its vision.	**72%**	**14%**		**14%**

Summary:

- The College vision and mandate is understood by Council.
- A handful of Council members may have questions about when its vision will be updated or, believe that the time has come to review the vision.

Comments:

- *The presentation to council members provides excellent information regarding the vision and mandate of the college.*
- *Being new to the council I am not certain how frequently the CPSO reviews its vision.*
- *I believe there is a process to regularly review the vision and mandate for the CPSO but I am not sure of the time interval between reviews.*

B. STRATEGIC PLAN AND PRIORITIES

QUESTIONS	RATING			
	Yes	Somewhat	No	Don't Know
1. The College's strategic plan is documented	**96%**	**4%**		
2. The Council creates a set of key priorities that must be implemented in support of the strategic plan of the College	**92%**	**4%**		**4%**
3. The Council establishes a small number of strategic initiatives to focus attention and resources to help achieve the College vision.	**82%**	**18%**		

[1] One respondent did not answer questions 1 and 2

4. The dashboard report presented by the Registrar clearly reports progress on College priorities.	**92%**	**4%**		**4%**

Summary:

- Council members are aware that the College has a documented strategic plan and that priorities are established to help achieve the plan.
- The dashboard report presented by the Registrar is perceived to be clear and is viewed positively.
- There appears to be some uncertainty about the degree to which Council creates a set of strategic initiatives to focus resources and help achieve the College vision.
- The respondent who answered "don't know" to the fourth question is a new member of Council.

Comments:

- *The dashboard provides ideal information and demonstrates where the college is going. This has been the most and clearly presented information ever provided in all my years on medical professional boards.*
- *It seems at times that there are a lot of competing priorities on the go…hard to understand how they are being prioritized.*
- *The dashboard reports are very clear and easy to read.*
- *Registrar's Report extremely detailed but delivered clearly and easy to understand.*
- *New strategic priorities soon.*

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.	**73%**	**27%**		
2. The Council effectively develops and approves principles and policies that fulfill its duty to protect the public interest.	**86%**	**10%**		**4%**
3. The Council effectively discharges its statutory functions.	**90%**	**10%**		
4. The Council periodically monitors and assesses its performance against its strategic direction and goals.	**86%**		**4%**	**10%**

5. The College has an effective system of financial oversight.	**86%**	**14%**		
6. The Council meets with external auditors, reviews their reports and recommendations and, ensures any deficiencies are corrected.	**82%**	**4%**		**14%**

Summary:

- Council members are less familiar with College governance practices and policies than in 2016 (new members of Council).
- Respondents feel that the Council:
  - develops and approves policies that full fill its public interest mandate (86% yes, 10% somewhat);
  - effectively discharges its statutory functions (90% yes, 10% somewhat).
- Respondents generally feel that the College has an effective system of strategic oversight (86% yes, 14% somewhat).
- Respondents who rated a "*don't know*" response to questions in this section have been on Council for less than one year.

Comments:

- *Council is made aware of the performance of the CPSO against its strategic direction and goals but does not really "perform" as such in the strategic goals.*
- *What about future challenges?*
- *Not certain what types of financial reviews are done and how the findings are addressed (if any).*
- *I would say that it's the College that effectively develops principles etc., with Council approving direction and providing oversight.*
- *Very effective council. Members are conscientious and knowledgeable. Staff ensures all info. is prepared. The College's financial oversight is excellent.*

D. GOVERNANCE OPERATIONS

QUESTIONS	**RATING**			
	Yes	**Somewhat**	**No**	**Don't Know**
1. As a Council member I understand my fiduciary obligations.	**90%**	**10%**		
2. I know and understand the Code of Conduct.	**100%**			
3. I understand the Conflict of Interest Policy.	**100%**			

4. As a member of Council, I declare potential conflicts of interest according to Council's conflict of interest requirements.	**100%**			

Summary:

- There is a clear sense amongst respondents that in the area of governance operations that they as members of council:
    - Understand their fiduciary obligations;
    - Know and understand the Code of Conduct;
    - Understand the COI policy;
    - Declare conflicts.
- The results in this governance operations section are again very good this year.

Comments: *(none)*

E. COUNCIL OPERATIONS

QUESTIONS	**RATING**			
	Yes	**Somewhat**	**No**	**Don't Know**
1. I receive appropriate information for Council meetings.	**96%**	**4%**		
2. I receive information for Council meetings on a timely basis.	**96%**		**4%**	
3. Council's meetings are effective and efficient.	**90%**	**10%**		
4. The President chairs Council meetings in a manner which enhances performance and decision-making.	**100%**			
5. I feel comfortable participating in Council discussions.	**86%**	**14%**		
6. Council has a formal written orientation package for Council members.	**82%**	**4%**		**14%**
7. My orientation to the College Council was effective.	**82%**	**4%**	**10%**	**4%**
8. I am aware that Council has a mentorship program.	**96%**	**4%**		
9. Council's mentorship program is helpful.	**82%**	**4%**	**4%**	**10%**

10. I find Council's continuing education activities useful.	**96%**	**4%**		

Summary:

- Overall, results in this section are very positive demonstrating that Council members are quite satisfied with Council meetings and the quality of the materials.
- Council members appear to be quite satisfied that they receive appropriate and timely information for Council meetings (with just one respondent disagreeing).
- Council feels that meetings are carefully planned, effective, efficient and well chaired by the President.
- There is an opportunity and feeling that more orientation for new members of Council would be helpful.
- The mentorship program was strengthened two years ago. There is growing awareness of the program. All but one Council member who has participated in the program found it helpful (82% helpful, 4% somewhat helpful, 4% no).

Comments:

- *Please, please, please – notify me on personal e-mail to check CPSO e-mail; Don't have easy access to my CPSO account so sometimes mail is not open for months (**NOTE: this is generally not appropriate, Council members should be checking their CPSO email regularly**)*
- *Was hardly oriented – just by Deb McLaren.*
- *I sincerely thank you for the mentorship program. This has helped significantly in the orientation process.*
- *It is somewhat difficult to respond as I have attended only one Council meeting.*
- *It would be helpful to have all the orientation materials in one package. There is a lot of information but is in various formats and documents. In addition, it would be helpful to have more guidance around billing for prep time and how to submit expenses.*
- *The meetings are well run but tend to have a fair bit of repetition/review.*

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.	**82%**	**14%**		**4%**

2. The President asks Council for feedback which informs the Registrar's performance review and advised Council of the outcome of the review.	**72%**	**14%**		**14%**
3. The Council maintains a collegial working relationship with the Registrar.	**100%**			
4. The Council <u>does not</u> get involved in day-to-day operational matters.	**90%**			**10%**
5. Committees <u>do not</u> get involved in day-to-day operational matters.	**72%**	**14%**		**14%**

Summary:

- Council maintains a collegial working relationship with the Registrar (100%).
- Further orientation is required for new members of Council to ensure that they are aware of their role as a Council member.

Comments:

- *Re question 5 - answer is yes but I only can speak for committees I am a member of.*

STRENGTHS AND DEVELOPMENTAL NEEDS

1. List two strengths of the Council. *(all responses are contained below)*

- *Respective open discussion*
- *Diversity*
- *Wealth of experience and diversity*
- *Invited speakers are excellent and add to collective considerations of strategic direction/initiatives/etc.*
- *I usually find the presentations regarding policy reviews to be well presented in regards to summarizing the issues and not being too repetitive of information received in the package.*
- *I usually like the guest speakers and would encourage more speakers regarding topics that are of highest priority at the time – i.e. Opiate crisis, sexual abuse.*
- *Knowledge*
- *Dedication*
- *Excellent public membership and the collegiality of the council members*
- *The orientation and educational sessions*
- *Timely and efficient flow of information to members*
- *Level of discipline, professionalism amongst the members of the council*
- *The Board operates in an open and transparent manner*
- *There is a culture of trust, respect and candor among board members*
- *Focused on honest discussions between Council members*
- *Understanding and addressing the public's concerns and physicians' practical challenges*
- *The governance and adherence to that governance*

- *The collegial nature of the Council is helpful*
- *The in-depth material generated which is available particularly on the website is public sector friendly*
- *Very good communication*
- *Excellent President*
- *Dedicated physicians and staff*
- *Open discussion is encouraged*
- *Members do not hesitate to speak out even if their opinion is controversial*
- *Business is conducted in an efficient and professional manner.*
- *All Council members are approachable and friendly, very supportive of new members*
- *There are very clear strategic plans with great staff that are able to help Council meet these goals in a timely fashion.*
- *There is lots of opportunity to provide feedback (e.g. new and revised policies, concerns or complaints etc.) both from the public, physician members, as well as Council*
- *Diversity, shared commitment to values, willingness to express views*
- *Diversity of opinions and background between public and physician members*
- *All members work towards the goal of protecting the public*
- *Excellent members – knowledgeable and conscientious*
- *Presentations from other experts (e.g. at current meeting the representative from College of Nursing) always informative and interesting*
- *Members free to speak up*
- *Excellent Chair this year*

SUMMARY: Council strengths – key themes:

- Diversity
- Experience, knowledge and dedication
- Staff support
- Open discussions, collegiality
- Excellent President
- Common goal – protect public
- External presentations at Council meetings

1. List two ways Council could be improved.

- *It is hard as a new member to participate…lots of experienced people hold the floor – with (sic) is ok and valuable – but there is a younger/newer member perspective that might be helpful.*
- *When presenting revised policies, is it possible to highlight changes made?*
- *Public members should be asked to do presentations*
- *Less concern about what the members will think*
- *<u>Diversity!!</u>*
- *Would like to have the PowerPoint presentations to review prior to council as they often summarize the key issues.*
- *Additional information of ongoing issues*
- *More time should be provided to Council members to discuss more challenging topics*
- *I have been on the Council for too short a time to recommend improvements*

- *I believe the complicated system of payment for expenses, etc. is unnecessary, although the Government's Health Board Secretariat is responsible for that function.*
- *It would be helpful for new Council members to informally meet staff and other Council members.*
- *A smaller council would be more effective.*
- *A short education session on an upcoming policy issue so that Council would be better understanding of the status quo before looking at changes.*
- *Reduction in size.*
- *Meetings could be shorter if there was more condensed review of frequently discussed issues. The meeting materials contain detailed summaries of many of the meeting agenda items. The presentations could be shorter with more emphasis on discussion.*
- *Size limits engagement.*
- *More public engagement by the Registrar and President to explain the role of the CPSO in the health care system in Ontario.*
- *I would prefer 8:30 start, so that end time is 15:30 – allows people from out of town to leave earlier.*
- *Availability of PowerPoint slides presentations where possible.*
- *Smaller number of members?*

ADDITIONAL COMMENTS:

- *Formal mentorship program excellent and information mentorship very helpful. Staff are amazing. Completely enjoy my association with the CPSO Council.*
- *What's up with lack of diversity? Council so homogeneous – how does that represent the public?*
- *I regret that I will be leaving Council at the end of this year on the expiry of my OIC. I have greatly enjoyed my years as a public member on Council but I am finding that travel to Toronto is becoming a challenge. Being a public member on Council has both a pleasure and a great privilege. I wish the College every future success.*
- *I have really enjoyed my first year at the College and look forward to getting more involved.*

SUMMARY: Ways Council could be improved – key themes:

- Reduction in size, (four respondents suggest reducing the size of Council)
- Diversity
- Variety of comments about presentations and materials (highlight policy changes in presentations, availability of presentations, condensing review of items that have been frequently discussed and opposing opinions…)

Suggested Next Steps:

- There appears to be support amongst some members of Council for discussion about the size of Council and a perception that a smaller Council would be more effective. Work is required to consider next steps, what Council may wish to achieve in the area of governance in the short term and what it may want to advocate for in the future. Discussion about governance reform is timely.
- Continued work to consolidate orientation materials and programming.
- Increased orientation programming given the large number of new members of Council.
- Reinforce the roles of Council and committee members as part of orientation programming and throughout the year.

QUESTIONS FOR CONSIDERATION:

1. How do you feel about the results?
2. Are there other potential next steps that should be considered?

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2. Non-Council Public Members on Committees

ISSUE:

The College's public Council member resources are stretched at a time when caseloads are growing on committees where public members are required in order to meet quorum requirements. Strategies are required to ensure that the College is able to meet quorum requirements and support a ballooning workload. Retaining public members where possible who are not members of Council to help support the work of College committees is one strategy that warrants consideration.

BACKGROUND:

- Some committees are having difficulty meeting their public Council member quorum requirements. This poses a risk to the College's ability to meet its mandate and legislative time periods for investigations and hearings.
- Growing complaints and discipline case-loads mean that public Council members must devote more time to ICR and Discipline Committee work because of quorum requirements (2 public members on DC panels and 1 on ICR panels).
- The College's public Council member resources are stretched and the risk of public member burnout is a growing concern.
- Other committees that rely on public Council member participation in their work are also having difficulty because of the need for these same public Council members to focus time on Discipline and ICR.
- To make matters even more challenging, there are ongoing issues with the public member appointments process. Government appoints between 13 and 15 public members of the College Council. Because of the College workload, the College has asked government to ensure the appointment of 15 public members. Vacancies are frequently left unfilled by government for months. Government also continues to appoint some members of Council who understandably may not be able to meet the required time commitment of public members (more than 80 days a year). Government frequently appoints public members who have either part or full time positions. Typically these public Council member appointees are not able to complete even a single three year term and if they do, the contribution is far less (from a time perspective) than those public members who are retired. In light of this experience, we have asked that government only appoint public members who do not have full time positions and preferably do not have part time positions.
- To help ensure best use of Council public member resources, the Governance Committee is looking at developing a recruitment process to bring on additional public members who are not members

of Council to serve in designated committee positions where there is no legislative requirement to have a public member of Council serve on these committees.

- A move in this direction is positive for a number of reasons. It would expand public involvement in the work of the College. It would also help focus precious public Council member resources in those areas where we are constrained by quorum requirements.

- Under the RHPA and the College By-laws, certain College committees and committee panels are required to have a certain number of LGIC public members. However, the following committees are not required to have LGIC public members:
    - Premises Inspection Committee (PIC)
    - Education Committee
    - Finance Committee
    - Outreach Committee
    - Patient Relations Committee
    - Quality Assurance Committee

- There is currently no overlap in membership between the Patient Relations Committee and the College Council. Two public members serve on the committee (the chair and one other member of the committee) who are not members of the College Council.
- The Premises Inspection Committee is currently having difficulty forming panels to review inspection reports because of a lack of availability of public Council members. In the case of the Premises Inspection Committee they are required to have a public member participate on each panel. The public member does not however have to be a member of the College Council.
- The 2017 Governance Committee suggests that work continue in early 2018 to develop a process to recruit and retain public members who are not on the College Council to help manage the College workload.
- There will be financial implications to this proposal. The government compensates public members of Council for their work. The College would compensate public committee members who are not members of Council (as is the case for the PRC today). Public members of the PRC are compensated at the member rate.

Proposed Next Steps

- The Governance Committee will develop a process to recruit public members who are not public Council members for College committees, focusing first on the Premises Inspection Committee in early 2018.
- The recommended process and appointments approach will be brought to Council for consideration in February 2018.
- Ongoing and focused work with government to address ongoing issues with the public appointments process.

Note: The Governance Committee makes committee nomination recommendations. All committee appointments are made by Council. The Executive Committee can make committee appointments in between meetings of Council.

QUESTION FOR CONSIDERATION:

1. Does Council support the proposed next steps?

FOR DECISION:

Nominations:

3. 2017- 2018 Governance Committee Election

ISSUE:

- There will be an election for one physician member and two public members for the 2017-2018 Governance Committee (if more than one physician member is nominated and more than 2 public members are nominated).
- Two nominations have been received for one physician member position:
    - Dr. Haidar Mahmoud
    - Dr. Jerry Rosenblum
- Two nominations have been received for two public member positions:
    - Mr. John Langs
    - Ms. Joan Powell
- Nomination Statements are included in Appendix A.

DECISION FOR COUNCIL:

1. Vote for elected positions for 2017-2018 Governance Committee; 1 physician member and 2 public members on the Council.

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4. Methadone Specialty Panel: Vice Chair Appointment for 2017-2018

- The Methadone Committee is expected to transition from an independent Committee formed in bylaw to a specialty panel under the Quality Assurance Committee in 2018.
- This will require a by-law amendment to revoke Section 45 of the General By-Law. This by-law amendment is expected to be brought to Council in 2018.
- In the meantime, there is a desire to set up the specialty panel and appoint members to the Quality Assurance Committee for this specialty panel.
- Dr. Meredith MacKenzie has served as Co-chair of the Methadone Committee over the past year.
- The Governance Committee recommends that Dr. Meredith MacKenzie be appointed as 2017-2018 Vice Chair of the Methadone Specialty Panel on the Quality Assurance Committee.

DECISION FOR COUNCIL:

1. Appoint Dr. Meredith MacKenzie as 2017-2018 Vice Chair of the Methadone Specialty Panel on the Quality Assurance Committee.

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5. Committee Membership Appointments for 2017-2018

- The Governance Committee is responsible for recruiting committee members and for making nominations recommendations for committee and chair positions.
- In making these recommendations, the committee follows Council's nominations guidelines contained in the Governance Process Manual: Governance Process Manual[2]
- The Governance Committee identified non-Council committee opportunities mid-year. All non-Council committee member applicants are interviewed. Particular attention is taken to avoid potential apprehension of bias and conflicts.
- As a number of interviews for the new committee positions are pending, the proposed 2017-2018 committee rosters will be circulated to Council closer to the meeting date. It is anticipated that interviews for those committee positions that can be filled with current applicants, will be completed in advance of the November/December AGM.
- The proposed committee membership rosters (as Appendix B) reflect a combination of factors set out in the *Nominations Guidelines* including: competencies; individual preferences; length of time on a committee; and succession planning.
- The Governance Committee works to ensure that every committee has the required expertise to meet statutory duties and other obligations set out in the College's governing legislation and by-laws.

[2] Governance Practices and Policies, Nominations Guidelines, pgs. 44-55

DECISION FOR COUNCIL:

1. Election of nominated committee members to committees as set out in Appendix B. (Appendix B will also be circulated to Council, prior to the annual meeting of Council).

FOR INFORMATION:

6. Completion of Annual Declaration of Adherence Form for 2017-2018

- Council members are asked to read, and then sign and submit your annual Declaration of Adherence Form for 2017-2018. Please provide staff with your Declaration form by the adjournment of the Council meeting on December 1, 2017.
- The purpose of signing the annual Declaration of Adherence Form, on an annual basis, is to ensure that all members of Council understand and adhere to our legislative obligations and respect the by-laws and policies applicable to the Council including the following:
    - Statement on Public Interest
    - Council Code of Conduct
    - Conflict of interest Policy
    - Impartiality in Decision-Making Policy
    - Confidentiality Policy
    - Role Description of a College Council Member
- A copy of the Declaration of Adherence Form (for completion) is attached and the relevant governance policies are linked to the Governance Process Manual (as Appendix C).
- A current copy of the CPSO General By-Law is available on the College's website: General By-Law

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For Completion:

1. All Council members are asked to print, sign and submit their annual Declaration of Adherence Form (Appendix C) at the December Council meeting.

Contact: Joel Kirsh, Chair, Governance Committee
Debbie McLaren, ext. 371
Louise Verity, ext. 466

Date: November 23, 2017

Attachments:

Appendix A: Nomination/Election Process for 2017-2018 Governance Committee Vote at Council meeting, includes *Nomination Statements for*: Dr. Haidar Mahmoud, Dr. Jerry Rosenblum, Mr. John Langs, Ms. Joan Powell
Appendix B: Proposed 2017-2018 Committee Membership Roster
Appendix C: Declaration of Adherence Form

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
MEMORANDUM

To: All Council Members

From: Dr. Joel Kirsh, Chair, Governance Committee

Date: **October 16, 2017**

Subject: **Nomination/Election Process for 2017-2018 Governance Committee Vote at November/December Council Meeting**

At the upcoming Council meeting in November/December, there will be a vote for the three elected positions on the 2017-2018 Governance Committee.

The three elected positions are: one physician member on Council who is not a member of the Executive Committee, and two public members on Council who are not members of the Executive Committee.

The *General By-Law 44-(3)* states the mandate of the Governance Committee: 44-(3) The Governance Committee shall,

(a) monitor the governance process adopted by the Council and report annually to the Council on the extent to which the governance process is being followed;
(b) consider and, if considered advisable, recommend to the Council changes to the governance process;
(c) ensure nominations for the office of president and vice-president
(d) make recommendations to the Council regarding the members and chairs of committees; and
(e) make recommendations to the Council regarding any other officers, officials or other people acting on behalf of the College.

Please refer to the Governance Process Manual for role descriptions and key behavioural competencies that are necessary to fill the positions.

All Council members who wish to be nominated for an elected position on the Governance Committee are invited to submit an optional **Nomination Statement. The Nomination Statement is limited to 200 words**. The **Nomination Statement** will include brief biographical information and a CPSO photo, or alternatively, you may submit your own photo. N**omination Statements that are submitted by the deadline** (set out below) will be circulated to all Council members by e-mail, prior to the November/December Council meeting, and will be included in the Governance Committee Report to Council.

Nomination Statements will assist Council members to identify candidates who are running for election, and provide more information regarding a candidate's background, qualifications and reasons for running for a Governance Committee position.

In addition, to the **Nomination Statement**, a completed ***Nomination Form*** is due on the first day of the Council meeting to validate Council's support of candidates. Each nomination requires the signatures of a nominator, a seconder, and the agreement of the nominee. A Council Contact list will be provided for you to facilitate your communication with Council members.

I have attached a sample **Nomination Statement** template, and the ***Nomination Form*(s).**
If you wish to be nominated for a 2017-2018 Governance Committee position, please contact Debbie McLaren at dmclaren@cpso.on.ca Debbie will complete the section on the **Nomination Statement** form regarding your CPSO work and provide you with a personalized template to fill in your 200 words (or less) statement.

For your reference, a list of the proposed non-elected 2017-2018 Governance Committee members as per the General By-Law, a list of the current composition of the 2017 Governance Committee, and a list of the 2017-2018 Executive Committee membership are attached.

1. **The deadline for submission of your completed Nomination Statement is: Friday, November 3, 2017 at 5:00 p.m.**
2. **The deadline for submission of your completed *Nomination Form (this Form includes your signature for nomination and signatures of your mover and seconder)* is Thursday, November 30, 2017, prior to the commencement of the Council meeting.**
3. **The vote (if applicable) will take place at the Council meeting on Friday, December 1, 2017.**

Election Process:

1. If there is more than one nomination for the position of physician member and/or more than two nominations for the 2 positions of public member on the Governance Committee, a vote will take place at the Council meeting on the second day.

2. Each nominee will have the opportunity to address Council, if they wish, for a maximum of two minutes about his/her candidacy for the position before the vote takes place. Audio/visual presentations will not be accepted.

3. 2017-2018 Council members will vote for Governance Committee positions.

If you have any questions regarding the nomination process, please contact Debbie McLaren at dmclaren@cpso.on.ca or by phone: 416-967-2600, ext. 371 or toll free: 1-800-268-7096, ext. 371.

Thank you,

Joel A. Kirsh MD, MHCM, FRCPC
Chair, Governance Committee

att.

2017 (current) Governance Committee:

Dr. Joel Kirsh, (Past President), Chair ♦×
Dr. David Rouselle, (President) ♦
Dr. Steven Bodley, (Vice President) ♦
Dr. Brenda Copps (Physician Member) *(ineligible for 2018)*
Mr. John Langs (has served for 1 year)
Ms. Joan Powell (has served for 1 year)

Proposed 2017-2018 Governance Committee:

Dr. David Rouselle, (Past President), Chair ♦×
Dr. Steven Bodley (President)♦
Dr. Peeter Poldre (Vice President)♦
Physician member of Council (voted by Council)*
Public member of Council (voted by Council)*
Public member of Council (voted by Council)*

♦The Governance Committee is composed of, the president, the vice-president and a past president as per the *General By-Law 44.-(1)(a)*

*A physician member of Council and two public members of Council who are appointed by Council at the annual meeting, and are not members of the Executive Committee as per the *General By-Law 44.-(1)(b) and 44.-(1)(c)*

×A past president chairs the Governance Committee as per the *General By-Law, 44(2)*

2017-2018 Executive Committee:

(appointed by Council at the May 2017 Council meeting)
(Physician member and two public members on the Executive Committee are not eligible for 2017-2018 Governance Committee)

Dr. Steven Bodley, (President)
Dr. Peeter Poldre, (Vice President)
Dr. Brenda Copps, (Physician Member)
Ms. Lynne Cram, (Public Member)
Mr. Pierre Giroux, (Public Member
Dr. David Rouselle, (Past President)

GOVERNANCE COMMITTEE NOMINATION FORM

FOR PHYSICIAN MEMBER ON THE GOVERNANCE COMMITTEE:

I_____am willing to be
Print name here

nominated for the Physician Member on the Governance Committee.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

GOVERNANCE COMMITTEE NOMINATION FORM

FOR THE 2 PUBLIC MEMBERS ON THE GOVERNANCE COMMITTEE:

(You may nominate 1 or 2)

I_____ am willing to be
Print name here

nominated for the Public Member on the Governance Committee.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

Please fill out below for 2nd public member if you are nominating 2 public members.

I_____ am willing to be
Print name here

nominated for the Public Member on the Governance Committee.

Signed: _____ _____
Signature of Nominee ***Date***

Nominated by: _____ _____
Signature ***Date***

Seconded by: _____ _____
Signature ***Date***

DR. HAIDAR MAHMOUD

District 10 Representative
Toronto, Ontario

Principal Area of Practice or Specialty:
Obstetrics and Gynecology

Elected Council Terms:
2014-2017
2017-2020

CPSO Committees/Positions Held and Other CPSO Work:

Inquiries, Complaints and Reports Committee	2014 – 2017
Peer Assessor	2004 – 2014 (as non-Council member)

NOMINATION STATEMENT:

As a District 10 Council member, I am exceptionally committed to the Council, ensuring the provision of the highest quality service.

My ICRC involvement developed my communication and leadership, as I critically engaged with policy and governance issues. As a safeguard, the ICRC allows the highest calibre of provided service, ensuring physicians and the public are protected and treated fairly. The implemented policies reflect the best interests of the physician community.

Education and betterment are crucial to stay ahead of any changes. The debate surrounding medically assisted death was a pivotal moment, allowing me to contribute to the development of healthcare, crucially engaging in governance and policy-making. My Masters Certification on Patient Safety and Quality Assurance positioned me to ensure that we keep striving towards excellence. Along with my experiences as Departmental Chief, I will bring real and achievable goals by properly planning successful program implementation, maintaining the standard of practice.

My commitment to the CPSO's values will allow me to continue providing the highest quality services that will meet the needs of the public and our members as they develop, as I serve on the Governance Committee.

DR. JERRY ROSENBLUM

District 3 Representative
Waterloo, Ontario

Principal Area of Practice or Specialty:
Anesthesiology

Elected Council Terms:
2013-2016
2016-2019

CPSO Committees/Positions Held and Other CPSO Work:

Finance Committee:	2014 – 2017
Inquiries, Complaints and Reports Committee	2013 – 2017 2010 – 2013 (as non-council member)
Outreach Committee	2014 – 2017
Medical Review Committee	2001 – 2004 (as non-council member)
Patient Relations Committee	1996 – 2000 (as non-council member)
Peer Assessor	2004 – 2010 (as non-council member)

NOMINATION STATEMENT:

The upcoming year will be eventful and crucial for the College in general and the Governance Committee in particular. Externally, with implementation of Bill 87 and internally with the retirement of the registrar, the election of members to the Governance Committee will have an even more significant impact.

My proven dedication, experience, skill and motivation qualify me to serve effectively and competently on the Governance Committee.

I have taken leadership roles in my local medical community, serving on the executive of the anesthesia department, and the executive of the Medical Staff Association. I have been involved with the CPSO for almost 21 years. I have been a member of 5 committees, worked as a peer assessor, and sat on Council for the past four years (and counting). From this experience, I have gained knowledge of CPSO governance and have developed skills in working co-operatively and effectively in committees.

My organizational, communication and analytical skills and my passion for governance make me the ideal candidate for this position.

I am asking for your support in the upcoming vote for physician member of the Governance Committee.

MR. JOHN LANGS

Public Member of Council
Toronto, Ontario

Occupation: Lawyer

Appointed Council Terms:
2014 – 2017
2017 – 2020

CPSO Committees and Other CPSO Work:

Discipline Committee:	2014-2017
Governance Committee	2016-2017
Outreach Committee:	2015-2017
Quality Assurance Committee:	2014-2017
Policy Working Group : *Accepting New Patients / Ending the Physician-Patient Relationship*	2015- present

NOMINATION STATEMENT:

I am just completing my first year on the Governance Committee, and I would appreciate your support for my nomination for a second one-year term.

This year, will be a significant year of transition on a number of fronts for the College, including implementation of new legislation, which will have a direct impact on the College and its Governance processes.

I would welcome the opportunity to continue on the Governance Committee using my experience of the past year as we face many new challenges.

MS. JOAN POWELL

Public Member of Council
Thunder Bay, Ontario

Occupation: Director of Education (retired)

Appointed Council Terms:
2015 – 2018

CPSO Committees and Other CPSO Work:

Education Committee	2016-2017
Governance Committee	2017
Inquiries, Complaints and Reports Committee:	2015-2017
Registration Committee:	2015-2017
Policy Working Group : *Continuity of Care* and *Test Results Management*	October 2016 - present

NOMINATION STATEMENT:

This year, I served on the Governance Committee from March to present. I found the work to be very interesting and rewarding, and I would be happy to continue to serve on the committee as the Public Member for 2018.

As many of you know, my career was spent in education. I have worked as a classroom teacher, Vice-Principal, Principal, Superintendent of Schools, and most recently, Director of Education. As Director, I was the Chief Education Officer and Chief Executive Officer, reporting to an elected Board of Trustees. I was responsible for providing leadership for growth in student achievement and well-being; and for the operations and strategic direction of a school board comprised of 20 schools, serving 7500 students (JK to Grade 12), with 1100 employees and a $95 million budget.

I believe that my experience in educational governance, along with my work on this year's committee, has prepared me well for continued service on the Governance Committee.

COUNCIL AWARD SELECTION COMMITTEE:

COUNCIL MEMBERS:	
Dr. David Rouselle	**Chair**
Dr. Steven Bodley	
Ms. Lynne Cram	
NON-COUNCIL MEMBERS:	
Dr. Joel Kirsh	
Dr. Carol Leet	

DISCIPLINE COMMITTEE:

COUNCIL MEMBERS:	
Ms. Debbie Giampietri	**Co-chair**
Dr. Philip Berger	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Dr. Paul Hendry	
Major Abdul Khalifa	
Mr. John Langs	
Dr. Barbara Lent	
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Dr. Dennis Pitt	
Dr. Peeter Poldre	
Dr. John Rapin	
Dr. Patrick Safieh	
Dr. Elizabeth Samson	
Ms. Gerry Sparrow	
Dr. Andrew Turner	
Dr. Scott Wooder	
NON-COUNCIL MEMBERS:	
Dr. Carole Clapperton	**Co-chair**
Dr. Ida Ackerman	
Dr. Vinita Bindlish	
Dr. Pamela Chart	
Dr. Paul Casola	
Dr. Melinda Davie	
Dr. Marc Gabel	
Dr. Paul Garfinkel	

DISCIPLINE COMMITTEE: (continued)

Dr. Kristen Hallett
Dr. William L.M. King
Dr. Bill McCready
Dr. Veronica Mohr
Dr. Tracey Moriarity
Dr. Joanne Nicholson
Dr. Harvey Schipper
Dr. Robert Sheppard
Dr. Fay Sliwin
Dr. Eric Stanton
Dr. Peter Tadros
Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Sheila-Mae Young
Dr. Paul Ziter

EDUCATION COMMITTEE:

COUNCIL MEMBERS:	
Dr. Akbar Panju	Chair
Dr. Brenda Copps	
Dr. Paul Hendry	
Dr. Barbara Lent	
Ms. Joan Powell	
NON-COUNCIL MEMBERS:	
Dr. Mary Bell	
Dr. Suzan Schneeweiss	CPD:COFM
Dr. Robert Smith	
Dr. Janet Van Vlymen	

EXECUTIVE COMMITTEE:
(appointed at May 2017 Council Meeting to commence at 2017-2018 Council session)

COUNCIL MEMBERS:	
Dr. Steven Bodley	President/Chair
Dr. Brenda Copps	
Ms. Lynne Cram	
Mr. Pierre Giroux	
Dr. Peeter Poldre	Vice President
Dr. David Rouselle	Past President

FINANCE COMMITTEE:

COUNCIL MEMBERS:	
Mr. Peter Pielsticker	Chair
Dr. Steven Bodley	
Mr. Pierre Giroux	
Mr. Harry Erlichman	
Dr. Peeter Poldre	
Dr. Jerry Rosenblum	
NON-COUNCIL MEMBER:	
Dr. Thomas Bertoia	

FITNESS TO PRACTISE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Dennis Pitt	Chair
Ms. Debbie Giampietri	
Dr. Deborah Hellyer	
Major Abdul Khalifa	
Dr. Barbara Lent	
NON-COUNCIL MEMBERS:	
Dr. Pamela Chart	
Dr. Carole Clapperton	
Dr. Melinda Davie	
Dr. Marc Gabel	
Dr. Paul Garfinkel	
Dr. William L.M. King	
Dr. Bill McCready	
Dr. Tracey Moriarity	
Dr. Robert Sheppard	
Dr. Eric Stanton	
Dr. John Watts	
Dr. Paul Ziter	

GOVERNANCE COMMITTEE:

COUNCIL MEMBERS:	
Dr. David Rouselle	Chair
Dr. Steven Bodley	
Dr. Peeter Poldre	

GOVERNANCE COMMITTEE: (continued)

Physician member of Council	**Council to vote on Dec 1, 2017**
Public member of Council	**Council to vote on Dec 1, 2017**
Public member of Council	**Council to vote on Dec 1, 2017**

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE:

COUNCIL MEMBERS:	
Dr. David Rouselle	**Chair**
Ms. Lynne Cram	**Co-Vice Chair, General Panels**
Mr. Harry Erlichman	**Co-Vice Chair, General Panels**
Ms. Joan Fisk	
Dr. Rob Gratton	
Dr. Haidar Mahmoud	
Ms. Judy Mintz	
Dr. Akbar Panju	**Vice Chair, Internal Medicine**
Dr. Judith Plante	
Ms. Joan Powell	
Dr. Jerry Rosenblum	
Mr. Emile Therien	***Appointment ends Dec. 31-17***
NON-COUNCIL MEMBERS:	
Dr. George Arnold	
Dr. Haig Basmajian	
Dr. Mary Bell	
Dr. Harvey Blankenstein	
Dr. Brian Burke	**Vice Chair, Mental Health & Health Inquiry Panel**
Dr. Bob Byrick	
Dr. Angela Carol	
Dr. Anil Chopra	
Dr. Nazim Damji	
Dr. Naveen Dayal	
Dr. William Dunlop	
Dr. James Edwards	**Co-Vice Chair, Settlement Panels**
Dr. Daniel Greben	
Dr. Andrew Hamilton	
Dr. Christine Harrison	

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE: (continued)

Dr. Keith Hay	
Dr. Elaine Herer	
Dr. Robert Hollenberg	
Dr. Nasimul Huq	
Dr. Francis Jarrett	
Dr. John Jeffrey	
Dr. Carol Leet	Co-Vice Chair, Settlement Panels
Dr. Edith Linkenheil	Vice Chair, Obstetrical
Dr. Jack Mandel	
Dr. Edward Margolin	
Dr. Bill McCauley	
Dr. Robert McMurtry	
Dr. Patrick McNamara	
Dr. Dale Mercer	Vice Chair, Surgical
Dr. Lawrence Oppenheimer	
Dr. Peter Prendergast	
Dr. Anita Rachlis	
Dr. Nathan Roth	
Dr. Ken Shulman	
Dr. Wayne Spotswood	
Dr. Michael Szul	
Dr. Lynne Thurling	
Dr. Donald Wasylenki	
Dr. Stephen White	
Dr. Stephen Whittaker	Vice Chair, Family Practice
Dr. Lesley Wiesenfeld	
Dr. Jim Wilson	

OUTREACH COMMITTEE:

COUNCIL MEMBERS:	
Ms. Lynne Cram	Chair
Dr. Steven Bodley	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Mr. John Langs	
Dr. Peeter Poldre	
Dr. Jerry Rosenblum	
Dr. David Rouselle	
Ms. Gerry Sparrow	

PATIENT RELATIONS COMMITTEE:

NON-COUNCIL MEMBERS:	
Ms. Lisa McCool-Philbin	Chair
Dr. Philip Cheifetz	
Dr. Timothy Frewen	
Ms. Julie Kirkpatrick	

PREMISES INSPECTION COMMITTEE:

COUNCIL MEMBERS:	
Dr. Dennis Pitt	Chair
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Dr. Jerry Rosenblum	
Dr. Andrew Turner	

NON-COUNCIL MEMBERS:
Dr. Bob Byrick
Dr. Wayne Carman
Dr. John Davidson
Dr. Bill Dixon
Dr. Marjorie Dixon
Dr. Pawan Kumar
Dr. Gillian Oliver
Dr. James Watson

QUALITY ASSURANCE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	Co-chair
Ms. Debbie Giampietri	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Mr. John Langs	
Mr. Peter Pielsticker	
Dr. Patrick Safieh	
Dr. Barbara Lent	*Methadone Specialty Panel*

QUALITY ASSURANCE COMMITTEE: (continued)

NON-COUNCIL MEMBERS:	
Dr. Deborah Robertson	Co-chair
Dr. Jacques Dostaler	
Dr. Miriam Ghali Eskander	
Dr. Natasha Graham	
Dr. Hugh Kendall	
Dr. Bill McCready	
Dr. Bernard Seguin	
Dr. Robert Smith	
Dr. Leslie Solomon	
Dr. Tina Tao	
Dr. Smiley Tsao	
Dr. Janet Van Vlymen	
Dr. James Watters	
Dr. Meredith MacKenzie	Vice Chair, *Methadone Specialty Panel*
Dr. Lisa Bromley	*Methadone Specialty Panel*
Dr. Michael Franklyn	*Methadone Specialty Panel*
Dr. Trevor Gillmore	*Methadone Specialty Panel*

REGISTRATION COMMITTEE:

COUNCIL MEMBERS:	
Dr. Akbar Panju	Chair
Mr. Harry Erlichman	
Dr. Barbara Lent	
Dr. Judith Plante	
Ms. Joan Powell	

NON-COUNCIL MEMBERS:
Dr. Bob Byrick
Dr. John Jeffrey
Dr. Jay Rosenfield

Declaration of Adherence Form for Members of Council - 2017-2018

I acknowledge that, as a **member of Council** of the College of Physicians and Surgeons of Ontario:

- I have read and am familiar with the College's By-laws General By-Law and governance policies. Governance Process Manual[3]

- I stand in a fiduciary relationship to the College.

- I am bound to adhere to and respect the By-laws and policies applicable to the Council, including without limitation, the following:

    - Statement on Public Interest
    - Council Code of Conduct
    - Conflict of Interest Policy
    - Impartiality in Decision Making Policy
    - Confidentiality Policy
    - Role Description of College Council Member

- I am aware of the obligations imposed upon me by Sections 36 (1) (a) through 36 (1) (k) of the *Regulated Health Professions Act, 1991*.
- I have also read Section 40 (2) of the *Regulated Health Professions Act*, 1991, a copy of which is attached to this undertaking, and understand that it is an offence, carrying a maximum fine on conviction for a first offence of $25,000.00, and a fine of not more than $50,000 for a second or subsequent offence to contravene subsection 36 (1) of the *Regulated Health Professions Act, 1991*. I understand that this means in addition to any action the College or others may take against me, I could be convicted of an offence if I communicate confidential information in contravention of subsection 36 (1) of the *Regulated Health Professions Act, 1991*, and if convicted, I may be required to pay a fine of up to $25,000.00 (for a first offence), and a fine of not more than $50,000 for a second or subsequent offence.

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

_____

_____

_____

Signature: _____
Print Name: _____
Date: _____

[3] See Governance Process Manual, pages 58-76 for governance policies listed, and pages 9-12 for Role Description of a College Council Member.

Council Briefing Note - Addendum

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: Governance Committee Report - Addendum

FOR DECISION:

1. **Committee Appointment: Dr. Thomas Faulds for appointment to 2017-2018 ICR Committee**
2. **Appointment of 2017-2018 Methadone Committee**

FOR DECISION:

1. Committee Appointment: Dr. Thomas Faulds for appointment to 2017-2018 ICR Committee

- Dr. Thomas Faulds was interviewed by the Governance Committee, and 2 members of the ICR leadership team on November 21, 2017.
- The Governance Committee recently met to consider Dr. Fauld's nomination to the 2017-2018 ICR Committee.
- The Governance Committee recommends that Dr. Thomas Faulds be appointed to the 2017-2018 ICR Committee.
- The 2017-2018 Proposed Committee Roster has been revised to reflect Dr. Fauld's nomination to the ICR Committee (see Appendix A).

2. Appointment of 2017-2018 Methadone Committee

Background:

- One component of the College Opioid Strategy is the planned transition of the Methadone Committee (currently a By-law committee) to a specialty panel of the Quality Assurance Committee (QAC).
- It was originally intended that a motion to rescind the Methadone Committee (by amending the General By-law) would be brought to December Council.
- Methadone Committee staff have been working to ensure that all details related to the transition are addressed. This includes ongoing management of existing methadone related member specific issues. As a result, a decision was made to postpone bringing the motion for the by-law amendment to the December Council to allow the current outstanding MSI matters to be dealt with.

- On a teleconference, held on November 29, 2017, the Governance Committee was informed that as a result of the above information, a 2018 Methadone Committee needs to be appointed at the annual meeting of Council.
- The Governance Committee recommends to Council that the following members be appointed to the 2018 Methadone Committee. The membership is consistent with the proposed membership on the Methadone Specialty Panel of the Quality Assurance Committee.
- The Governance Committee also recommends that Dr. MacKenzie be appointed as Chair.:

    - Dr. Lisa Bromley
    - Dr. Michael Franklyn
    - Dr. Trevor Gillmore
    - Dr. Barbara Lent
    - Dr. Meredith MacKenzie (Chair)

DECISIONS FOR COUNCIL:

1. Appoint Dr. Thomas Faulds to the 2017-2018 ICR Committee.
2. Appoint Dr. Lisa Bromley, Dr. Michael Franklyn, Dr. Trevor Gillmore, Dr. Barbara Lent and Dr. Meredith MacKenzie to the 2017-2018 Methadone Committee.
3. Appoint Dr. Meredith MacKenzie as Chair of the 2017-2018 Methadone Committee.

Contact: Joel Kirsh, Chair, Governance Committee
Debbie McLaren, ext. 371
Louise Verity, ext. 466

Date: November 29, 2017

Attachments:

Appendix A: Revised Proposed 2017-2018 Committee Membership Roster

COUNCIL AWARD SELECTION COMMITTEE:

COUNCIL MEMBERS:	
Dr. David Rouselle	Chair
Dr. Steven Bodley	
Ms. Lynne Cram	
NON-COUNCIL MEMBERS:	
Dr. Joel Kirsh	
Dr. Carol Leet	

DISCIPLINE COMMITTEE:

COUNCIL MEMBERS:	
Ms. Debbie Giampietri	Co-chair
Dr. Philip Berger	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Dr. Paul Hendry	
Major Abdul Khalifa	
Mr. John Langs	
Dr. Barbara Lent	
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Dr. Dennis Pitt	
Dr. Peeter Poldre	
Dr. John Rapin	
Dr. Patrick Safieh	
Dr. Elizabeth Samson	
Ms. Gerry Sparrow	
Dr. Andrew Turner	
Dr. Scott Wooder	
NON-COUNCIL MEMBERS:	
Dr. Carole Clapperton	Co-chair
Dr. Ida Ackerman	
Dr. Vinita Bindlish	
Dr. Pamela Chart	
Dr. Paul Casola	
Dr. Melinda Davie	
Dr. Marc Gabel	
Dr. Paul Garfinkel	

DISCIPLINE COMMITTEE: (continued)

Dr. Kristen Hallett
Dr. William L.M. King
Dr. Bill McCready
Dr. Veronica Mohr
Dr. Tracey Moriarity
Dr. Joanne Nicholson
Dr. Harvey Schipper
Dr. Robert Sheppard
Dr. Fay Sliwin
Dr. Eric Stanton
Dr. Peter Tadros
Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Sheila-Mae Young
Dr. Paul Ziter

EDUCATION COMMITTEE:

COUNCIL MEMBERS:	
Dr. Akbar Panju	Chair
Dr. Brenda Copps	
Dr. Paul Hendry	
Dr. Barbara Lent	
Ms. Joan Powell	
NON-COUNCIL MEMBERS:	
Dr. Mary Bell	
Dr. Suzan Schneeweiss	CPD:COFM
Dr. Robert Smith	
Dr. Janet Van Vlymen	

EXECUTIVE COMMITTEE:
(appointed at May 2017 Council Meeting to commence at 2017-2018 Council session)

COUNCIL MEMBERS:	
Dr. Steven Bodley	President/Chair
Dr. Brenda Copps	
Ms. Lynne Cram	
Mr. Pierre Giroux	
Dr. Peeter Poldre	Vice President
Dr. David Rouselle	Past President

FINANCE COMMITTEE:

COUNCIL MEMBERS:	
Mr. Peter Pielsticker	Chair
Dr. Steven Bodley	
Mr. Pierre Giroux	
Mr. Harry Erlichman	
Dr. Peeter Poldre	
Dr. Jerry Rosenblum	
NON-COUNCIL MEMBER:	
Dr. Thomas Bertoia	

FITNESS TO PRACTISE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Dennis Pitt	Chair
Ms. Debbie Giampietri	
Dr. Deborah Hellyer	
Major Abdul Khalifa	
Dr. Barbara Lent	
NON-COUNCIL MEMBERS:	
Dr. Pamela Chart	
Dr. Carole Clapperton	
Dr. Melinda Davie	
Dr. Marc Gabel	
Dr. Paul Garfinkel	
Dr. William L.M. King	
Dr. Bill McCready	
Dr. Tracey Moriarity	
Dr. Robert Sheppard	
Dr. Eric Stanton	
Dr. John Watts	
Dr. Paul Ziter	

GOVERNANCE COMMITTEE:

COUNCIL MEMBERS:	
Dr. David Rouselle	Chair
Dr. Steven Bodley	
Dr. Peeter Poldre	

GOVERNANCE COMMITTEE: (continued)

Physician member of Council	**Council to vote on Dec 1, 2017**
Public member of Council	**Council to vote on Dec 1, 2017**
Public member of Council	**Council to vote on Dec 1, 2017**

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE:

COUNCIL MEMBERS:	
Dr. David Rouselle	**Chair**
Ms. Lynne Cram	**Co-Vice Chair, General Panels**
Mr. Harry Erlichman	**Co-Vice Chair, General Panels**
Ms. Joan Fisk	
Dr. Rob Gratton	
Dr. Haidar Mahmoud	
Ms. Judy Mintz	
Dr. Akbar Panju	**Vice Chair, Internal Medicine**
Dr. Judith Plante	
Ms. Joan Powell	
Dr. Jerry Rosenblum	
Mr. Emile Therien	***Appointment ends Dec. 31-17***
NON-COUNCIL MEMBERS:	
Dr. George Arnold	
Dr. Haig Basmajian	
Dr. Mary Bell	
Dr. Harvey Blankenstein	
Dr. Brian Burke	**Vice Chair, Mental Health & Health Inquiry Panel**
Dr. Bob Byrick	
Dr. Angela Carol	
Dr. Anil Chopra	
Dr. Nazim Damji	
Dr. Naveen Dayal	
Dr. William Dunlop	
Dr. James Edwards	**Co-Vice Chair, Settlement Panels**
Dr. Thomas Faulds	
Dr. Daniel Greben	
Dr. Andrew Hamilton	
Dr. Christine Harrison	

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE: (continued)

Dr. Keith Hay	
Dr. Elaine Herer	
Dr. Robert Hollenberg	
Dr. Nasimul Huq	
Dr. Francis Jarrett	
Dr. John Jeffrey	
Dr. Carol Leet	Co-Vice Chair, Settlement Panels
Dr. Edith Linkenheil	Vice Chair, Obstetrical
Dr. Jack Mandel	
Dr. Edward Margolin	
Dr. Bill McCauley	
Dr. Robert McMurtry	
Dr. Patrick McNamara	
Dr. Dale Mercer	Vice Chair, Surgical
Dr. Lawrence Oppenheimer	
Dr. Peter Prendergast	
Dr. Anita Rachlis	
Dr. Nathan Roth	
Dr. Ken Shulman	
Dr. Wayne Spotswood	
Dr. Michael Szul	
Dr. Lynne Thurling	
Dr. Donald Wasylenki	
Dr. Stephen White	
Dr. Stephen Whittaker	Vice Chair, Family Practice
Dr. Lesley Wiesenfeld	
Dr. Jim Wilson	

METHADONE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Barbara Lent	
NON-COUNCIL MEMBERS:	
Dr. Meredith MacKenzie	Chair
Dr. Lisa Bromley	
Dr. Michael Franklyn	
Dr. Trevor Gillmore	

OUTREACH COMMITTEE:

COUNCIL MEMBERS:	
Ms. Lynne Cram	Chair
Dr. Steven Bodley	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Mr. John Langs	
Dr. Peeter Poldre	
Dr. Jerry Rosenblum	
Dr. David Rouselle	
Ms. Gerry Sparrow	

PATIENT RELATIONS COMMITTEE:

NON-COUNCIL MEMBERS:	
Ms. Lisa McCool-Philbin	Chair
Dr. Philip Cheifetz	
Dr. Timothy Frewen	
Ms. Julie Kirkpatrick	

PREMISES INSPECTION COMMITTEE:

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Dr. Dennis Pitt	Chair
Ms. Ellen Mary Mills	
Mr. Peter Pielsticker	
Dr. Jerry Rosenblum	
Dr. Andrew Turner	

NON-COUNCIL MEMBERS:
Dr. Bob Byrick
Dr. Wayne Carman
Dr. John Davidson
Dr. Bill Dixon
Dr. Marjorie Dixon
Dr. Pawan Kumar
Dr. Gillian Oliver
Dr. James Watson

QUALITY ASSURANCE COMMITTEE:

COUNCIL MEMBERS:	
Dr. Brenda Copps	Co-chair
Ms. Debbie Giampietri	
Mr. Pierre Giroux	
Dr. Deborah Hellyer	
Mr. John Langs	
Mr. Peter Pielsticker	
Dr. Patrick Safieh	
Dr. Barbara Lent	*Methadone Specialty Panel*
NON-COUNCIL MEMBERS:	
Dr. Deborah Robertson	Co-chair
Dr. Jacques Dostaler	
Dr. Miriam Ghali Eskander	
Dr. Natasha Graham	
Dr. Hugh Kendall	
Dr. Bill McCready	
Dr. Bernard Seguin	
Dr. Robert Smith	
Dr. Leslie Solomon	
Dr. Tina Tao	
Dr. Smiley Tsao	
Dr. Janet Van Vlymen	
Dr. James Watters	
Dr. Meredith MacKenzie	Vice Chair, *Methadone Specialty Panel*
Dr. Lisa Bromley	*Methadone Specialty Panel*
Dr. Michael Franklyn	*Methadone Specialty Panel*
Dr. Trevor Gillmore	*Methadone Specialty Panel*

REGISTRATION COMMITTEE:

COUNCIL MEMBERS:	
Dr. Akbar Panju	Chair
Mr. Harry Erlichman	
Dr. Barbara Lent	
Dr. Judith Plante	
Ms. Joan Powell	

REGISTRATION COMMITTEE (continued):

NON-COUNCIL MEMBERS:
Dr. Bob Byrick
Dr. John Jeffrey
Dr. Jay Rosenfield

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Discipline Committee Annual Committee Report 2017

REPORT OF THE DISCIPLINE COMMITTEE

Discipline Committee Objectives

In keeping with Council's strategic priority to optimize the discipline process, the Discipline Committee's objectives are aimed at the effectiveness and efficiency of the discipline process, while ensuring fairness.

Fairness, transparency and accountability are core values of the discipline process.

To further these values and Council's strategic priority, the objectives of the Discipline Committee are to:

- **I.** Provide orientation and specialized education to committee members;
- **II.** Review committee processes, practices and procedures to improve the timeliness and efficiency of hearings, while ensuring fairness;
- **III.** Improve timeliness and enhance the quality of committee decisions;
- **IV.** Improve transparency and communication of committee activities and decisions.
- **V.** Review Costs and Expenditures

I. Orientation and Specialized Education Sessions

In 2017, the Discipline Committee delivered the following training sessions:

New Member Orientation	January 19 and 20, 2017 March 3 and October 23, 2017
Decision Writing	February 10, 2017
Chairing Case Conferences / Hearings	March 10, 2017

Business Meetings

The Discipline Committee also employs biannual business meetings to provide education on hearing topics, policies and practices of the Committee and the College and the decisions of other committees, tribunals and courts. As well, the Committee reviews its performance against the hearings and decision benchmarks and its rules of procedure. Business meetings were held on May 23 and October 25, 2017.

a) Social Context Education

The Discipline Committee's social context education regarding equality, diversity and the adjudicative role is continuing.

At decision training in February 2017, Professor Rosemary Cairns Way, professor of criminal law, constitutional law and legal theory with the Faculty of Law at the University of Ottawa and senior educator at the National Judicial Institute, presented to the Committee regarding what regulators can learn from the November 29, 2016 Report of the Inquiry Committee of the Canadian Judicial Council regarding the Honourable Justice Robin Camp.

In May 2017, Ms Amanda Dale, Executive Director, Barbara Schlifer Commemorative Clinic, presented regarding the clinic's role in providing legal representation, professional counselling and multilingual interpretation to women who have experienced abuse.

In October 2017, Dr. Ken Lee, Canadian Mental Health Association Medical Clinic, London, provided an update on street drugs, community opioid programs and front-line medical response to drug overdose and addiction.

b) Protecting Patients Act, 2017

The Discipline Committee considered its process and practices in light of the changes made to the *Regulation Health Professions Act, 1991* pursuant to the *Protecting Patients Act, 2017*, which came into force on May 30, 2017.

c) Case Rounds

A standing item at Discipline Committee business meetings is case rounds to discuss court cases, cases from other colleges and appropriate Discipline Committee cases (appeal waived or appeal period expired) that raise learning points or practice and procedure before or within the Committee.

II. Processes, Practices and Timelines

The Discipline Committee reviews continually its processes, practices and timelines.

a) Stages of the Discipline Process

The stages of the discipline process are:

- Referral of the matter by the Inquiries, Complaints and Reports Committee

- Reciprocal Disclosure (for cases referred as of August 1, 2016)
- Pre-hearing processes, including case management conferences and pre-hearing conferences
- Resolution resulting in withdrawal or an uncontested hearing
- Hearing
- Written Decision and Reasons for Decision

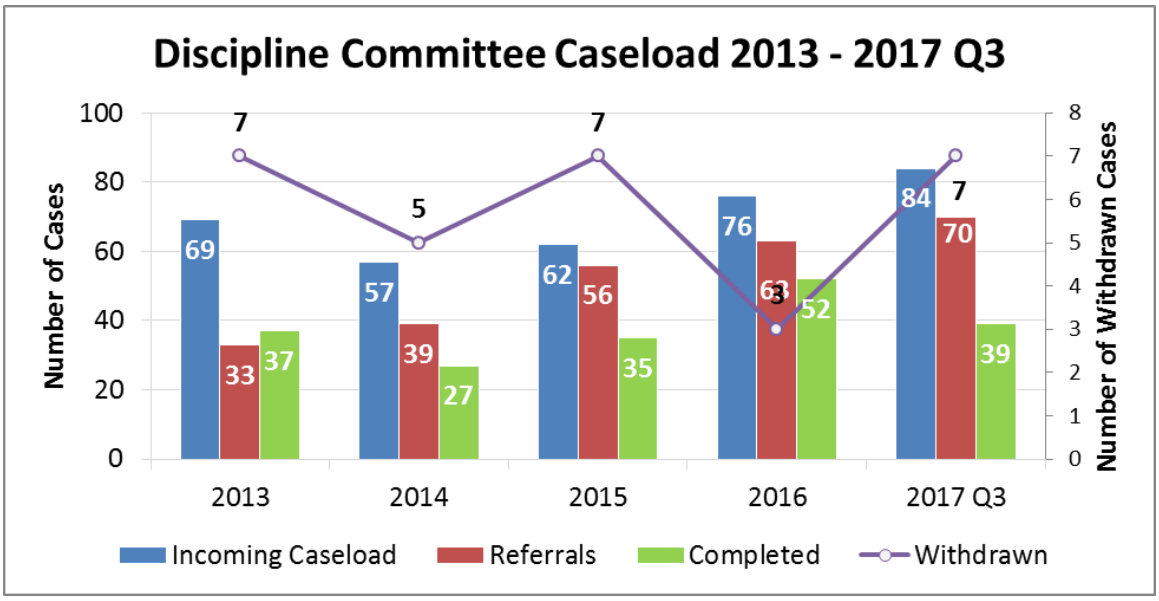
The Discipline Committee manages each case from the time of referral to decision.

b) Caseload

There has been a 79% increase in the number of referrals to the Discipline Committee since 2014.

The Committee increased the number of closed cases by 94% from 2014 to 2016.

However, the influx of cases is exceeding the number of cases completed and there has been a 74% increase in the caseload from 2014 to 2017 Q3.



As of 2017 Q3, 108 cases were before the Committee, comprising one motion to vary, three applications for reinstatement and 104 cases of allegations of professional misconduct and / or incompetence. Of the 104 cases, 38% relate to allegations of sexual abuse or sexual impropriety, 29% to allegations of failing to maintain the standard of practice and/or incompetence, 30% to allegations of disgraceful, dishonourable or unprofessional conduct, and 3% to allegations of found guilty of offence relevant to the member's suitability to practice. These cases are in various process stages – 43% pre-hearing, 39% hearing, 12% decision and 6% adjourned or on hold pending the conclusion of a concurrent proceeding.

As of 2017 Q3, forty physicians against whom allegations of professional misconduct and / or incompetence were referred (38%) were subject to an interim order under s.37 or s.25.4 of the *Code* or an interim undertaking (six s.37 suspensions, nineteen s.37 restrictions and fifteen undertakings) pending disposition of the case by the Discipline Committee. The Committee is required to give precedence to these cases.

There continue to be complex, contested hearings involving motions before and during the hearing.

c) Managing the Caseload

In managing its cases, the Committee must balance process efficiency, effectiveness and fairness. Recognizing that there will always be a percentage of cases that for legitimate reasons take longer to commence and complete, the Committee's aim is to eliminate *unreasonable* delay in the hearings process and, in doing so, to reduce case time span.

The Committee put into effect a Practice Direction on Requests for Adjournment on May 20, 2013 and a Practice Direction on Case Management on January 6, 2014.

i) Case Management Conferences and Pre-Hearing Conferences

Seven members of the Discipline Committee conduct case management conferences (CMCs) and pre-hearing conferences (PHCs): Dr. Carole Clapperton, Dr. Pamela Chart, Dr. Melinda Davie, Dr. Marc Gabel, Dr. William King, Dr. Barbara Lent, and Dr. John Watts.

Case Management Conferences (CMCs)

CMCs provide enhanced committee oversight of cases throughout the discipline process and are conducted typically by teleconference.

Pursuant to the Practice Direction on Case Management, the Committee is conducting three types of CMCs:

1. Early Case Management Conference (Early CMC): An Early CMC is scheduled if a pre-hearing conference (PHC) is not scheduled within 120 days of referral. The purpose of the Early CMC is to determine what steps need to be taken for an effective PHC to take place and if appropriate, to schedule a date for the PHC.

2. Interim Case Management Conference (Interim CMC): Interim CMCs may be scheduled after a PHC, as the needs of the case require.

3. Hearing Case Management Conference (Hearing CMC): Hearing CMCs are scheduled three weeks before the commencement of a contested multiple-day hearing to identify any new issues,

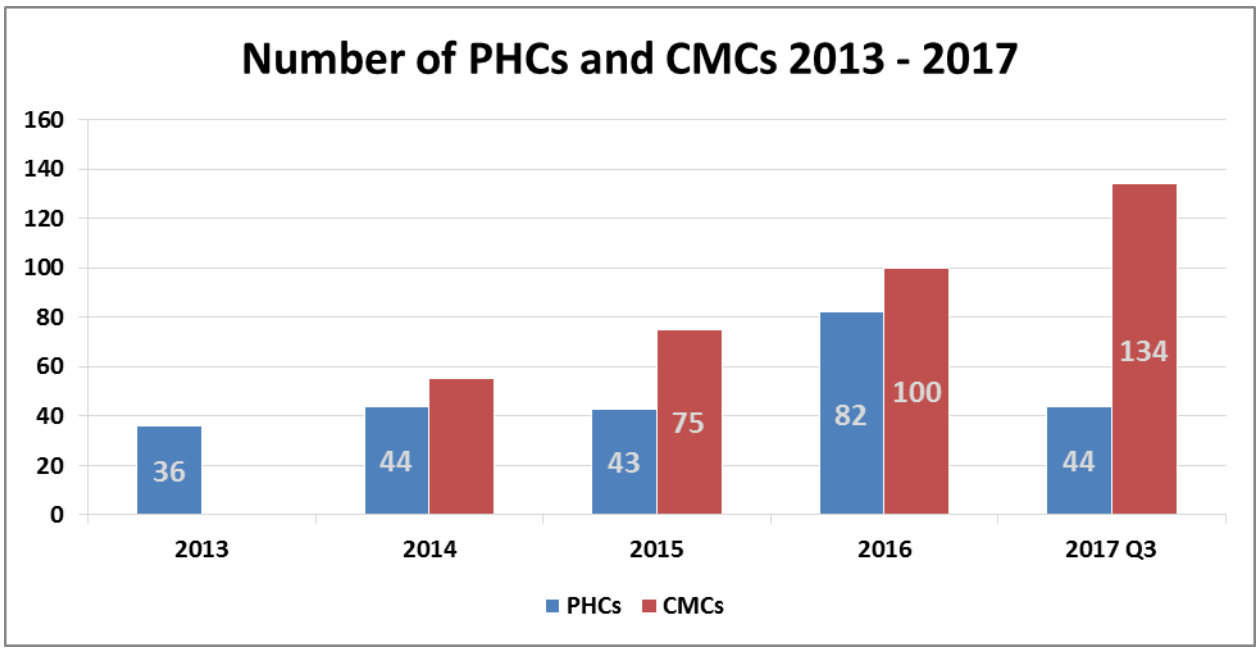
and to ensure an adequate number of hearing days and the efficient use of hearing time.

Pre-Hearing Conferences

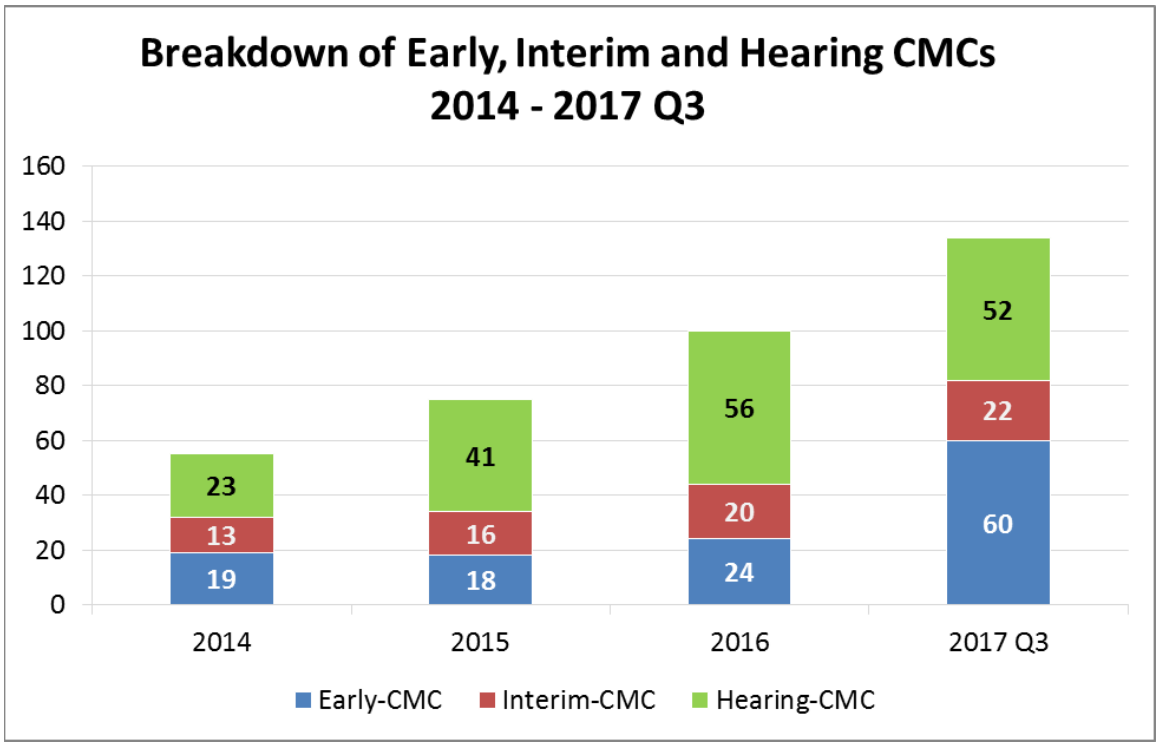
PHC's are also integral to the effective determination and scheduling of cases. PHCs, like CMCs, have a case management function. However, PHCs also have an important resolution function. The purpose of the PHC is to determine:

- Whether any or all of the issues can be settled
- Whether the issues can be simplified or clarified
- Whether there are facts that can be agreed upon
- Whether further disclosure or pre-hearing motions are required
- The scheduling of motions and the hearing

To effectively manage the increased number of referrals and caseload, as of 2017 Q3, the Committee has increased in its case management conference activity 140% since 2014.

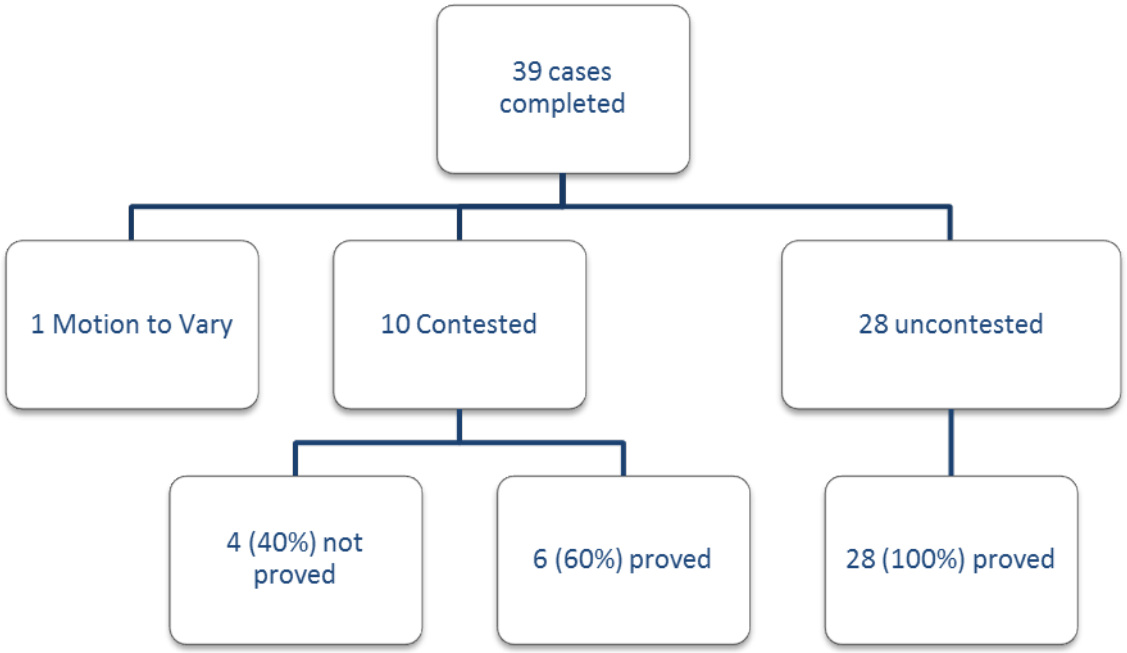


The following chart depicts the breakdown of early, interim and hearing case management conferences. The increased case conference activity relates primarily to an increase in the number of early case management conferences, which relates directly to managing the increase in the number of referrals.

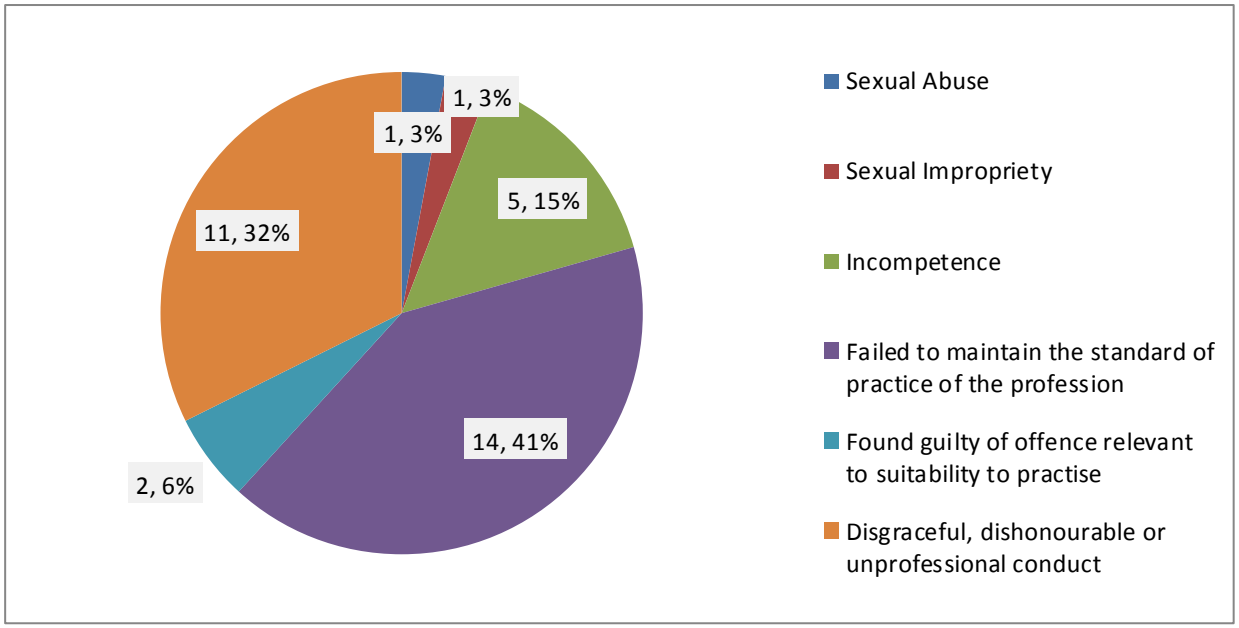


ii) Conducting Timely Hearings

The Discipline Committee also manages its caseload by conducting hearings of the cases referred to it. As of 2017Q3, the Committee has completed 39 cases.



The following depicts the percentage and types of findings made by the Committee as of 2017 Q3.



iii) Council's Strategic Indicator for Hearings

In 2014, Council established a strategic objective to schedule discipline hearings more quickly. The strategic indicator is the time period from the date of referral to the first date of the hearing.

The strategic target is for 90% of hearings to commence within 12 months of referral.

As at the end of 2017 Q3, 90% of hearings (34) began on average within 373 days (12.3 months) of referral.

iv) Case Time Span Analysis

To further understand the factors that influence case timelines, the Discipline Committee continues to track the number and percentage of cases that result in a single day hearing (ranging from 52.4 to 80.8%) and a multiple day hearing (ranging from 19.2 to 47.6%) in each year. The Committee is also tracking the average case time span, the average time span between process stages (e.g., time from referral to a pre-hearing conference, and time from the pre-hearing conference until the first date of hearing) and the percentage of multiple day cases that do not complete within the time initially scheduled.

The Committee reports that its enhanced case management practices have resulted in a downward trend since 2014 in both the average time from referral to the first hearing date and the average case time span, an increase in the number of multiple day cases that complete within the hearing time scheduled, and an increase in 2015 and 2016 in the number of cases that commence and

complete (i.e. written decision and reasons released) within one year from the date of referral.

III. Timeliness and Quality of Decisions and Reasons for Decision

a) Council's Strategic Indicator for Decisions

In 2016, Council established a strategic objective for discipline decisions. The strategic indicator is the time period from the last hearing date to the release of the written decision and reasons.

The strategic targets for decisions are:

- for 90% of written decisions and reasons in *uncontested cases* to be released within two months of the last hearing date; and
- for 90% of written decisions and reasons in *contested cases* to be released within six months of the last hearing date.

As of 2017 Q3:

- 90% of decisions in *uncontested cases (*20) were released on average 37.7 days (1.2 months) from the last hearing date; and
- 90% of decisions in *contested cases* (17) were released on average 135.4 days (4.5 months) from the last hearing date.

b) Appeals

From 2006 until 2011, there were no successful challenges on appeal to the Divisional Court on the basis of findings, rulings or orders made by the Discipline Committee.

In 2012, one matter was returned for rehearing.

In 2013, one matter was returned for rehearing, appeals by the physician were dismissed in three other cases and in one case, leave to appeal by the physician to the Supreme Court of Canada was denied.

In 2014, the Divisional Court dismissed the physician's appeal in one case and returned one matter for rehearing.

In 2015, the Divisional Court dismissed the physician's appeal in one case and one physician abandoned his appeal.

In 2016, the Divisional Court dismissed two appeals by physicians and one physician abandoned his appeal.

In 2017, the Divisional Court dismissed three appeals by physicians and one physician abandoned his appeal.

In *Sliwin v. CPSO (2017)*, the Divisional Court dismissed Dr. Sliwin's appeal. The Discipline Committee concluded based on the evidence that the complainant was Dr. Sliwin's patient during the period of their sexual relationship. The Committee rejected Dr. Sliwin's argument that this resulted from an officially induced error. In addition, the Committee rejected Dr. Sliwin's argument that the allegations should be stayed for abuse of process. The Committee found the mandatory revocation provisions of the Code constitutional. Accordingly, the Committee found that Dr. Sliwin committed an act of professional misconduct, in that he sexually abused a patient, and in that he has engaged in disgraceful, dishonourable or unprofessional conduct. The Committee ordered revocation of Dr. Sliwin's certificate of registration, a reprimand and costs. In addition, the Committee ordered that Dr. Sliwin reimburse the College fund for patient therapy or counselling, and that Dr. Sliwin post security to guarantee payment to the fund.

The Divisional Court upheld the Discipline Committee's decision with respect to all issues, with the exception of the Discipline Committee's order that Dr. Sliwin reimburse the College for funding for the complainant's therapy or counselling. In its decision on penalty, the Committee made the order that Dr. Sliwin post a security for funding for therapy in the event the complainant decides she needs help by way of therapy or counselling resulting from the sexual abuse. Although the complainant was not seeking therapy or counselling, the Committee made the order in the event the complainant decides to seek help in the future, noting that often patients realize much later in life that they require help in such circumstances. The Divisional Court granted this aspect of the appeal, stating that the order to post security for future therapy and counselling was unreasonable in the circumstances where there was no exploitation of the complainant, the relationship was consensual and where the complainant sought to withdraw the charge of sexual abuse.

In *McIntyre v. CPSO (2017)*, the Divisional Court dismissed Dr. McIntyre's appeal and the Court of Appeal denied Dr. McIntyre's motion for leave to appeal to the Court of Appeal. The Discipline Committee found that Dr. McIntyre committed an act of professional misconduct in that she engaged in the sexual abuse of Patient Y, she failed to maintain the standard of practice of the profession and she engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Dr McIntyre appealed only the finding of sexual abuse and the penalty of revocation as being excessive and unreasonable.

On the issue of liability, the Divisional Court found that the Committee conducted a fair hearing and did not breach any principles of procedural fairness. The Committee's findings on liability were well-reasoned and supported by the evidence. The Committee correctly placed the burden of proof

on the College throughout and that there is no basis to interfere with its conclusion that Dr. Mcintyre sexually abused Patient Y.

On the issue of penalty, the Divisional Court noted that the Committee based its determination on penalty on "the guiding principle of protection of the public." The Committee further identified the principles of proportionality, general deterrence, specific deterrence, denunciation and, where appropriate, rehabilitation as being relevant to its task as well as the importance of maintaining the public's confidence in the profession's ability to self-regulate in the public interest. The Court stated that these are the proper principles to be applied in imposing penalty sanctions. The Committee identified and applied these principles and made no error of principle in its determination that revocation was the appropriate penalty in this case.

In conclusion, the Court stated that in reaching its decision, the Committee was cognizant of the particular circumstances of this particular doctor and these particular patients. However, the Committee also took a broad policy-based view of its own mandate: to protect the public; to recognize the devastating impact on patients when the trust they place in doctors has been violated, particularly through sexual abuse; and to maintain public confidence in the ability of the medical profession to regulate itself in the public interest. The Court indicated that these are matters squarely within the particular expertise of the Committee and are entitled to great deference. In its view, the Committee's penalty decision was reasonable, defensible, and supported by cogent reasons.

In *CPSO v. Virani (2017)*, the Divisional Court dismissed Dr. Virani's appeal of the Discipline Committee's penalty decision. The Discipline Committee ordered an eight month suspension after finding that Dr. Virani had committed professional misconduct by borrowing substantial amounts of money from two patients. Dr. Virani lost all the money to a fraudster investor. Dr. Virani argued that the Committee wrongly relied on specific deterrence as a relevant penalty objective in the absence of any pattern or prior discipline history. The Court indicated the Committee proceeded on the basis that there was no prior discipline history, however, it had evidence upon which to conclude that specific deterrence was an appropriate consideration. Dr. Virani was not merely an innocent victim of the fraudster. He had actively deceived his patients in order to obtain loans including failing to disclose to the patients the loss of a previous investment to this investor and concerns raised by the RBC about the investor's backing association. He also provided his patients with cheques with the full knowledge of insufficient money in his bank account. He also withheld disclosure of the loans from the College. The Court stated that such dishonesty and misuse of patient trust was sufficient to engage specific deterrence.

Dr. Virani also argued before the Court that the Committee improperly took into account his ethnic background as an aggravating factor in relation to the Committee's view that the "eight month suspension would serve as a general deterrent to physicians against taking advantage of the vulnerability of patient who trust them due to shared common ethnicity and ability to speak the same language, for their own personal gain". The Court noted the statement of facts before the

Committee stated that in Dr. Virani's country of origin, a physician occupies a very high level in society and is viewed as an extremely trustworthy and important person. His patients trusted him and felt comfortable with him including because he spoke their language. The Court found nothing improper in the Committee's concern that such vulnerability can arise as a result of shared ethnicity and language between a physician and his or her patients and the status attached to the position of a physician in certain communities and that physicians should be sensitive to the position of trust in which they may be placed by their patients for these reasons. The Court in result found that the penalty imposed was within the range of reasonable penalties for the actions of a physician in Dr. Virani's circumstances.

In *Ruggiero v. CPSO*, Dr. Ruggiero abandoned his appeal of the Discipline Committee's decision of August 23, 2016, finding that he had committed an act of professional misconduct in that he engaged in sexual impropriety with a patient during a medical appointment in his office in approximately 1986.

The appeal of the matter of *Dr. Peirovy v. CPSO* is not yet finally determined. Dr. Peirovy appealed the Discipline Committee's decision on finding in 2015 and abandoned his appeal in 2016. The College appealed the Discipline Committee's penalty decision in 2016. On January 17, 2017, the Divisional Court granted the College's appeal, quashed the penalty order and remitted the matter of penalty to the Discipline Committee. Dr. Peirovy sought and was granted leave to appeal the decision of the Divisional Court to the Court of Appeal. The appeal is scheduled to be heard on November 27, 2017.

Nine appeals to the Divisional Court, including Dr. Peirovy's appeal, are awaiting determination.

IV. Transparency of Committee Activities and Decisions

Decisions

The Discipline Committee posts hearing dates, case status (whether a case is adjourned or a decision is under reserve) and its findings and orders on the College's website under Doctor Search. The decisions are also posted on the LexisNexis and Carswells legal databases and on CanLII, a free publicly accessible legal database managed by the Federation of Law Societies of Canada.

V. Costs and Expenditures

The Discipline Committee tracks its costs and expenditures. Discipline hearing costs are directly related to the number, length and complexity of hearings.

Paid hearing days (PHD) = Days used + Days not used but paid (due to late cancellation). The number of paid hearing days (PHD) for 2012 to 2017 Q3 was as follows:

Year	2012	2013	2014	2015	2016	2017Q3
PHD	171	90	109	210	232	162

Late cancellation costs continue to be incurred due to the late resolution or adjournment of cases or early completion of hearings. The number of late cancelled days (LCD) for 2012 to 2017 Q3 was:

Year	2012	2013	2014	2015	2016	2017Q3
LCD	57	56	28	92	75	58

In 2014, there were only 28 late cancelled days, an aspirational goal of the new case management practices. In 2015, late cancellation increased due to late settlement in four cases and the withdrawal, dismissal and the loss of hearing days in three cases, respectively, in which patients did not wish to attend to testify. Late cancellation costs in 2016 and 2017 relate to late settlement and late adjournment of cases. The Committee continues employ its case management practices to reduce the late settlement of cases and will assess the impact of the reciprocal disclosure rule, which was implemented on August 1, 2016, on the incidence of late settlement.

In June 2007, Council adopted a policy that the usual amount of costs sought by the College in appropriate discipline cases would be in accordance with the Discipline Committee tariff, which Council increased on May 30, 2013 from $3,650 to $4,460 per day. Council further increased the costs tariff to $5,000 per day as of January 1, 2016 and to $5,500 as of January 1, 2017. The referring committee retains the discretion to change the amount sought in specific cases. As of 2017 Q3, the Discipline Committee has ordered $469,861 in costs awards to the College including costs in specific cases of $69,538 (*Dr. D.J. Hill*), $54,560 (*Dr. A.W. Taylor*), $35,500 (*Dr. R. Yaghini*), $27,500 (*Dr. R.N. Morzaria*), $25,000 (*Dr. D.A. Ruggiero*), $24,420 (*Dr. W.A. Beairsto*).

2018 Initiatives

In accordance with the strategic plan, the Committee will continue to focus on ways to improve the effectiveness and efficiency of the discipline process while ensuring fairness, including ways to achieve early settlement. The Committee is continually reviewing its governance strategies including its training and education cycle and its recruitment and succession planning to ensure adequate resources in light of the increased caseload and potential statutory changes to committee and panel composition requirements. This will include enhancing capacity and diversity through recruitment, and training experienced members in the role of case management conference and pre-hearing conference chair. Also, the Committee is working to enhance its qualitative data regarding physicians who are referred to discipline (e.g., age, gender, place and area of practice, length of time in practice) with a view to better inform and educate the public and the profession. The Committee will also post additional information on the website to enhance transparency and understanding of its processes for the benefit of hearing participants, the public and the profession.

We commend our Committee members who have dedicated significant time and effort to the hearing schedule.

The Committee would like to thank the Hearings Office staff and the Independent Legal Counsel team for their outstanding work in assisting the Committee to fulfil its mandate and for their support throughout the year.

Dr. Carole Clapperton
Co- Chair, Discipline Committee

Dr. Peeter Poldre
Co-Chair, Discipline Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Education Committee Annual Report 2017

Committee Mandate and Objectives

The Education Committee's mandate and objectives, as defined in by-law are to:

a) review and make recommendations to Council respecting matters of undergraduate and postgraduate medical education in Ontario;
b) establish mechanisms to enhance continuing professional development by College members including:
   (i) systematically tracking College-observed trends of needs in physician education;
   (ii) advocating for these needs to be met by external educational providers; and
   (iii) endorsing methods for measuring outcomes of educational interventions by the College.
c) approve, monitor and/or evaluate methods for use by the College, which may include the following:
   (i) assessment methods and tools for competence and performance;
   (ii) programs to promote and enhance professionalism; and
   (iii) supervision roles.

Year in Review

In 2017, the Education Committee engaged in and provided feedback on CPSO initiatives pertaining to medical education (undergraduate, postgraduate and physicians in practice), continuing professional development (CPD), and physician assessment. In addition, the Education Committee has played, and will continue to play, a key advisory role in the development of the CPSO Education Strategic Initiative (ESI) that was initiated last year, including the Education Strategic Initiative framework and the New Member Orientation.

1. Education Strategic Initiative (ESI)

The Committee engaged in further shaping and refining of initiatives that fall under the ESI area of work.

1.1. Educational Visioning

The Committee continued contributing their expertise to Educational Visioning. Throughout the year, members provided focused feedback around several areas of the vision, as outlined below.

1) Focus: the Committee stressed the importance of focusing on physician education while being inclusive of all groups involved in medical education, including undergraduate, postgraduate, and continued professional development stakeholders.

2) Evaluation: The committee underscored the importance of an evaluative component to

demonstrate through data that education is effective, and supported a specific focus on the evaluation of outcomes.

3) Outreach: Members stressed the importance of liaising with other partners within the field of medical education, including CMPA and postgraduate education faculties.

Draft ESI framework will be presented to the Committee by the end of 2017.

1.2 New Member Orientation

The Committee engaged in providing direction to the development of the New Member Orientation project, and in the course of the discussions provided feedback that helped shape the project. Specifically, the Committee members emphasized that the experience should not be onerous, should be accessible and well designed, and stressed the importance of making this module available for all members and building it into the Continued Professional Development portfolio in the future.

2. Other CPSO strategic initiatives

Members received regular updates on the development of other CPSO-wide strategic initiatives, namely Data Strategic Initiative, and Opioids Strategy.

2.1 Data Strategic Initiative

The Committee received an update on the development of the Data Strategic Initiative and stressed the importance of aligning data collection with College initiatives, especially in the areas of education and opioids management.

2.2 Opioids Strategy

The Committee members were provided with updates on the overall Opioids Strategy and on specific projects related to education and remediation.

1) Overall strategy: The Committee received an update on the Opioids Strategy in June 2017, and underscored the importance of the College's influence to impact change. Committee members stressed the need to stay connected with the work of other regulators that can inform the College's approach.
2) Remediation plan: The Committee members were presented with a Remediation plan as part of the opioids investigations of the first cohort of physicians identified through the Narcotics Monitoring System. The proposed plan outlined specific short-term strategy to ensure the consistent and targeted approach to supervision and the development of individual education plans (IEP). The Committee stressed the importance of supervisor

training and selecting supervisors based on a set of characteristics, and the clarity of outcomes.

3. Undergraduate Student (UGME) and Postgraduate (PGME) Engagement

3.1 CPSO Professionalism and Practice Undergraduate Medical Education (UME) Program

The Committee was kept apprised of the development of a new module on *Maintaining Boundaries to Prevent Sexual Abuse* policy. The Committee appreciated the usefulness of the module, noting that the ongoing efforts to make the material more accessible on the CPSO website are critical to its uptake.

3.2 Focusing Role of Academic Representatives

In 2017, the Committee continued discussions around better integrating the role of Academic representatives on the Committee with the CPSO's work in medical education. A draft Role expectations document was developed and tabled for discussion. The Committee provided feedback on the draft document, and updates are expected to be brought to the Committee by the end of 2017.

3.3 Post MD Non-Residency Training

The Committee provided direction on three medical schools (Queen's, and subsequently University of Toronto and University of Ottawa) developing programs for individuals who had been unsuccessful in securing a residency position. The Committee underscored the importance for any post MD non-residency training programs to adhere to professional regulation, to track reasons for initial failed match as well as subsequent successful match, and to limit the programs to one year.

4. Continuing Professional Development (CPD)

4.1 CPD Component of Quality Assurance Regulation – Definition of Practice of Medicine

In 2017, the Committee was asked to provide input on the proposed definition of practice of medicine. The Committee discussed the value of including different areas of practice in the definition, and exploring how other regulators define practice of medicine. The feedback provided will be taken into account in the development a definition.

4.2. Ontario College of Family Physicians (OCFP) – Collaborative Mentoring Network

The OCFP presented to the committee members their CPD programs, specifically the Collaborative Mentoring Networks. The Committee engaged in the discussion around mentor selection, training procedures, and mandatory reporting.

4.3 Update on the Medical Psychotherapy Association of Canada 's (MDPAC/GPPA) Continued Status as a Third Pathway (Alternative CPD Tracking Organization)

Council approved the Education Committee's recommendation to approve MDPAC for an additional three years as an alternative CPD tracking organization, and asked the Committee to consider developing a review and approval process for extension of Third Pathway Tracking. The work of developing this process will be ongoing in 2018.

4.4 Ontario Medical Association (OMA) Request for Member Self-Reporting

The Committee considered the OMA's request to be considered as a Third-Pathway Tracking Organization for a small subset of its members. This request was denied , noting the College's position that it is not set up to be a tracking body and that any program put in place to track a small number of physician's CPD would be prohibitively expensive. This decision was supported by the Council.

5. Research at the College

The Committee was provided with updates and gave feedback on the following research projects at CPSO:

- Evaluation of CPSO Pathways
- Peer Assessment Redesign
- Identification of Physicians at Risk of Recurrent Investigations
- Facility Leads Needs Assessment.

Respectfully submitted,

Barbara Lent,
Chair, Education Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Executive Committee Annual Committee Report 2017

Executive Committee Annual Report 2017

The Executive Committee has 2 main functions:

1. Under section 12 (1) of the *RHPA*, between meetings of Council, the Executive Committee has almost all the powers of the Council with respect to any matter that, in the Committee's opinion, requires immediate attention. The only power it does not have is to make, amend or revoke a regulation or by-law.

2. In order to ensure that the work of the College is able to proceed between Council meetings, the Executive Committee also guides the response to significant issues. Executive Committee gives direction to staff about what may be required before the matter is ready to go to Council. In addition, the Executive Committee makes recommendations to Council as to outcome.

Communication with Council:

1. Executive Committee Update: A summary of Executive Committee's deliberations and direction circulated to all Council members within a day or two of each Executive Committee meeting.
2. Telephone Calls: Executive Committee members contact each Council member to ensure that Council members understand what was considered and have access to further information.
3. Executive Committee's Reports to Council: The Executive Committee provides quarterly reports to Council in accordance with *Section 12 HPPC.*

Council members are invited to attend Executive Committee meetings and several Council members took advantage of this opportunity in 2017.

The Executive Committee held 7 meetings and 1 teleconference in 2017. Specific issues considered included:

- **Policies**: Uninsured Services: Billing and Block Fees , Accepting New Patients, Ending the Physician-Patient Relationship, Physician Services during Disasters and Public Health Emergencies

- **Guidelines/Other Documents**: Peer Assessment Redesign, Data and Analytics Strategy, Education Strategic Initiative, CPD Compliance, Clean vs. Sterile Technique for Neuraxial Blocks, 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

- **CPSO Feedback on External Consultations:** Ministry of Transportation of Ontario re Mandatory Reporting, Council of Canadian Academies re MAID

- **Other Issues**: *Bill 87 – Protecting Patients Act*, Opioids Strategy, Extension of Pilot Project for Independent Legal Advice to Complainants/witnesses in Discipline Hearings re Sexual Misconduct, Revocation of Methadone By-law, Oversight of Health Facilities and Devices Act (part of Bill 160), College Oversight of Fertility Services, New Member Orientation Project, CPSO Governance

- **Registration**: Practice Ready Assessments in Ontario (PRA), Renewal of Third Pathway Status – Medical Psychotherapy Association of Canada (Formerly GPPA), Post MD Non-Residency Training, Ensuring Competence: Changing Scope of Practice and/or Re-Entering Practice Policy, Registration Pathways Program Evaluation

- **Guest Presenters:**
  Dr. Beth Sproule provided an overview of prescription monitoring programs in different provinces. Dr. Sproule is a Clinical Scientist at the Centre for Addiction and Mental Health and on the Faculty of Pharmacy at the University of Toronto.

  Dr. Michael Kaufmann, founding Medical Director of the Physician Health Program of the Ontario Medical Association, spoke about the College's ongoing relationship with the PHP, as a means of managing and guiding the care and treatment of physicians who have substance use or mental health issues.

  Dr. Jeffrey Turnbull, Medical Director of Ottawa Inner City Health, described the treatment of homeless patients and the escalating number of opioid overdoses within his patient population in the last several months. In addition to various treatment options, the clinic recently implemented opiate assisted therapy (OAT), for people addicted to opiates who wish to manage their use with medical help.

Selection Committee

In addition to its regular work, the Executive Committee spent considerable time in 2017 on activities related to the search for the new CPSO Registrar.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Fitness to Practise Committee

Annual Committee Report 2017

ANNUAL REPORT OF THE FITNESS TO PRACTISE COMMITTEE

Mandate:

The Fitness to Practise Committee hears matters of possible member incapacity.

If the Fitness to Practise Committee finds that the member is incapacitated it can make an Order:

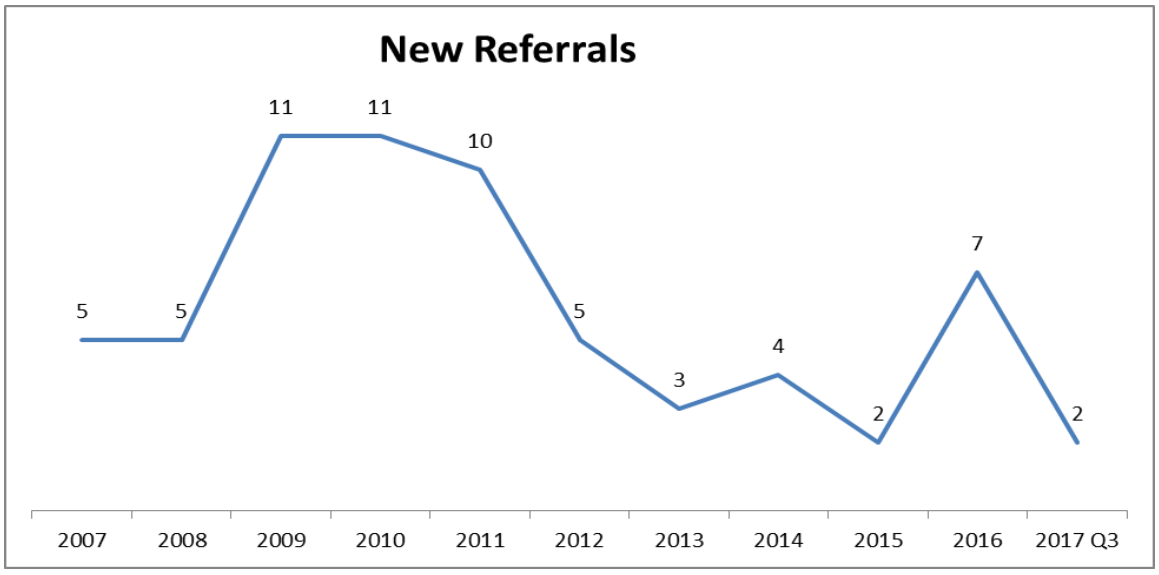
- directing the Registrar to revoke the member's certificate of registration.
- directing the Registrar to suspend the member's certificate;
- directing the Registrar to impose specified terms, conditions or limitations on the member's certificate.

An Order made by the Fitness to Practise Committee seeks to address the member's capacity to practise safely while ensuring public protection from a member who is found to be incapacitated. Revocation or suspension may be required, or a member may be able to practise safely subject to terms, conditions and limitations on his or her certificate of registration that require monitoring and/or treatment.

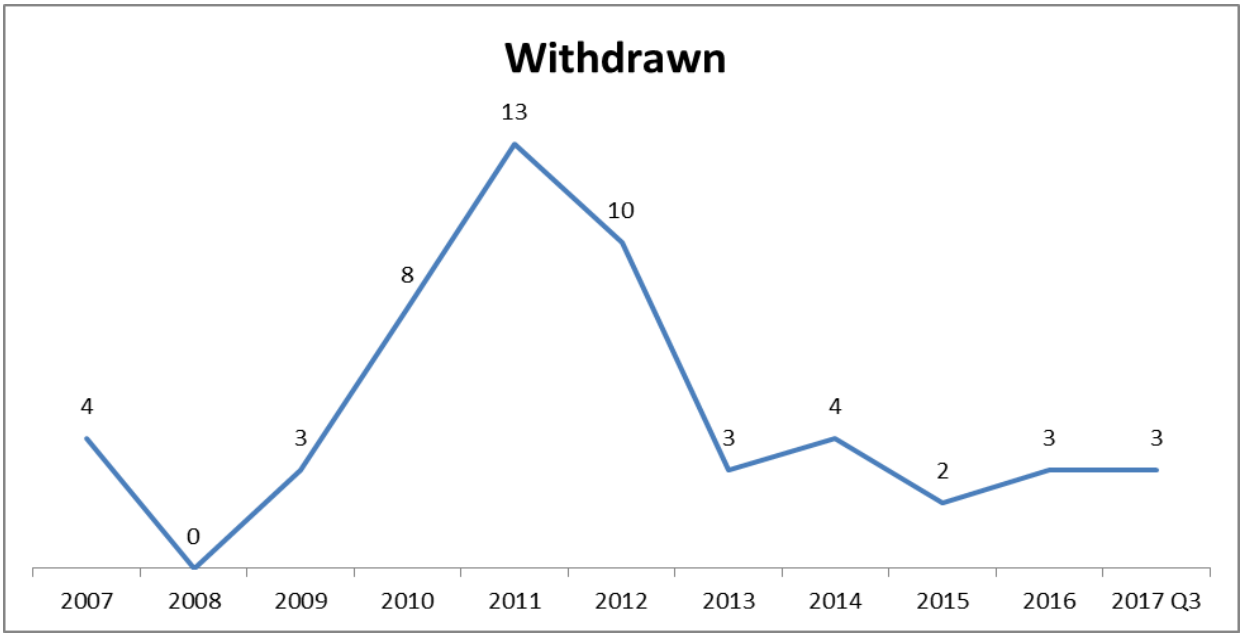
Core Activities:

Referrals

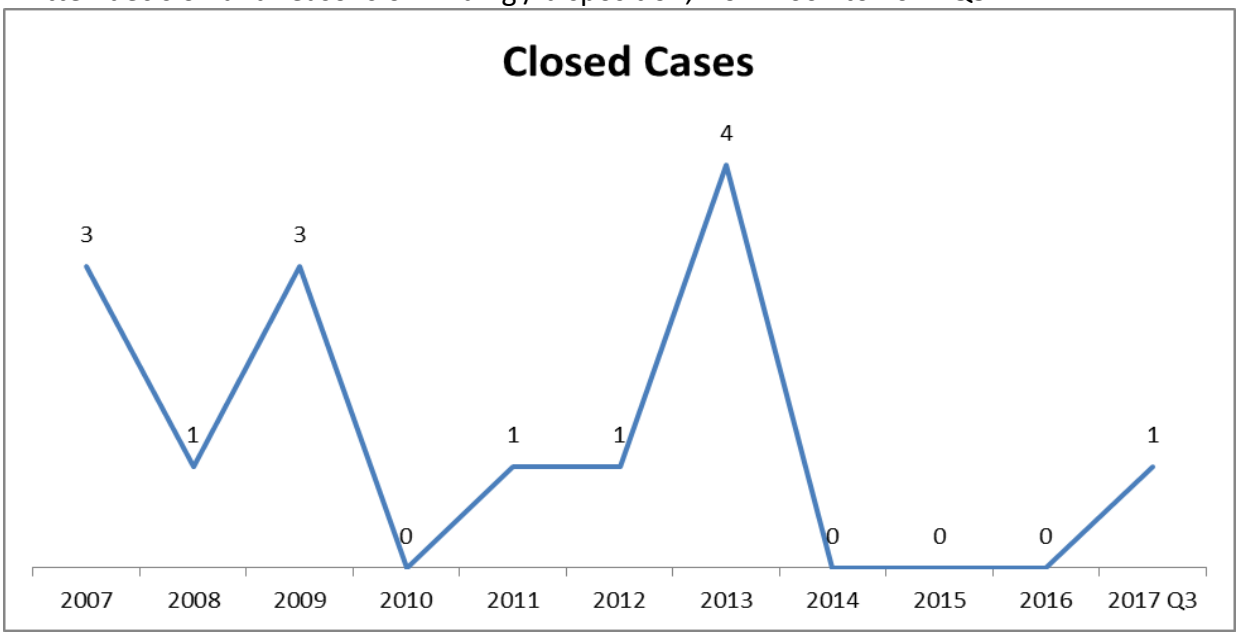
Overall, there has been a decrease in the number of referrals to the Committee. Although the Committee received seven referrals, in 2016, it has received two referrals as of September 30, 2017 (2017 Q3). This is in contrast to ten to eleven referrals in the years from 2009 to 2011.



The practice to resolve incapacity matters through monitoring agreements continues. As of 2017 Q3, three matters were resolved and the referrals withdrawn.



Consequently, there was also a decrease in the Committee's pre-hearing and hearing activity. In 2017, the Committee granted one motion for the removal of public register information in relation to a 1988 order. There have been two pre-hearing conferences (PHCs), however, no hearings to date in 2017. There were no hearings in relation to an allegation of incapacity in 2014, 2015 and 2016. The following table shows the closed cases, i.e., closed motions or incapacity cases that had a written decision and reasons on finding / disposition, from 2007 to 2017 Q3.



There are nine matters currently before the Committee, six referrals regarding an allegation of incapacity and one motion to vary a prior order. One physician is subject to interim suspension, one physician is subject to interim practice restrictions and one physician signed an undertaking to cease practice pending the disposition of the referral.

The Fitness to Practise Committee commends the effort to achieve early intervention and resolution of these matters and the involvement of the Physician Health Program and monitoring physicians in assisting physicians in their recovery.

Orientation and Business Meeting

The Committee will hold an educational and business meeting for Fitness to Practise Committee members on November 22, 2017.

Although infrequent, the issues that are involved in Fitness to Practise hearings and motions to vary previous fitness orders are unique and the stakes are high in terms of protection of the public and the consequences for the physician. The Fitness to Practise Committee provides an annual education program to address the unique requirements of the FTP process so that members are well prepared to conduct a hearing or motion when required. FTP members are also members of the Discipline Committee and, therefore, receive transferable training regarding hearing processes, chairing a panel, chairing a pre-hearing conference and decision writing.

Future Initiatives:

In 2018, the Fitness to Practise Committee will continue to focus on educational programs for its members.

Dr. Dennis Pitt
Chair
Fitness to Practise Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Governance Committee

Annual Committee Report 2017

Governance Committee
2017 Annual Report

Overview

The Governance Committee is a College operating committee. The mandate is set out in the College by-law. The committee is responsible for overseeing and making recommendations to Council to enhance the College's governance structure. The Committee also oversees the nominations process, orientation and mentoring programming, the Council and committee performance assessment process, as well as the governance policy function.

The Committee strives to ensure effective and current governance practises. College governance resources are maintained and consolidated in the *Governance Process Manual* available on the College website.

2017 Highlights

Areas of focus in 2017 included the following:

- Oversight of College nominations processes;
- Development of an approach to facilitate the election of a public member president of the College Council;
- Continued focus on orientation, mentoring and training;
- Contribution to activity in support of governance reform.

Oversight of College nominations processes

Chair and committee membership appointments are a focus of the Governance Committee each year. All committee appointments are made on an annual basis. The Governance Committee oversees the recruitment and screening processes for these positions. The Nominations Guidelines are utilized to guide nominations decision-making.

The Governance Committee has worked to support membership renewal and succession planning on College committees. Finding that right balance of bringing in new qualified committee members and retaining expertise is important, yet can be challenging.

The Committee actively works with committee chairs to identify committee membership requirements. Chairs are also asked to help identify future leaders of College committees. This approach of looking and planning for the future is designed to better facilitate and support succession planning.

Committee recruitment for non-Council positions is an important aspect of the nominations process. Recruitment for these positions was further refined in 2017. To help support the recruitment of qualified candidates in defined specialty areas, the committee considered lists of pre-screened potential non-Council committee candidates who are or have recently done other work for the College. This approach has had mixed results. Recruitment of applicants through this method takes considerable time. The pool of candidates identified through this method is however excellent and the committee recommends continuing to utilize this approach together with others (unsolicited, referrals) in the year ahead.

All committee members who are not members of Council undergo conflict of interest screening and an interview led by the Chair of the Governance Committee and the appropriate committee chair. The Governance Committee in its December report to Council makes committee membership recommendations for the next year. The process to identify opportunities and recruit qualified members for College committees now occurs throughout the year.

Enhancement of the College's recruitment process for non-Council members requires ongoing focus and refinement. With the passage of Bill 87, the Protecting Patient Act, we anticipate that a larger pool of both non-Council physicians and, non-Council public members will be required for College statutory committees. Government has not yet made its intentions clear as to whether it intends to utilize this new regulatory authority. The College has supported and recommended that there be no overlap in membership between the Discipline Committee and Council in order to strengthen the independence and the integrity of the discipline process. There are currently statutory quorum requirements that require the participation of both public and professional members of Council on the College Discipline and ICR Committees.

The Committee is again very supportive and appreciative of the contribution made by Council's public members on Council and College committees. Public members of Council have heavy workloads and perform invaluable work. The Governance Committee continues to have concern with the government's support of the public appointment process. Public members are not appropriately compensated for their work. Further, vacancies are often not filled in a timely manner putting further strain on remaining public members and on vital regulatory processes.

Facilitating a Public Member President

As part of the College's desire to ensure currency of its governance practices, the Committee developed an approach to facilitate the election of a public member president of the College Council. While existing provisions in College By-Laws permit the election of any member of Council as College President (including public members), the existing practise and assumption is that once a physician is elected to the Executive Committee, they will automatically progress to the position of Vice-President and then President.
Council has supported a new direction and approach that will encourage public members to serve as College Vice-President and President. The approach consists of the following elements:

- The Executive Committee will continue to be composed of six members, but a new minimum of two public members and a minimum of two physician members will be instituted.
- The Past President will continue to serve as a member of the Executive Committee.
- The current Vice-President will generally progress to be President.
- There will no longer be an assumed progression path to Vice-President Position, but ideally nominees will have recent experience serving on the Executive Committee.
- The remainder of the Executive Committee (other than the Past President) will be elected after the President and Vice-President. One or more elections may be needed to properly fill the minimum requirements for 2 physician and 2 public members.

On Council's direction, the Committee will develop by-law changes and supporting communication material next year so the changes are in place for the May 2019 election for the 2020 Council year.

Continued focus on orientation, on-going education and mentorship

Strengthening the Council and committee orientation and training programming was another area of focus for the committee this past year. The annual day-long session open to members of Council and committees in February is highly rated.

This programming needs to be available throughout the year. The Committee has suggested that it be available on more than one date and that it be available in other forms (such as by video, online module). Public members join the Council at various points during the year and orientation is vital.

An inventory of educational/orientation activities and material has been collected. Work is underway to make it available to Council and committee members in an accessible format.

We note a growing expectation that members of Council and committees complete mandated training programming. All members of College committees have been asked to complete an e-learning training module addressing issues of sexual harassment. Attention and resources are required to ensure such programming is kept current.

Council's mentorship program is highly valued by new members of Council. All new members of Council are assigned mentors to help support their transition onto the College Council and College committees. A special thank you to our Council members who have served as mentors in 2017: Dr. Brenda Copps, Dr. Joel Kirsh, Dr. Jerry Rosenblum, Dr. Peeter Poldre, Mr. John Langs, Ms Lynne Cram, Mr. Harry Erlichman.

Oversight of Assessment/Feedback Program

The Committee continues to oversee the Council Performance Feedback program. The program consists of a number of different feedback surveys that together provide valuable feedback to Council as a whole, committees, committee chairs, Council members and committee members. The program is designed to help individual Council and committee members grow in their roles with the goal of improving performance.

This year, as a result of competing resources for staff time and the need to prioritize activities, only the Council survey was conducted. Council's 2017 performance assessment report is contained in the Governance Committee's December Council report. The results are again quite positive. They reinforce those areas of focus that have been identified by the Governance Committee as areas of focus in 2018.

We plan to execute the full performance assessment program in 2018.

Looking ahead to 2018

The Committee will continue to focus and strengthen orientation and mentorship programming to support new members of Council and College committees. In particular, there is a need to focus orientation and training resources on public members given the heavy workload and the degree of turnover anticipated over the next 18 months.

Continued time and attention is required to enhance the College's nominations processes. We anticipate a larger pool of both public and professional non-Council appointments and want to be prepared to support a larger pool of committee members who are not members of Council. Use of non-Council public members on College committees makes good sense as it would help alleviate the workload of public members of Council.

In a related vein, governance reforms and regulatory modernization is coming. It is simply a question of when. The College has taken some steps forward including the development of a process to facilitate the election of a public member president and the recommendation to government that there be no overlap in membership on the Council and the Discipline Committee to ensure integrity and independence of the adjudication process.

There appears to be some support on Council for discussion about the size of Council and a perception amongst some Council members that a smaller Council would be more effective. Work is required to consider next steps, and what Council may wish to achieve in the short term and what it may want to advocate for in the future.

November 10, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Inquiries Complaints and Reports Committee

Annual Committee Report 2017

The Inquiries, Complaints and Reports Committee

Mandate

Implementation

The Inquiries, Complaints and Reports Committee (ICRC) is a statutory Committee of the College, formed on June 4, 2009, under Ontario's *Health System Improvements Act, 2007*. The ICRC has jurisdiction over all College investigations, of which there are three kinds:

- Complaints investigations (which before 2007, were managed by the Complaints Committee)
- Registrar's investigations (before 2007, managed by the Executive Committee)
- Incapacity investigations (before 2007, managed by the Board of Inquiry and the Executive Committee).

ICRC Composition

The entire ICRC is currently (November 2017) composed of 54 members.

The members may be physicians who are members of Council, physicians who are not members of Council, staff physicians, or public members of Council. The ICRC currently has five public members.

Quorum consists of three panel members, at least one of whom must be a public member of Council.

ICRC Review and Disposition Powers

Review

The ICRC may consider a variety of factors when reviewing any investigation, including:

- facts of the case
- number and seriousness of care and/or conduct concerns at issue
- standard of care expected of practitioners
- whether the physician is practising within his or her area of expertise
- physician's response to the investigation
- insight and self-identification of areas for improvement and changes to practice
- physician's apparent capacity for remediation
- physician's investigative and disciplinary history
- expert opinions obtained in the course of the investigation
- other documentary and witness information.

Dispositions

The ICRC may, following a complaints or Registrar's investigation:

- refer allegations of professional misconduct and/or incompetence to the Discipline Committee
- require a physician to appear in person to be cautioned before an ICRC panel
- refer a complaints or Registrar's investigation for incapacity proceedings

- require the physician to complete a specified continuing education or remediation program (SCERP); the ICRC no longer has the power to refer any clinical information to the College's Quality Assurance (QA) Committee
- take any action not inconsistent with the legislation (including "no action," "advice," "direct or accept remedial agreements and/or undertakings," etc.)

The ICRC may, during an incapacity inquiry, require the physician to participate in health examinations or assessments.

The ICRC may, following the completion of the incapacity inquiry, refer the matter of the physician's capacity to the Fitness to Practise Committee, if appropriate and if the matter has not been addressed through an undertaking with the College or a monitoring agreement with the Physician Health Program.

Interim orders

The Ontario Legislature passed the *Protecting Patients Act*, *2017*, in May 2017. It conferred on the ICRC the power, **at any time** following the receipt of a complaint or following the appointment of an investigator, to make an interim order directing the Registrar to suspend, or to impose terms, conditions or limitations on, a physician's certificate of registration if the ICRC is of the opinion that the conduct of the physician exposes or is likely to expose his or her patients to harm or injury. This represented a significant change from previous legislation, where ICRC could make such an order only after a referral to the Discipline Committee or to the Fitness to Practice Committee. The ICRC may exercise the interim power without notice, in very specialized circumstances.

Interim Orders issued under Section 25.4, June to September, 2017

June 2017	July 2017	August 2017	September 2017
3	2	4	5

TOTAL: 14

The Committee has not yet (to the end of October 2017) exercised the power to issue an interim order without notice under section 25.4.

Core Activities

Panel Meeting Types and Formats

The ICRC meets in a variety of different panel types, including:

- general panels
- specialty panels, including:
  - Surgical Panel
  - Obstetrical Panel
  - Mental Health Panel
  - Family Practice Panel
  - Internal Medicine Panel

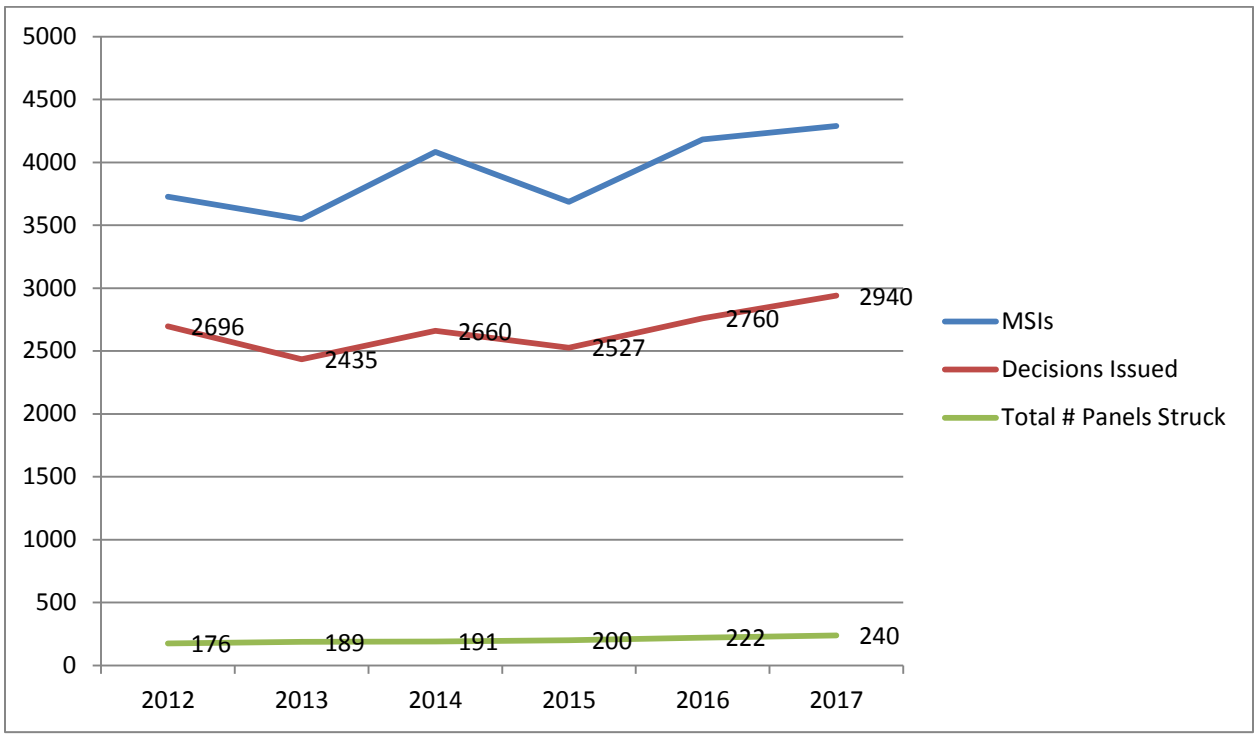
- Prescribing – formerly Narcotics Monitoring System (NMS) – Panel

- standing weekly teleconferences
- ad hoc teleconferences
- fast-track panels for abbreviated investigations
- medium track panels for low risk matters
- incapacity (or "health") inquiry panels
- settlement panels
- caution in person panels
- business/policy meetings.

New Investigations January 1 - June 30, 2016 and January 1 - June 30, 2017

	2016 – 6 months	2017 – 6 months	% change from 2016
Public Complaints	1665	1646	-1%
Registrar's Investigations	235	348	48%
Incapacity Investigations	46	42	-9%
TOTAL	1946	2036	5%

ICRC Matters Considered, Decisions, and Panels



NOTE: 2017 totals are projected to year end

ICRC dispositions – first 6 months, 2017

Public Complaints

	2016 – 6 months	2017 – 6 months	% change from 2016
No Action	713	850	19%
Advice	238	249	5%
Remedial Agreements	23	68	196%
Caution in Person	35	31	-11%
SCERP	49	37	-24%
Undertaking	6	22	267%
Referred to Discipline	35	67	91%
Total	1099	1324	20%

ICRC dispositions – first 6 months, 2017

Registrar's Investigations

	2016 – 6 months	2017 – 6 months	% change from 2016
ICRC: No Action	43	27	-37%
ICRC: Advice	18	18	0%
ICRC: Remedial Agreements	1	1	0%
ICRC: Caution in Person	8	8	0%
ICRC: SCERP	17	10	-41%
ICRC: Undertaking	36	61	69%
ICRC: Referred to Discipline	37	43	16%
Total	160	168	5%

ICRC dispositions – first 6 months, 2017

Incapacity Investigations

	2016 – 6 months	2017 – 6 months	% change from 2016
No Action	2	11	450%
Undertaking	15	15	0%
Referred to Fitness to Practice	1	1	0%

Total	18	27	50%

Decision Release

The ICRC continued in 2017 to fulfill its statutory mandate to release written decisions and reasons, as required under the *Health Professions Procedural Code*. As the number of ICRC meetings increases, and the number of matters considered at those meetings increases, the number of decisions and reasons released also continues to increase.

YEAR	Decisions Issued	Decision TRENDS
2013	2436	↓10%
2014	2651	↑9%
2015	2527	↓5%
2016	2760	↑9%
2017 (Jan – June)	1519 (6 months)	n/a

- Decisions = Written Outcome: Decision and Reasons
- **Statistics for 2017 are based on 6 months of data*

Transparency

On May 29, 2015, Council approved a range of by-laws as part of its Transparency Initiative that provides more information on the public register. The new information included, from the ICRC's perspective, ICRC outcomes of caution-in-person or SCERPs.

In 2017, ICRC outcomes resulting in publicly-posted summaries continued to increase.

Transparency Outcomes

SCERP & CIP Decisions Rendered during ICRC Meetings held from **June 1, 2016 – September 30, 2017**		
	Decisions Rendered	**Decisions Appealed**
Caution in Person	131	18 (13.74%)
SCERP	62	19 (30.65%)
Caution in Person and SCERP	64	14 (21.88%)
TOTAL:	**257**	**51(19.84%)**

These 257 decisions will have associated summaries posted on the College's Register (after processing). Summaries stay posted during any HPARB appeal process, with a note added to the effect that the matter is under appeal. If HPARB orders a matter reconsidered, the associated summary is removed.

Reviews by the Health Professions Appeal and Review Board

Most of the ICRC's *public complaints* decisions are subject to review, on request of either the complainant or the physician, to the Health Professions Appeal and Review Board ("HPARB", or the "Board"). Excluded are complaints investigations where the outcome is a decision to refer allegations of professional misconduct or incompetence to the Discipline Committee or to refer a physician for incapacity proceedings. ICRC decisions on Registrar's Investigations cannot be reviewed by HPARB.

Upon holding a review, the Board may confirm the Committee's original decision, make recommendations to the Committee, or require the Committee to do anything the Committee could have done at the first instance. ICRC panels consider such returned HPARB matters regularly.

The Board continues to aggressively scrutinize the quality, depth and reasonableness of ICRC investigations and decisions.

ICRC Committee members discuss matters returned by HPARB at the semi-annual business/policy meetings, to highlight trends and to enhance future decision-making.

HPARB Statistics

	2012	2013	2014	2015	2016	*2017** *Jan-June*
ICRC Appealable Decisions Issued	2406	2161	2326	2162	2361	1257
Total HPARB Reviews Completed	459 (19%)	349 (16%)	336 (14%)	308 (14%)	419 (18%)	203 (16%)
HPARB Returns (i.e., ICRC decisions which HPARB did not uphold)	47 (10%)	34 (10%)	33 (10%)	26 (8%)	43 (10%)	18 (9%)
Total ICRC Decisions which HPARB Upheld	412 (90%)	412 (90%)	303 (90%)	282 (92%)	376 (90%)	185 (91%)
Complainant seeks HPARB review	n/a	n/a	n/a	340/431 (79%)	391/436 (90%)	130/144 (90%)
Respondent (physician) seeks HPARB Review	n/a	n/a	n/a	91/431 (21%)	75/436 (10%)	14/144 (10%)

*2017 = 6 months of data

- The rate of HPARB reviews (as a percentage of appealable ICRC decisions) was 14% in 2014 and 2015. As of 2016, the rate of appeals increased to 18%. The number of reviews for the first six months of 2017 indicates that this percentage is at 16%.

- The number of HPARB returns (as a percentage of HPARB reviews) was consistent at 10% in 2012-2014, and then dropped to 8% in 2015. In 2016, the percentage returned to 10% and, for the first six months of 2017, the percentage of HPARB returns is at 9%.

- The percentage of appeals by the complainant versus the respondent in 2016 and the first six months of 2017 indicate that complainants, rather than respondents, continue to bring the vast majority of appeals (90% versus 10%).

Trends

- The watchword for ICRC in 2017 has been "change" – change in our powers, with the addition of the new interim order power; change due to the increasing number and complexity of ICRC decisions; change reflected in the upward trend of public outcomes, under the transparency initiative. We underwent a major change in the electronic discussion platform we use (SharePoint). ICRC has worked hard to prepare for and embrace change, via member training and process improvements.

- In 2017, the number of ICR Committee meetings continued to increase, in part due to consideration of 81 Narcotic Monitoring System (NMS) files. Five to seven meetings will have been held to process these files, by the end of 2017.

- Public Members of ICRC continued to be extremely busy in 2017. The ICRC operated with only five public members for most of 2017. The average number of meetings per public member in 2017 will be over 60, and some public members will sit on as many as 80 ICRC panels over the course of 2017.

New in 2017

As noted above:

- Legislation change in May 2017 gave the ICRC the power to make an interim order, at any time in the course of an investigation, imposing terms, conditions or limitations on a physician's certificate of registration, or suspending the certificate.

- The ICRC instituted NMS/Prescribing panels in 2017.

- ICRC moved to the new SharePoint system in 2017 with all members undertaking training in the new software.

- Significant work was done towards revising the organization of case materials, with the goal of streamlining reviews by ICRC panel members, to be implemented in 2017/18.

ICRC Goals

The ICRC developed a program evaluation in 2014. Following a program logic model the Committee defined three broad program goals:

Enhance Public and Member Trust in ICRC Processes through:
(1) Quality Services
(2) Consistent and Reasoned Decisions

Enhance the Quality of the Profession through:
(3) Physician Performance

Each program goal identifies activities, associated measures, and indicators which tie to short and long-term outcomes. ICRC plans to use this framework over a five-year period to evaluate the effectiveness of its work.

Strategic Initiatives

Council's Strategic Directions include optimizing investigations, discipline and monitoring processes, and facilitating physician enhancement. The ICRC's investigations and decision-making are an integral aspect of this strategic priority.

To that end, the ICRC has continued to participate in a number of initiatives, including:

The ICRC Leadership Team

Given the size and complexity of the ICRC's workload and meeting schedule, the Chair of the ICR Committee is assisted by the Vice-Chairs of the specialty panels, as well as a Vice-Chair of general panels, a senior Public Member.

In 2017, the Leadership Team has met quarterly in order to develop processes (e.g., proper process for following up on an issue flagged at a member-specific issue meeting); deal with ICRC operational policy and administrative matters; set agendas for business meetings, etc.

In 2017, the ICRC Leadership Team reviewed and revised the ICRC Committee Competencies document, previously updated in 2009. After discussion at the Leadership Team, the document was finalized for review and approval of the entire ICRC at the October 2017 ICRC Business Meeting.

The "Risk Assessment Tool"

The Risk Assessment Tool pilot involved the use of a risk-based approach to case assessment and committee decision-making. The aim was to develop a simple tool that will provide a structure for panels to systematically assess the level of risk presented in a complaint, with a view to minimizing potential risk to future patients. The tool was revised in 2017 to include a tenth question. The questions cover the physician's clinical care, conduct, insight, record-keeping and complaints history; the new tenth question involves the physician's available support and integration within the medical community. ICRC panel members considering investigative files must consider and evaluate the ten enumerated factors and rate how concerning they perceive them to be.

In 2017, use of the tool was automated with new SharePoint.

Complaints Feedback Survey

In August 2016, the launch of a real time feedback survey began. Parties (Complainants and Physicians for Public Complaint Files) have been instructed that they can visit a separate web portal operated by Environics Research, to complete a confidential survey.

The survey has two phases:

- Phase 1 - satisfaction with investigation (end of investigation pre decision) explores:
    - Speed of process
    - Objectivity/neutrality of investigator
    - Ability of investigator to understand the issues and details of the concerns
    - Degree to which the parties were kept informed about the progress of

the investigation
- Degree to which they felt their complaint was taken seriously(complainants only)

- Phase 2 - satisfaction with the decision (post receipt of decision) explores:
  - Whether the decision adequately provides clear reasons for the decision

Results and feedback are being collected. There is not enough data at this time to report back. Staff are exploring with Environics different ways to increase participant uptake.

ICRC member Education and Training

The ICRC Leadership Team continues to identify opportunities for Committee member education, with the goal of enhancing consistency and reasonableness of committee decisions.

In March 2017, an education training session for Chairs/Vice Chairs and Alternates was held. Topics included deliberative privilege and its application to ICRC, a checklist for use of Independent Opinions, and further training on administrative law and on the role of evidence in the ICRC process.

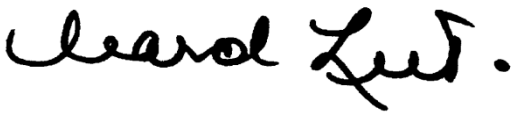
Also in March 2017, specialized training in narcotics prescribing issues was offered to a number of ICRC members who would go on to form NMS meeting panels.

Over the summer of 2017, all ICRC members were offered training via the WebEx platform on the implications of the passing of Bill 87 into law, including ICRC's new power to make interim orders.

The ICRC Panel members regularly incorporate educational sessions into the Committee's semi-annual business meetings. At its spring business meeting, Dr. Greg Murphy of Kingston addressed the ICRC on NMS data, Medical Advisor Dr. Keith Hay addressed ICRC on what other Medical Regulatory Authorities are doing with prescription monitoring programs, and Committee Chair Dr. Leet addressed the ICRC on Medical Assistance in Dying. The ICRC received updates from legal staff on a recent Divisional Court decision and other legal issues. At its October 2017 Business Meeting, the ICRC heard from Dr. Tom Lloyd, of the Saegis Safety Institute (a subsidiary of the CMPA) on the brand-new Saegis program. The ICRC also received legal updates and training at its October meeting.

Staff Support

The members of the ICRC wish to thank staff for their excellent work in assisting the Committee to implement operations and fulfil its mandate.



Dr. Carol Leet
Chair, Inquiries, Complaints and Reports Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Methadone Committee Annual Committee Report 2017

METHADONE COMMITTEE

Mandate:

The goal of the College's methadone program in Ontario is to improve the quality and accessibility of methadone maintenance in the treatment of opioid dependence. The College actively manages the practice of methadone prescribing in Ontario and receives funding for its activities from the Ministry of Health and Long Term Care.

The Methadone Governance Committee was established in by-law in June, 1999 by Council. The by-laws state that the Committee shall administer the College's methadone opioid agonist program, including:

I. Brief programs of education in addiction medicine,
II. The establishment of guidelines or standards applicable generally to the use of opioid agonists in the management of opioid dependence,
III. A program to review prescribing of opioid agonists by members in the management of opioid dependence, and
IV. Decide whether to issue, refuse to issue, or withdraw a permit for a member to administer, prescribe or otherwise furnish opioid agonists for the management of opioid dependence.

Assessments

The core activities of the Methadone Program are to support physicians in obtaining an exemption under the Controlled Drugs and Substances Act from Health Canada to prescribe methadone, assess their practice and provide educational opportunities to ensure their prescribing practices meet the standard of practice.

All physicians wishing to obtain an initial exemption must have the following:

- An independent practice license in Ontario
- Be in good standing with the CPSO at the time of application
- Complete the first course in the Opioid Dependence Treatment Certificate Program provided by the Centre for Addiction and Mental Health (with all modules to be completed within 3 years of initiating the exemption process). The certificate program requirements include a core MMT Prescribing course in addition to elective courses, for a total of 39 or more hours; the physician must complete the core course before applying for an exemption

- Complete a 2-day (or 4 half day) preceptorship with a College approved methadone prescriber or CAMH's one day practice simulation program
- Complete an application to the CPSO
- All of the above requirements must be completed within 1 year of initial application.

Upon completion of the above, the application is forwarded to Health Canada for the initial one year exemption to prescribe methadone for the treatment of opioid dependence.

After the physician has been prescribing methadone for one year, the program conducts an assessment to ensure the physician is adhering to the Methadone Maintenance Treatment Standards and Clinical Guidelines. If successful, the Committee recommends the renewal of the Methadone exemption for a 3 year period. The physician is assessed again at the end of 3 years. If that assessment is successful, the physician then enters a 5-year assessment cycle.

In addition to physician assessments, the program completes assessments of methadone practices where physicians delegate the administration only of methadone to another qualified regulated health professional (Registered Nurse (RN) or Registered Practical Nurse (RPN)). In these clinics, physicians have been given an expanded exemption by Health Canada that allows them to delegate the administration of methadone. This offers patients increased access and convenience by receiving their methadone doses from their physician's office or clinic, rather than attending a pharmacy. The assessment focuses primarily on issues related to the transportation, safety and storage of methadone. The College retains a pharmacist assessor to conduct these assessments.

This year 40 applications for exemptions were approved and there were 86 prescriber assessments and 1 delegation assessment conducted.

Transition of the Methadone Committee to be a Specialty Panel of the Quality Assurance Committee

As part of the College's Opioid Strategy, work has been underway this year to transition the Methadone Committee to be a specialty panel of the QAC. This involves taking to December Council the motion to amend Section 41 and rescind Section 45 of the General By-law and formally transition the work of the Methadone Committee under the QAC as a specialty panel. A working group has been formed to oversee the transition. There will be 4 member specific panels focused on methadone assessments in 2018.

Annual Methadone Prescribers Conference

This year responsibility for planning the conference transferred to the Center for Addiction and Mental Health (CAMH) and the College is represented on the planning committee. The event will be held on November 24th, 2017. We anticipate attendance well in excess of 280 including prescribers, pharmacists, methadone case managers, MOHLTC & CPSO staff and addiction treatment providers. The conference will include sessions on fentanyl, Health Quality Ontario practice standards, the National Opioid Use Disorder Guidelines, Opioid Overdose & Naloxone, and Heroin & Hydromorphone.

Methadone Newsletter

This past year has seen the continuation of the quarterly newsletter provided now in electronic format on the CPSO website. Feedback remains positive on the content; especially the Q&A section. The program receives a number of inquiries from prescribers related to patient care as a result of the newsletter. Additionally prescribers receive emails specific to particular issues throughout the year (for example, addressing methadone initiation with a negative urine drug screen or a physician's responsibilities for safe storage of methadone when they have a delegation exemption).

Health Quality Ontario Draft Practice Standards Feedback

Committee members had the opportunity to provide individual feedback as methadone prescribers to the patient and clinician versions of the three draft standards developed to address the following:

- **Opioid Use Disorder (Opioid Addiction) - Care for People 16 Years of Age and Older**
- **Opioid Prescribing for Chronic Pain - Care for People 15 Years of Age and Older**
- **Opioid Prescribing for Acute Pain - Care for People 15 Years of Age and Older**

Withdrawal of College Role in Supporting Applications for Section 56 Exemptions

The College signalled to Health Canada this year that as part of moving away from its focus on providing a single drug focussed program it intends to withdraw from its current role in supporting applications by physicians to prescribe methadone for the treatment of opioid use disorder. This aligns with the College's current practice that does not have any role in supporting applicants for the use of methadone for analgesic purposes. However, the College has committed not to change its role in the current process until the recommendations from the Section 56 consultation have been made and a process to ensure continued access to exemptions in Ontario is in place. (See below)

Health Canada Section 56 Consultation

Health Canada initiated a national consultation process in the late summer of 2017 on the use of the section 56 exemption to allow physicians to prescribe methadone outside of the prohibitions in the Controlled Drugs and Substances Act. The Committee was given an opportunity to provide feedback as part of the College's response to the consultation. The Committee commented on the pros and cons of keeping the exemption including support for the continued focus on assessment of methadone prescribers especially if there is no longer an exemption. When the recommendations are available the College will consider their implications and determine next steps with respect to our current role in the exemption system in Canada.

Respectfully submitted,

Meredith MacKenzie, Co-Chair

Steven Bodley, Co-Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Outreach Committee Annual Committee Report 2017

Outreach Committee
2017 Annual Report

Overview

The Outreach Committee works with staff to:

- *Develop major communications and outreach initiatives for the profession and the public;*
- *Assist in the development of major communications initiatives and government relations activities;*
- *Develop plans to deliver on each of the communications and outreach-related components of the College's strategic direction.*

The Committee is supported by the Policy and Communications Division.

Areas of Focus

The Committee focused on outreach and communications-related priorities contained in the College's strategic direction. They include the following:

- Media monitoring and measurement
- Integrated social media/communications
- Membership/public outreach
- Public polling and engagement
- Government relations activities

Following is a summary of the each of the major initiatives.

Media Monitoring and Measurement

The Outreach Committee reviews the results and analysis of media monitoring and measurement at each meeting. Using the Media Relations Rating Points (MRP), all media activity related to the College is carefully measured and evaluated. This 10-point system measures coverage across several key dimensions including tone, (whether the overall story is positive, negative or neutral) and criteria including whether the College is mentioned, if a spokesperson is quoted, if a key message is included, if the mandate is mentioned or evident and accuracy. Using this point system, every type of media (print, radio, online, television) is rated.

Highlights:

Media attention has been very high during the first three quarters in 2017, with 987 stories about the College or in which we were mentioned. By comparison, in 2016, there were 957 stories measured by this point in the year, up from 776 stories during the entire year in 2015.

Importantly, the tone of the media coverage has been very good, with 20% (202 stories) positive; 64% neutral (631); and only 16% negative (154).

Although CPSO discipline cases received extensive media attention this year as usual, the media continues to cover MAID-related issues fairly extensively, and in the 1st and 2nd quarters in particular, there were many stories that mentioned the College's policy. The effective referral requirement in the policy was noted in many stories related to Bill 84, when "conscience protection rights" for physicians were being sought by individuals and advocacy groups. The court challenge to the effective referral requirement in the CPSO's Human Rights policy and MAID policy also garnered significant media attention in late May and early June. The stories in which our effective referral requirement were mentioned were generally either neutral or negative in tone, and have accounted for a significant portion of the negative stories overall.

Communications/Social Media

In 2017, the College continued to build its social media audience across its four key platforms: Twitter, Facebook, LinkedIn and YouTube. These platforms now have a total combined audience of nearly 5,000 users.

We continue to hold regular social media campaigns for all open consultations, and use these tools to promote job openings, issues of *Dialogue* and other College publications, and to provide real-time customer service to both physician members and the general public.

Other specific initiatives for 2017 include:

- A new CPSO policy app has been developed which will be downloadable to iPhone and Android devices. This app will provide users with fast, up-to-date policy information in the palm of their hand, as well as access to our open consultations and issues of *Dialogue*. Users will also be able to send us real-time feedback on policies as they use them, which can be fed in to our consultation process.
- A major revamp of the CPSO's public website has been completed. This included the launch of an entire new section, called Public Information & Services, which links to all of the public-relevant content (complaints, the public register, etc.) in one place. The website was also updated with a new, modernized home page and colour palettes that comply with our new visual identity. Phase 2 of the project, which involves a new and improved DocSearch capability (now renamed "Find a Doctor") is expected to launch in late 2017/early 2018.
- A new whiteboard animation video, targeted at our physician members and called "Getting Communication Right with Your Patients" will be released shortly. In this video, deputy registrar Dan Faulkner discusses why it's important that doctors learn to build rapport with and empathy for patients and provides tips on how doctors can improve or strengthen their communication skills. Once released, this video will be shared on our various social media channels, on the website, in *Dialogue* and other publications, and at relevant Outreach-related events.

Public/Profession Engagement

The College's public engagement program consists of a number of coordinated activities designed to connect with and obtain public and professional perspectives and feedback to inform College policy development and other activity. Public opinion polling is just one way in which the College obtains public

perspectives and feedback in its work. In 2017, one survey cycle was undertaken. The survey polled on issues relating to Continuity of Care and the public's awareness of the CPSO and perceptions of professional regulation. As with all polling conducted, the results will be considered by the Outreach Committee and will be used to inform Working Groups, Committees, and Council on policy issues.

In addition, enhancements to the policy consultation process continue to be made to facilitate engagement with the public and the profession. In 2017, focused social media promotion, dedicated policy newsletters and user-friendly blogging software were used to make it as easy as possible for anyone to participate in a consultation. The level of engagement can vary quite significantly depending on the subject of the consultation, and whatever the subject, efforts are focused on receiving quality feedback from a variety of stakeholders. A policy consultation summary page is also developed once policies have been finalized by Council. It includes a summary of the quantity of feedback received and a breakdown of who we heard from, highlights of the key things heard during the consultation and other relevant considerations, how the feedback was responded to including what changes were made and the rationale for those changes. Links to the final policy as well as some of the key messages are also included in this summary page. It was felt that it was really important to demonstrate, particularly to those who participate in consultations, that their feedback is carefully considered and that we evaluate and integrate all the feedback we receive.

Public/Profession Outreach

The goals for the 2017 Outreach program focused on proactively seeking out opportunities to engage with members of the public, medical students, residents, CPSO members and other health professionals. Outreach efforts are accomplished largely through our participation in speaking events, conferences and attending community meetings. CPSO spokespeople completed 56 speaking engagements in 2017.

Highlights:

- Collaborated with Dying with Dignity Canada (Kingston Chapter) to develop a well-attended attended public information session on Medical Assistance in Dying (MAID).
- Hosted web-based education sessions on MAID, opioids and communication skills for medical staff teams in Algoma, Iroquois Falls, Matheson, Cochrane and Wawa.
- Spokespeople delivered remarks during medical school milestones including: convocation, orientation week and other significant points in the undergraduate medical education calendar.
- Hosted the 6th Annual Future Leaders' Day (FLD) attracting 22 physician leaders from across the province representing 13 specialties – inspiring several participants to get involved in CPSO work.
- Attended Ontario Medical Students' Weekend hosted by the Northern School of Medicine (NOSM) and met with 350 of Ontario's first-year medical students.
- Published three issues of the *Medical Student Update* – the CPSO's student and resident focused e-newsletter
- Produced a video message entitled "Reflections of a Seasoned Regulator" which showcased the journey of Dr. Rocco Gerace from student to CPSO Registrar. The video included a call to action for physicians new to the profession to participate in regulation.
- Hosted international delegations from Denmark and China showcasing our policy work and our organizational processes.

- The opioids topic is emerging as a frequently requested presentation. Four speaking engagements on opioids took place in the fall of 2017. Many more requests for talks on this topic are anticipated in 2018.

Government Relations Activities

The College's government relations activities in 2017 have been significant and directed at a variety of issues and initiatives including:

- working closely with government on the prevention of sexual abuse of patients including work on Bill 87, *Protecting Patients Act*;
- ongoing work with regards to Medical Assistance in Dying (MAID);
- appointment and compensation of public members of Council;
- regulation of fertility services;
- overhaul of out-of-hospital facility regulation, and
- issues surrounding opioids and medication management.

In order to carry out this work, the College is in contact with a variety of government decision-makers. This includes regular interaction with the Minister of Health's office, the Premier's office, senior Ministry staff, and the opposition parties at Queen's Park.

In Summary:

2017 was an interesting year for the Outreach Committee. We will continue to look for opportunities to enhance the quality and quantity of our interactions with all stakeholders and take advantage of technology to broaden our outreach. The committee will help guide and inform the College's ongoing work to update its public engagement program and will continue our ongoing focus to move to digitization and making best use of technology connect with the public and with physicians.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Patient Relations Committee Annual Committee Report 2017

Patient Relations Committee
2017 Annual Report

Mandate and Objectives

The Patient Relations Committee (PRC) is a statutory committee of Council. The *Regulated Health Professions Act, 1991* (*RHPA*) requires all colleges to have a patient relations program that includes measures for preventing and dealing with sexual abuse of patients by members.

The PRC is responsible for advising Council with respect to the patient relations program, as necessary.

The PRC is also responsible, under Section 85.7 of the Health Professions Procedural Code under the *RHPA* (the Code), for administering a program of therapy and counselling for persons who, while patients, were sexually abused by members. The PRC administers the fund for therapy and counselling by:

- Determining eligibility for funding; and
- Dispersing funds to eligible applicants' therapists/counsellors.

The PRC advises Council with respect to its activities by way of an annual report.

Committee Composition

The PRC is composed of two physician non-Council members[1] and two public non-Council members. A physician who is the subject of an application for funding for therapy and counselling may also be the subject of concurrent or future complaints or discipline matters, therefore only non-council members are appointed to this committee in order to avoid any apprehension of bias or conflict issues that could arise. The PRC members have experience in the areas of mental health, psychotherapy, psychiatry as well as knowledge of sexual abuse issues.

The Policy Department provides policy and administrative support to the PRC, and a representative from the Legal Department provides legal advice.

Core Activities & Statistics

The PRC's primary activity is administering funding for therapy and counselling. The PRC also advises Council with respect to the patient relations program and broader sexual abuse issues.

Administering Funding for Therapy and Counselling

[1] There are typically three physician non-Council members on the PRC; however, there is currently a vacancy that needs to be filled.

Patients who were sexually abused by their physician can apply for funding for therapy and counselling. If eligible, patients are awarded funding for therapy and counselling and payment for the therapy and counselling obtained is made directly to the therapist/counsellor if the services are not covered by the Ontario Health Insurance Plan (OHIP) or a private insurer.

The PRC makes two determinations upon receipt of a funding application: whether the applicant is eligible for funding, and if so, the amount of funding that should be awarded. The eligibility criteria are set out in the Code[2] and Ontario Regulation 114/94 under the *Medicine Act, 1991*.[3] It is notable that the eligibility criteria is so broad that an applicant doesn't even have to make a complaint first before applying for funding. Ontario Regulation 59/94[4] under the *RHPA* states that the maximum amount for funding is the amount that OHIP would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist. The maximum amount of funding has increased over time in accordance with changes to the OHIP rate. Currently, the amount is $16,060; at the program's inception, the amount was approximately $10,000. Typically, the PRC awards eligible applicants the maximum amount of funding allowed by regulation.

The PRC has approved 181 applications since its inception (1994-2017), and has denied 19 applications.[5] The total amount awarded for the same period is $2,273,185. The total amount paid out to date is $1,310,628. The monies are paid out to therapists/counsellors as applicants use therapy and counselling. Some patients may not use the full award and some may use it at different intervals over a period of time. The following chart summarizes the funding for therapy and counselling that has been approved and used over the last nine years:

[2] Section 85.7(4).
[3] Section 42(2).
[4] Section 1(a).
[5] The PRC typically denies applications because either there isn't a physician-patient relationship (e.g. applicant is a family friend or employee of the physician) or there isn't sufficient evidence to support a reasonable belief that the applicant was sexually abused while they were a patient (e.g. little information about the allegations, alleged touching is determined to be non-sexual, or no records to confirm there was a physician-patient relationship).

	2017 *(Jan-Nov)*	2016	2015	2014	2013	2012	2011	2010	2009
Applications Approved	15 (17 were reviewed; 2 are pending)	16 (22[6] were reviewed)	10 (13[7] were reviewed)	4 (5 were reviewed)	3 (4 were reviewed)	8	4 (5 were reviewed)	5	4 (5 were reviewed)
Funding Approved	$240,900	$256,960	$160,060	$64,240	$48,180	$128,480	$63,120	$71,740	$56,800
Money Paid Out[8]	$119,229	$108,176	$77,388	$46,090	$78,502	$53,583	$33,575	$51,870	$29,676

The number of applications received by the PRC has remained relatively consistent at approximately four to five applications per year. However, in 2012 and for the past three years (2015-2017), the PRC received a higher number of applications.[9] It is not clear what might have caused these increases, but it is possible that the increase in 2012 was a result of the administrative improvements made to ensure all potential applicants receive an application for funding for therapy and counselling, and are supported in the application process. It is also possible that the increase in 2015-2017 was a result of the steps the College has taken to promote the existence of the funding for therapy and counselling program as part of its Sexual Abuse Initiative (e.g. via media releases, enhancing the information on the College's website, and developing patient-specific resources such as the Educational Brochure and What to Expect During Medical Encounters document).

In addition to reviewing new applications for funding for therapy and counselling, the PRC has also considered new requests to fund specific types of therapy or counselling from eligible patients who had been awarded funding in previous years.[10] To use the fund for therapy and counselling, eligible patients must select the therapist/counsellor they would like to receive therapy/counselling from. Because the Code specifies that the funding must only be used to pay for 'therapy or counselling', with some limited restrictions, the PRC has been determining on a case-by-case basis what constitutes 'therapy or counselling' in relation to sexual abuse by a physician.

Given the considerable amount of choice the Code affords eligible patients in selecting a therapist/counsellor, the PRC has funded a range of therapies, including some therapists/counsellors who are not regulated health professionals. Eligible patients are advised of the implications associated with selecting an unregulated therapist/counsellor, and must confirm that they understand the therapist/counsellor would not be subject to regulatory oversight. Ultimately, the legislation entitles eligible

[6] One of these applications was deferred (and will be reconsidered in November 2017).
[7] One of these applications was deferred (and still remains deferred as of October 2017).
[8] To therapists/counsellors of approved applicants.
[9] 2012: 8 applications reviewed; 2015: 13 applications reviewed; 2016: 22 applications reviewed; 2017: 17 applications reviewed.
[10] As of the date of this report, the PRC has considered four requests to fund specific types of therapy or counselling in 2017.

patients to select the therapist/counsellor that best meets their needs.

Other Activities

In 2017, the PRC focussed primarily on funding for therapy and counselling applications. The PRC also closely monitored and was supportive of the College's Professionalism and Practice Program work, including the development of the Boundaries and Sexual Abuse Module, and Bill 87, the *Protecting Patients Act, 2017*.[11] Looking forward to 2018, the PRC's main focus will continue to be reviewing funding applications. The PRC's other two areas of focus will be adjusting PRC activities and processes to be consistent with relevant provisions in Bill 87, and assisting with the College's Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy review by providing its advice and content expertise as the review continues into 2018 and beyond.

[11] Some of the provisions in Bill 87 are not currently in force; they still have to be proclaimed and/or regulations have to be developed.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Premises Inspection Committee

Annual Committee Report 2017

PREMISES INSPECTION COMMITTEE

MANDATE:

The Premises Inspection Committee shall administer and govern the College's premises inspection program in accordance with Part XI of Ontario Regulation 114/94 and its duties shall include, but not be limited to:

(a) Ensuring appropriate individuals are appointed to perform inspections or re-inspections as authorized by Ontario Regulation 114/94;
(b) Ensuring adequate inspections and re-inspections are undertaken and completed in a timely way using appropriate tools and mechanisms;
(c) reviewing premises inspection reports and other material referred to in Ontario Regulation 114/94 and determining whether premises pass, pass with conditions or fail an inspection;
(d) Specifying the conditions that shall attach to each "pass with conditions";
(e) Delivering written reports as required under Ontario Regulation 114/94; and
(f) Establishing or approving costs of inspections and re-inspections and ensuring the member or members performing the procedures on the premises are invoiced for those costs.
(g) Reviewing reports of adverse events from premises.

COMMITTEE ACTIVITIES:

The Out-of-Hospital Premises Inspection Program (OHPIP) is overseen by the Premises Inspection Committee (PIC). Committee membership attempts to reflect the breadth of inspection assessment activities that occur in out-of-hospital (OHP) settings. Members on PIC practice in areas such as anesthesia, colonoscopy, interventional pain, and general surgery. For the 2017 program year, there have been 33 individual committee panels to review inspection assessment reports, as well as 4 policy meetings to give overall direction to the program. Below is a list of the 2017 program activities and milestones:

OUT-OF-HOSPITAL PREMISES PROCEDURES:

Procedures performed in OHPs include, but are not limited to, cosmetic surgery, endoscopy, hair transplantation and interventional pain management that are performed using specified types of anesthesia (e.g. general anesthesia, sedation, most types of regional anesthesia and, in some cases, local anesthesia).

STAKEHOLDER ENGAGEMENT ACTIVITIES:

Medical Director Education Day

In December 2016 significant changes were made to the OHPIP Standards which resulted in additional responsibilities for the role of the Medical Director in an OHP. As a result, for the first time since the inception of the Program a Medical Director Education Day was held in April. The event provided Medical Directors of OHPs with the opportunity to gain a better understanding of their role and responsibilities as well as receive program updates.

Presentations were focused on recent revisions to program standards; common outcomes from assessments; and the process the committee uses to make decisions. An evaluation was provided to attendees and staff received positive feedback and requests for additional sessions to be held in different regions across the province. Over 200 medical directors and facility staff attended the session as well as Committee members.

Fertility Services – Standards Development/Regulation Submission

In August 2015, the Deputy Minister wrote to the College requesting our participation in establishing a quality and inspections framework for the fertility services sector, including Out-of-Hospital Premises (OHPs) and hospital settings.

Earlier this year the College's Expert Panel on Fertility finalized the Companion document, "Applying the Out-of- Hospital Premises Inspection Program (OHPIP) Standards in Fertility Services Premises". The document is intended to be used in conjunction with the core OHPIP Standards and applies to fertility services offered in both OHPs and hospital-based clinics. The Companion document, and core OHPIP standards, will help fertility services practitioners plan for and participate in their inspection-assessments. The requirements in the document will also be incorporated into the assessment criteria and tools used by College inspectors.

In order to fulfill the Ministry's request, the College needs authority to enter and inspect the premises where fertility services are performed, regardless of whether anaesthesia or sedation is used. An amendment to *Ontario Regulation 114/94, Part XI (Inspection of premises where certain procedures are performed)* made under the *Medicine Act, 1991* is proposed to bring premises, including hospital-based fertility clinics which perform fertility services, under the OHPIP. Council considered a draft regulation amendment at its September 2016 meeting and approved it for external consultation.

Council has since approved the amendment to the regulation which was formally submitted to government as a regulation amendment proposal in February. Once government enacts the necessary changes to *Ontario Regulation 114/94, Part XI*, the College will have 24 months to complete inspections of all existing premises and will have 180 days to complete the inspections of any new premises that are not yet operational.

Ongoing Collaboration with Public Health Ontario

The CPSO has become involved in a variety of initiatives with system stakeholders to improve infection prevention and control (IPC) practices among members, and to develop consistent approaches to managing IPC lapses in out-of-hospital premises.

PIC continues to be involved with conducting joint IPC assessments with regional public health units across the province. Collaboration has also included ongoing consultation regarding the selection of appropriate

assessors and infection control experts, and discussions related to the public posting of inspection outcomes.

Public Health Ontario (PHO) continues to provide ongoing support with training initiatives and literature reviews for concerns identified by OHPIP assessors and Committee workgroups. This past summer PHO also completed updates to a series of IPC checklists designed to support IPAC lapse investigations in clinical office practice settings. These checklists are posted on the PHO website and will be posted on the OHP website once training is completed with OHP assessors and communication provided to medical directors. The checklists will also be used by most of the public health units across the province.

Quality Management Partnership (QMP)

In December 2015 the Ministry of Health and Long-Term Care mandated that the Quality Management Partnership, a CPSO strategic initiative, start implementing Quality Management Programs (QMPs) in colonoscopy, mammography and pathology.

At each of its policy meetings, PIC continues to receive updates related to the partnership quality activities, as endoscopy represents a major component of the current out-of-hospital premises inspection program.

Specifically, QMP has proposed that the addition of the Colonoscopy Quality Management Program Facility Lead role be embedded in the OHPIP Standards. The aim of embedding the Colonoscopy QMP Facility Lead role into OHPIP standards is to assure participation in Partnership activities and achieve the following goals: enhance quality of care and improve patient safety, increase the consistency in the quality of care provided across facility types (e.g. hospitals and Out of Hospital Premises), and improve public confidence by increasing accountability and transparency. Including the Facility Lead in the OHPIP companion document is a lever that can be used to ensure alignment with and participation in Partnership programs.

Oversight of Health Facilities

In the fall of 2014, concerns were raised by the media about the adequacy and amount of information available to the public about assessments of out of hospital facilities and infection outbreaks in these facilities. In response and in recognition that facilities play an important role in providing Ontarians with quality health care services, the Minister of Health and Long-Term Care created a panel chaired and supported by Health Quality Ontario (HQO) to provide advice to government on the comprehensiveness and effectiveness of the current quality oversight programs for facilities.

In May 2016, the Health Minister, endorsed recommendations made by HQO in the report titled *Building an Integrated System for Quality Oversight in Ontario's Non-Hospital Medical Clinics*. Of significance was the HQO recommendation to develop a consolidated approach to the care provided to patients in out-of-hospital settings. The general approach to the consolidation of the IHF and OHPIP under one quality regime requires new legislation that is also intended to capture other services being performed in health facilities.

On September 20, 2017 the Minister of Health and Long-Term Care, introduced the *Strengthening Quality and Accountability for Patients Act, 2017*, which has now completed Second Reading in the Legislature.

Program staff has been engaged in discussions with the Ministry during the drafting of the legislation and have been given the opportunity to provide feedback to its content. Staff and Committee will continue their collaboration with the Ministry in the development of regulations to support the enactment of various aspects of the Act.

Education

A number of education opportunities and presentation at national conferences have been undertaken to continue communication with the membership and other stakeholders about the OHP program and work of the Committee. These have included regular representation and updates at Assessor Network Group meetings, Medical Director Day, meeting with executives of the Canadian Fertility and Andrology Society in preparation for the implementation of the fertility services assessments (as mentioned above), presentation about collaborative efforts with OHPIP and regional public health units at the annual Canadian Public Health conference, to name a few.

Respectfully Submitted,

Dr. Dennis Pitt
Chair, Premises Inspection Committee

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Quality Assurance Committee

Annual Committee Report 2017

QUALITY ASSURANCE COMMITTEE

MANDATE

The Quality Assurance Program must include:

- Self, peer and practice assessments
- A mechanism for the College to monitor members' participation in, and compliance with, the quality assurance program
- Continuing education or professional development designed to promote continuing competence and quality improvement among the members, address changes in practice environments and incorporate standards of practice, advances in technology, changes made to entry to practice competencies and other relevant issues at the discretion of Council

This report covers activities of the Committee for this year to date.

STRATEGIC PROJECTS

There are two strategic priorities under the direction of, or with significant input from, the Quality Assurance Committee:

1. ASSURE AND ENHANCE PHYSICIAN COMPETENCE

The objectives of this priority include:

- Ensuring the effective assessment of every doctor every 10 years
- Determining whether College interventions produce change
- Ensuring policies improve quality of care/safety

As noted in last year's report the Research and Evaluation Department is leading a multi- year project under the Assessment Revisioning mantle to redesign the protocols used for peer assessment. Under the direction of a dedicated RED research associate the following activity / targets have occurred in 2017:

- 6 of the assessor network groups are now being assessed using their Assessor Handbook. To date 30 reports have been reviewed by QAC or given staff No Further Action; 35 on-site assessments have been completed (i.e., report received by College); There are 133 redesign assessment currently underway (as of Nov 4th).
- 17 of the assessor network groups are or will be in the process of developing their Assessor Handbook by December.
- The proposed handbooks that were tested as of Nov 4th: FM/GP, Walk In Clinics, Medical Psychotherapy, Psychiatry, Cardiology, Hospitalist (these are the 6 mentioned in bullet 1). Dermatology, Emergency Medicine and Endocrinology have all their tools complete and ready but don't have assessors assigned to any cases yet but will by year's end).

- Research & Evaluation Department staff, in conjunction with assessors, have developed a new tool for assessors to engage in knowledge transfer with physicians being assessed called “Quality Improvement Resources” or “QIR”. To date 57 have been externally reviewed and/or endorsed by physician specialty organizations.
- Extensive external stakeholder consultation: 9 groups have finished their external consultation with overall positive results. Additionally, 2others are currently underway: Rheumatology will finish in December and Radiology will finish in early 2018.

Planned for 2018 will be an additional 6- 11 handbooks developed. This will be dependent on other College priorities (e.g., opioids, data strategy, electronic transmission of reports, etc.). Potential groups include:

1. Orthopedic Surgery
2. Plastic Surgery
3. Neurology/Neurosurgery
4. Chronic Pain Medicine
5. Gastroenterology
6. Obstetrics & Gynecology
7. Clinical Immunology/Allergy
8. Nephrology
9. Pediatrics
10. Respirology
11. Urology

2. CPD NON-REPORTERS

In 2014 the College undertook to ensure 100% compliance with the CPD regulation which, for Phase I required all physicians with an independent certificate be required to track their CPD with one of the three approved organizations. Late in 2017 staff have begun consideration of Phase Two which is focused on working with the three accrediting body’s efforts to ensure members are compliant with the annual and five year cycle requirements.

OTHER ACTIVITIES

QAC Education Day

A third successful Education Day was held in May addressing both the ongoing work of the Peer Redesign project, engaging committee members in activities focused on consistency in decision making, an overview of the College’s Opioid Strategy and the Physician Factors project. The event was well attended and feedback was that members found the information provided helpful in informing their role on the committee.

QAC Working Group

A sub-group was formed in late 2015 to review all Pathways and Peer Redesign pilot cases and to provide input into the ongoing use of MSF and the revision of the Assessor Feedback form. Since its inception this group has met monthly and has developed considerable confidence and expertise first in reviewing Pathways cases but as those have wound down have begun developing expertise in reviewing cases using the new Peer Redesign tool developed for Family Medicine. As additional handbooks are developed and assessments in those areas of practice conducted so will this group review and provide feedback. They continue to serve as a valuable sounding board for policy items considered for presentation at main QAC policy meetings

Ongoing QAC Training

It was agreed last year that each policy meeting would contain an education component and this section of the policy meetings has been well received. In addition to the all-day education session provided in May, this year the Committee heard presentations on the role of CPSO policy in support of decision making, received training in the use and application of a Decision Guide document developed by staff, received preliminary education on methadone maintenance and received regular updates on the College's opioid strategy.

Process Improvements

The Committee has continued to be involved in streamlining processes to improve the efficiency of the meetings and to continue to improve consistency in decision making. These include consideration of minimum expectations for physicians who attend an interview using an EMR, communication of expectations with respect to minimum retention of skeletal notes and adoption of expanded criteria that exempt a physician from a peer assessment.

Registration Pathways Evaluation

In February 2012, Council approved an evaluation of the College's alternative routes to registration for physicians who do not meet the requirements for membership set out in the Registration Regulation. The goal of the evaluation is to

- Ensure appropriateness of policies/pathways (are they meeting the intended purpose of licensing a qualified, safe practitioner?)
- Gain insight to inform decisions about changes to alternative pathways to registration (is the threshold for policy too high, too low, just right?)
- Understand educational needs of physicians for quality improvement purposes.

Upon completion of all assessments contained in this project staff in RED have presented preliminary findings in preparation for presentation to December Council of this year on the Multisource Feedback evaluation as well as outcomes from the evaluation itself.

QAC Member Interviews
Committee co-chairs agreed as part of their role to ensure speak directly with all members of the Committee annually to review goals and provide feedback as necessary. These meetings took place by June of this year.

Methadone Committee Transition
A motion at December Council will be brought to revoke section in the College's General By-law that identifies the need for a standalone Methadone Committee. Instead the function of this committee will be transitioned to a specialty panel under the QAC with a Vice-Chair for leadership of the member specific meetings. Staff has been working all year with the QAC to keep them informed of this proposed action and the committee has provided needed direction on the planned implementation in 2018.

Committee Internal Policy Review
Staff has committed to bringing to the committee all policies that require revision or updating which this year included **Criteria for Exemption from Peer Assessment.** This review function is ongoing as policies require review and/or updating.

Dr. Brenda Copps and
Co-Chair
Quality Assurance Committee

Dr. Patrick Safieh
Co-Chair

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Registration Committee
Annual Report 2017

REGISTRATION COMMITTEE

MANDATE

The Registration Committee's mandate is described in the *Health Professions Procedural Code*, to consider applications for certificate of registration to practice medicine in Ontario of individuals who, in the opinion of the Registrar, do not fulfill the registration requirements, prescribed in the Regulation.

When an individual applies to the College for registration, the Registrar has the following two options:

1. Register the applicant; or
2. Refer the application to the Registration Committee for its consideration.

The referral to the Registration Committee may be made for the following reasons:

- The applicant does not fulfill the registration requirements (examinations) set out in the Regulation; or
- The Registrar has doubts on reasonable grounds whether the applicant fulfills the non-exemptible requirements in the Regulation (requirements that pertain to conduct, character and competence).

Additionally, the Registration Committee is responsible for the development of policies and programs on issues pertaining to granting of certificates of registration to practice medicine in Ontario.

The Registration Committee is guided by the strategic direction established by Council. The Committee is committed to reducing barriers to registration for qualified individuals by facilitating the development of new registration policies that are fair and objective, while maintaining the registration standard.

The Registration Committee continues to collaborate with external stakeholders to identify alternative ways to evaluate the competence and performance of physicians. External stakeholders include the other provincial licensing authorities across Canada, Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, Medical Council of Canada, Ontario medical schools, Ministry of Health and Long Term Care, and Health Force Ontario.

CORE ACTIVITIES

Review of Applications

The Registration Committee, after considering an application, may make an Order directing the Registrar to issue a certificate of registration prescribed in the Regulation, to issue a certificate of registration with terms, conditions and limitations, or to refuse to issue a certificate of registration.

When the Registration Committee makes an Order to refuse the applicant's request, it must give written reasons for its decision. An applicant, who is dissatisfied with the Registration Committee decision may appeal the decision to the Health Professions Appeal and Review Board (HPARB) and may request a written review or an oral hearing.

If the applicant or the Registration Committee is dissatisfied with the Order of the HPARB, either party may appeal the HPARB Order to the Divisional Court of Ontario.

Volume of Applications

The Registration Committee's annual workload has continued to increase over the year. The increase in applications is a direct result of the College's commitment to reduce barriers to registration for qualified individuals by approving new registration policies. Complete data pertaining to the actual number of applications and the type of applications considered will be provided to Council in the spring 2018 report.

Efficiency in review with types of cases

The Committee and staff are always looking for ways to increase efficiency without compromising quality. With changes to the administrative processes and procedures, the Committee and staff have been successful in managing increasing caseloads without increasing the in-person meeting days.

How we did it:

- The addition of more memos for exemption policies that are deemed no discussion cases
- Moving the exemption cases that do not result in a restricted certificate to the assessor team
- Additional Monthly Panel meetings by teleconference
- Re-organizing the agenda to cover complex cases first (greatly reduced the meeting times)
- Grouping cases where only one member wishes to discuss case together quickens the response time by staff

- This year the committee was restructured into panels of 4 with both new and seasoned members to facilitate a timelier decision of its 100-150 meeting case load and to ensure cross training within its members

Timeliness of Review of Applications and Issuance of Decisions

Review time on the application is reported on the Council dashboard, and results remained in "the green" for the entire year. A benchmark of 5-7 business days was established for issuing the decision letter, following the Committee meeting. 100% of decisions were out in this timeline for 2017 and 200% increase of complex cases.

Registration Committee Goals and Objectives

At the beginning of 2017, the Registration Committee agreed to a set of goals and objectives for this year. The following provides an update:

Objective #1: Remove barriers to registration for qualified individuals – creating and maintaining mechanisms to enable registration of individuals who may not fulfill the requirements outlined in the Regulation, while maintaining the registration standard.

- The registration data for 2017 shows that for the 13th year in a row there has been an increase in the number of certificates of registration being granted by the College and this is a direct result of the policies approved by Council.
- The Registration Committee is continuing to review the registration policies on an on-going basis to determine if the policy is still relevant and if further changes are warranted.
- As a result of this review, the Registration Committee recommended the following revisions:

Council Policy

Change of Scope and Re-entry was updated with modern language and for clearer messaging around time spend out of practice and competency.

Practice Ready Assessments for Family Medicine in 2017 the launch made ready by committee and staff, is on hold with Ministry of Health. The Registration Committee approved initial certificates of registration to facilitate this mandate.

- CPSO successfully is scheduled for its bi-annual assessment on fairness and transparency by the Office of Fairness Commissioner in 2017.
- Initiated the frameworks for Obesity and Dermatology to provide new parameters in a

transparent informed guideline

Objective # 2: Provide evaluation of applications for registration in a timely manner.

- There continues to be a process in place, ”panel meetings” (teleconference), enabling expedited review of cases that are urgent and/or are not complex in nature
- 95% of cases were reviewed within published dashboard timelines
- Registrations new approved fee for expedited initial assessment is $103,000 to date.
- After the initial dry run for new BBV’s in the 2016 application, false positives and improper reporting caused a delay in processing. In 2017 the new Final Year Med student application was streamline which successfully avoided delays in processing
- 2017 was the pilot with Western to include Final Year Medical student LOA’s information in single document, drastically cutting down on the paper requirement for processing

Objective #3: Web-based registration improvements

- Significant changes were made to the website under Registration to include a pre-screening questionnaire by way of review of qualifications for those seeking registration in Ontario.
- The Website includes updated FAQ’s for Registration Committee Process, Supervision and cases requiring an assessment.
- The College is participating, through FMRAC, in the development of an on-line national application process for Independent Practice Certificates. Ontario’s commitment to commence development in late 2017 for all first time registered IMG’s.
- The website has been updated to reflect the new process and timelines to ensure transparency and facilitate better understanding of the Registration and Registration Committee process.

Objective #4 - Tracking quality of registration pathways

- A program evaluation of alternative registration pathways and policies began in 2012. The evaluation will seek to determine if there are potential performance differences between physicians who were registered through alternative pathways and those who registered with Canadian training. The purpose of the study is to ensure that all doctors are performing competently regardless of where training was obtained.
- Registration Committee, in a working group helped guide the data analysis to inform its key findings

Objective # 5 – Proactively regulates the profession

- Development of National Standards – The Registration Committee continues to be active in its participation in the development of national standards for licensure.
- Approval of a New member Orientation module was achieved to facilitate onboarding physicians in self-regulation with tools and expectations around professional medical

practice in Ontario

UPDATE ON OTHER ACTIVITIES

Significant changes to process and staffing structure resulted in more effective process efficiencies. These efforts resulted in improved timelines for initial assessments and issuance of certificates of registration. The creation of a program assistant pool allowed for the processing of ever increasing paper applications without the additional ask for resources.

Appeals to HPARB

2017 - 3 have withdrawn, 3 are awaiting disposition, 2 outstanding dispositions from 2012, and 2014.

UPDATE ON STAKEHOLDER INITIATIVES

Medical Council of Canada (MCC)

International delivery of the MCCQE Part I and phasing out of the MCCEE

The last MCCEE session will take place November 2018

The Medical Council of Canada is pleased to announce a more streamlined assessment process for international medical graduates and international medical students.

Starting in 2019, we will be delivering the Medical Council of Canada Qualifying Examination (MCCQE) Part I in Canada and internationally in over 80 countries, up to five times per year.

The MCCQE Part I is currently offered twice per year in Canada only. Internationally trained candidates must first pass the Medical Council of Canada Evaluating Examination (MCCEE) before being eligible to apply for the MCCQE Part I.

Once the MCCQE Part I is offered internationally, all candidates will be challenging this examination directly, without first having to pass the MCCEE.

As a result of this change, we will be phasing out the MCCEE. November 2018 will be the last session. Candidates will have until mid-November 2018 to take the MCCEE.

Application for medical registration (MRA onboarding)

The latest medical regulatory authorities to start using the Application for Medical Registration are College of Physicians and Surgeons of Prince Edward Island, the Yukon Medical Council and the College of Physicians and Surgeons for Manitoba.

MCC 360

The MCC has embarked on a national project to incorporate the multi-source feedback into physician quality assurance. The tool surveys to collect feedback from the physician him or herself, coworkers, colleagues and patients focused on the physician roles or Collaborator, Communicator and Professional. 500 Family Medicine physicians in Alberta will undergo an MCC 360 multi-source feedback assessment between Aug and December 2017 as part of proof of concept.

NAC PRA

Enhancements to the Communication and Cultural Competencies orientation program platform are underway. A new landing page, enhanced menu for ease of navigation and new content can be found online. The latest module, Professional challenges, launched in March 2017.

College of Family Physicians of Canada (CFPC)

1) Family Medicine Professional Profile

The CFPC has launched the Family Medicine Professional Profile that is intended to capture the collective capabilities and commitments of family physicians in the health care system and guide the work of the CFPC in representing our members and in setting professional standards. Details are available here: http://www.cfpc.ca/fmprofile/.

2) Certification Updates

The CFPC continues its work in ensuring that its Certification processes are robust and credible. Initiatives related to this area include:

a) Can MEDS-FM 2017 is a competency framework designed for all family physicians regardless of practice type, location, or populations served. Together with the College of Family Physicians of Canada's (CFPC) Family Medicine Professional Profile, it forms an overall picture of the roles and responsibilities of Canadian family physicians along with the competencies required to support their work.

b) Review of the Evaluation Objectives

The evaluation objectives guide the assessment of competence in family medicine, at the start of independent practice, for the purposes of Certification by the CFPC. They describe the skills and behaviors that are indicative of competence in dealing with the clinical tasks and problems that make up the domain of competence to be assessed.

Over the past few years, areas in Maternity and Newborn Care and Mental Health have been and are being reviewed. Regular review of the evaluation objectives allows the CFPC to ensure that our Certifications are assessed by relevant standards.

c) Examinations

The CFPC is updating its training program for examiners for our Certification Examination in Family Medicine. This will help ensure that decisions made from our examinations continue to remain valid.

d) Alternative Route to Certification

This route is ending in May of 2018. After this time, practicing family physicians who wish to achieve Certification can continue to do so by challenging our Certification Examination in Family Medicine through qualifying as a practice eligible candidate.

Respectfully submitted,

Barbara Lent
Chair, Registration Committee

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

November/December 2017

TOPIC: Opioid Strategy Update

FOR INFORMATION

ISSUE:

- The Opioid Strategy, attached as Appendix A, was approved by Council at its May 2017 meeting.
- This briefing note provides a status update on the elements of the strategy.

CURRENT STATUS:

	Elements	Status
1 Guide	Review Prescribing Drugs policy to include updated guidelines and new expectations, as required	Interim revisions to the Prescribing Drugs policy were made in September to incorporate the 2017 Canadian Guidelines and include a requirement for physicians to review available information prior to prescribing opioids. A full review of the policy will be conducted in 2018.
	Facilitate review of MMT guidelines	This work is currently on hold, pending resolution of the possible s56 methadone exemption changes and development of the HQO standards.

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

	Elements	Status
3 Investigate	Identify, investigate and monitor high risk (problem) opioid prescribing	Initial investigations are almost complete. Further information will be provided once this occurs. An evaluation will be conducted relating to the effectiveness of the algorithm and the investigative approach. Work is underway to identify high risk prescribing, within the context of work already being done by other partners (ICES and HQO).

	Elements	Status
4 Facilitate Education	Work with partners to: Ensure multiple educational offerings, targeted at multiple stages of practice: general education, awareness and remediation	Existing offerings have been identified. Regular communication with education providers, medical schools, and CPD programs is occurring to maintain an up-to-date list of resources. Opioids resources are available on the website: *http://www.cpso.on.ca/CPSO-Members/Continuing-Professional-Development/CPD-Practice-Improvement-Resources/Medical-Expert-Role-Resources*
	Work with partners to: Develop an Opioid Prescriber's Education Series, focused on the fundamentals of appropriate prescribing as well as particular areas of focus to be determined	Planning is underway for sessions beginning in 2018 in collaboration with the Ontario College of Family Physicians (OCFP). Sessions will focus on College policy and expectations relating to opioids.

ENABLING ACTIVITIES

	Elements	Status
A Communicate	Continue Dialogue coverage from multiple perspectives, including patients and families	**Issue 1 (Feb 2017)** • A Picture of Opioid Prescribing in Ontario – Infographic • Gaining Control - a family physician who inherited an opioid intense practice describes the techniques used to safely taper high-dose patients **Issue 2 (Jun 2017)** • Message from the Registrar – a description of approved Opioids Strategy • The Canadian Guideline Recommendations

		• Dr. David Juurlink's presentation to Council • Opioid Strategy Infographic • A case study of an elderly patient who died after being given a high opioid dose. **Issue 3 (Oct 2017)** • Opioids Investigations – Status report • Opioid Position Statement • Patient Perspectives: 'Anything to be Numb' • Patient Perspectives: After the Fall • Opining on Opioids: Dr. David Juurlink **Issue 4 (Feb 2018) In progress** • Prescribing opioids for the elderly: Care and caution needed • Buprenorphine: A safe and effective treatment for opioid use disorder. • New President Dr. Steve Bodley: experiences working with patients with chronic pain • HQO: Opioid Prescribing Snapshot Newest addition to HQO's MyPractice reports aims to provide data that helps doctors improve their care • Full page advert directing people to make use of the opioids resources on our website • Reminder notice about not cutting patients off abruptly from their opioids
	Compile all Dialogue articles into a resource for other educational initiatives	This will be incorporated into the planning related to the Opioid Prescriber's Education Series.
	Communicate directly with patients and the public	A Message to Patients Living with Chronic Non-Cancer Pain was released in September. http://www.cpso.on.ca/CPSO/media/documents/Positions%20and%20Initiatives/Opioids/Opioid-Patient-Communication.pdf A special issue of Patient Compass was also released in October, with a focus on the Opioid Crisis. http://www.cpso.on.ca/Policies-Publications/Publications/Patient-Compass-Archives/Special-Issue-The-Opioid-Crisis
	Develop an Opioids Statement that clearly sets out the role of the	The Opioids Position Statement was released in September.

	College, physicians and system partners.	http://www.cpso.on.ca/CPSO/media/documents/Positions%20and%20Initiatives/Opioids/Opioid-Position-Statement.pdf

	Elements	Status
B Use Data and Analytics	Accessing, analyzing and acting on prescribing data are key enablers of the strategy framework	• Work with ICES to define levels of prescribing and physician factors associated with those levels. • Work with HQO and ICES to use consistent definitions for levels of prescribing. • Using the defined levels to determine what information should come to the CPSO.
	Physicians need information to prescribe appropriately	CPSO has advocated for physician access to NMS data. Access is starting to become available to some physicians. Further work to be done to ensure community physicians have access.
	The CPSO needs data to fulfill its regulatory responsibilities and to identify factors that support appropriate prescribing.	CPSO is working with ICES to receive de-identified information for analytics purposes in order to determine what kinds of identified information it should request from government.

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

METHADONE TRANSITION

Information about the Methadone Committee transition to the QAC is included as a separate agenda item.

COMMUNICATIONS STRATEGY

A comprehensive Opioids Communication Strategy has been developed. Work to achieve the following objectives is ongoing:

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

The following communications products were released in September:

- News release
- Opioid Position Statement
- Opioid Strategy Fact Sheets
- Narcotics Monitoring System (NMS) Investigation Backgrounder
- CPSO Opioid Investigations - Infographic
- A number of patient communication products
    - A message to patients living with Chronic Non-Cancer Pain
    - FAQ for Patients
    - Videos and Information on safe opioid use
    - Information about Naloxone Kits

College communications messaging includes the following:

- Opioids are an important part of clinical care for patients.
- It is not appropriate for physicians to abruptly cut off or threaten to cut off a patient's access to care/medication or abandon a patient on long term opioid therapy.
- As set out in the Prescribing Drugs policy, physicians are expected to be aware of the opioids guidelines and use their clinical judgment address individual patient needs. Physicians are also expected to review relevant prescribing data when such data are available (this includes information about patients and about the physician's own prescribing).
- The College recognizes that
    - individual patients have particular needs,
    - providing care for patients with chronic pain or addiction can be complicated,
    - alternate resources are not always available, and
    - tapering a patient on opioids is a slow process.

OTHER UPDATES

PROVINCIAL

Minister/Ministry of Health

- The Ministry continues to implement its previously announced opioids strategy.
- The Ministry's Emergency Operations Centre has recently convened a regular Health System Coordination Call relating to the Ontario Opioid Crisis with health system partners, the purpose of which is to provide updates and share information on issues such as overdose deaths, problems arising in communities, and available resources. Recent updates have focused on safe injection sites in Toronto and Ottawa, naloxone availability, and reports of fentanyl laced 'purple' heroin.
- In October, the Ministry announced it was establishing an Opioid Emergency Task Force to include front-line workers and people with lived experience to strengthen the province's coordinated response to the opioid crisis.
- The Task Force will advise the government on a public education campaign to raise awareness about the risks of opioid use. Information will be shared with public health Ontario and pharmacies.
- The membership of the Task Force has not yet been announced, but the group is scheduled to meet soon.

Prescription Monitoring Leadership Roundtable (PMLR)

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

Health Quality Ontario (HQO)

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

2. **Primary care practice reports** for physicians relating to opioids are scheduled to be released in November. The reports will include information about the percentage of patients on opioids, new starts, patients on 90 OME or more per day and patients on opioids and benzodiazepines. The College is encouraging physicians to participate in this program, which is voluntary.

3. **Prescriber Supports for Primary Care**: HQO has continued its work to develop a collaborative and coordinated approach to supporting prescribers in their efforts to provide appropriate pain management. It has brought together groups that provide education and support for physicians including: Medical Mentoring for Addictions and Pain (MMAP), Project ECHO (Extension of Community Healthcare Outcomes), Centre for Effective Practice (Academic Detailing) and OntarioMD.

Institute of Clinical and Evaluative Sciences

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

Federal

Joint Statement of Action

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

NEXT STEPS:

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

DECISION FOR COUNCIL:

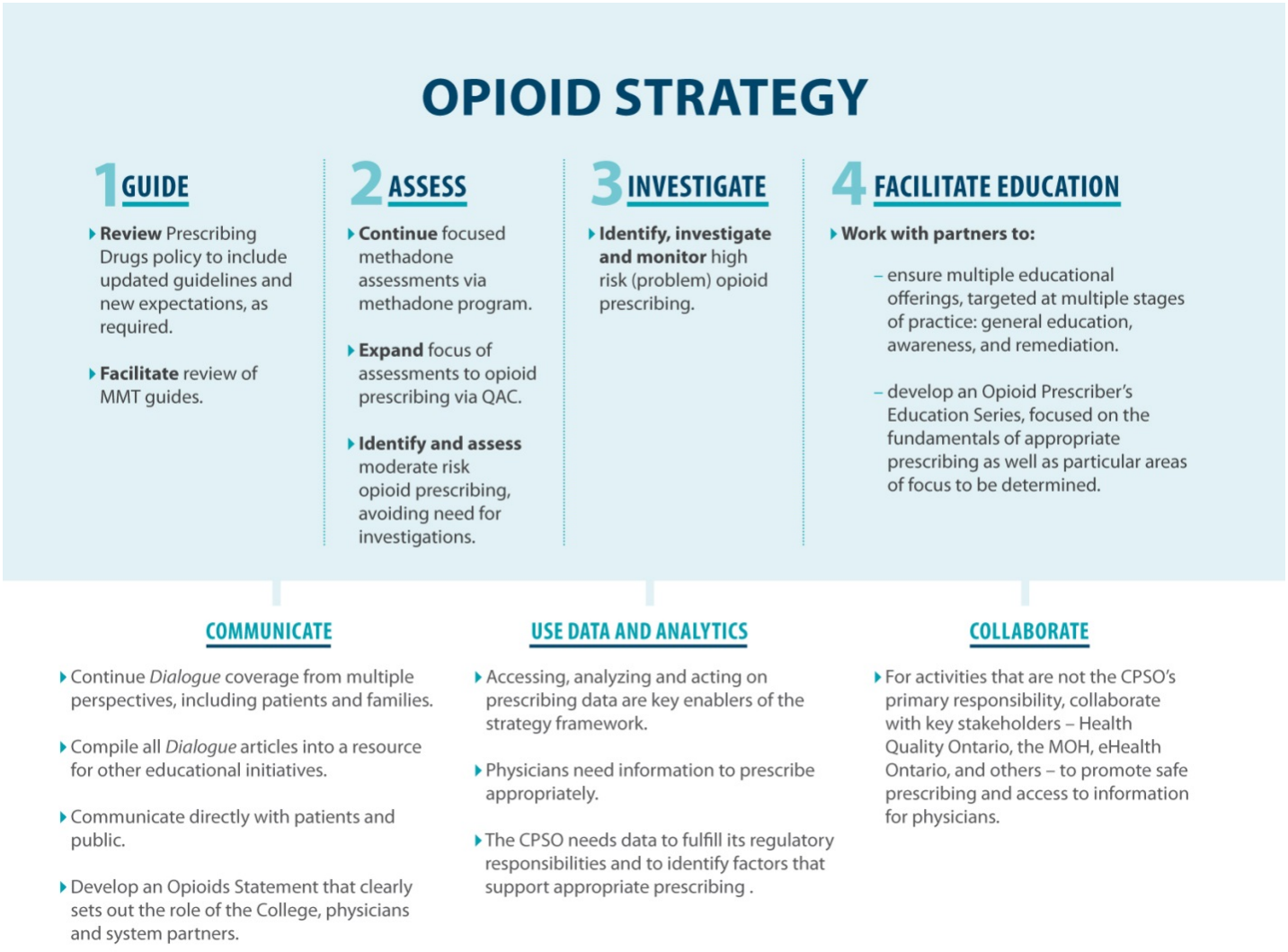
For Information

Contact: Maureen Boon, extension 276

Date: November 13, 2017

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

Appendix A: Opioid Strategy



Appendix B

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

The College of Physicians and Surgeons of Ontario commits to:

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

Rocco Gerace, Registrar

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: **GOVERNMENT RELATIONS REPORT**

FOR INFORMATION

Items:

1. Ontario's Political Environment
2. Issues of Interest
3. Interactions with Government

ONTARIO'S POLITICAL ENVIRONMENT:

- The fall session of the Legislature started on September 11th and is scheduled to end December 14, 2017.

June 2018 Provincial Election

- The next provincial election is scheduled for June 7, 2018, less than seven months away. The last possible day for the election call (when the writ is dropped) is May 9, 2018.
- In the next provincial election, the number of electoral districts will increase from 107 to 124. Fifteen new provincial ridings were added in order to line up with the new federal riding boundaries that came into effect for the 2015 federal election. Following the passage of legislation at Queen's Park this fall, two additional ridings were added in Northern Ontario to enhance Indigenous and Francophone representation at Queen's Park.
- A number of prominent MPPs have also announced that they will not seek re-election in 2018. This includes Liberals Deb Matthews, Liz Sandals, Dave Levac, Glen Murray, and Brad Duguid and the longest serving female MPP in Ontario's history, PC Julia Munro, has also announced that she will retire from politics in 2018. NDP MPP Cheri DiNovo has also announced that she will be retiring from politics as of January 2018.
- At this point, none of the political parties have nominated all of their candidates for the 2018 election. The PCs are, however, the furthest ahead with close to 100 candidates nominated, as of the writing of this note. The Liberals have nominated about 55 candidates and the NDP 35.

ISSUES OF INTEREST:

- The government has introduced two Bills this fall that are of interest to the College.
- *Bill 163, Protecting a Woman's Right to Access Abortion Services Act, 2017* was introduced and has subsequently passed. An overview of this Bill, along with the College's submission, is provided in the Policy Report.
- Bill 160, Strengthening Quality and Accountability for Patients Act, 2017 was introduced on September 27th.

Bill 160, Strengthening Quality and Accountability for Patients Act, 2017

- Bill 160 is a lengthy omnibus health bill that contains ten schedules. Of these ten schedules, the College has particular interest in *Schedule 9, the Oversight of Health Facilities and Devices Act 2017*. The Committee is provided with a separate briefing note which details Schedule 9 and the College's submission to the Legislative Standing Committee can be found on the College website.
- An analysis of the other nine schedules of the Bill has also been undertaken. A summary of the schedules are provided below and potential implications for the College are also identified.
- Given the length of the Bill and the complexity of changes contained in certain schedules the Committee is provided with an overview rather than a detailed accounting of the provisions contained in each schedule.

Schedule 1, Ambulance Act

Summary

Schedule 1 proposes changes to the *Ambulance Act* which would, according to communications from the government, 'enhance and modernize Ontario's emergency health services system to provide people with increased flexibility and more options for medical transportation and paramedic services.' Highlights are set out below.

Amendments would:

- Enable paramedics to transport patients to locations other than hospital Emergency Departments, such as primary care and community-based care and treat patients on-scene;
- Fund two pilot projects, enabling firefighters certified as paramedics to respond to low acuity calls to treat and release patients or refer patients, and to provide symptom relief in high acuity patients.

Potential Implications for the College

The College is supportive of the underlying objectives: to enhance efficiencies of the healthcare system, and to decrease burdens on hospital Emergency Departments. The College does, however, have concerns with the specific provisions through which the government seeks to

achieve the objective. Given that paramedics currently work within a delegation framework of directives and direct orders established by base hospital programs and physicians, the College has concerns about the higher degree of independence and autonomy contemplated by these amendments. The College has raised concerns about whether paramedics have the appropriate training to perform the actions set out in this Schedule and have noted that without proper training and oversight, quality care and patient safety may be compromised. Further comments on Schedule 1 are included in the College's Bill 160 submission to the Legislative Standing Committee.

Schedule 2, Excellent Care For All Act, 2010

Summary

Schedule 2 would allow Health Quality Ontario (HQO) to lease office space without obtaining the Lieutenant Governor in Council's approval. It would also permit HQO to collect, use and disclose personal health information (as prescribed by regulation) and to better maintain the confidentiality of Patient Ombudsman Investigations.

Potential Implications for the College

No implications anticipated.

Schedule 3, Health Protection and Promotion Act

Summary

Schedule 3, if passed, changes terminology, adds the Ontario Agency for Health Protection and Promotion as a recipient of reports regarding disease or events, and removes approval requirements for an acting medical officer of health appointed by a health board, among other measures.

This schedule also allows for the regulation of recreational water facilities like splash pads and wading pools and personal service settings like barber shops, nail salons, and tattoo parlours.

Potential Implications for the College

Once passed, housekeeping amendments to the College's Mandatory and Permissive Reporting policy may be required in order to update terminology and reflect reporting obligations. No additional implications are anticipated.

Schedule 4, the Health Sector Payment Transparency Act, 2017

Summary

Schedule 4 introduces a new piece of legislation, the *Health Sector Payment Transparency Act, 2017*. This Act would require reporting to the Minister of Health of any 'transfers of value' from payors which includes manufacturers that sell a medical product or someone who works on behalf of medical product wholesaler, distributer, marketer, etc. to certain recipients.

Recipients will be prescribed in regulation but we understand that they will include health care professionals, including but not limited to physicians, and organizations. The Minister will be responsible for analyzing the reported information and publicly posting reports at least once per year. The Minister is also permitted to publish the results of any analysis undertaken of the reported information.

The payor would have to report all information about a transfer of value including the names of the parties to the transaction, the date of the transfer, the parties' respective business address, the dollar value or the approximate dollar value of a non-monetary transfer, and a description of the transfer of value and the reasons for it. There is an exception to this reporting duty if the transfer of value is less than the prescribed threshold and other exceptions can be prescribed. Both payors and recipients would be required to retain records of the transactions for the time period specified in future regulations.

The Act also establishes a framework for inspections and other compliance mechanisms including authority for an inspector to enter any premises where they believe a record related to a reportable transfer of value is located. An inspector may audit the accounts and financial transactions of a recipient, payor, intermediary or affiliate. The Bill provides authority for a court to issue production orders and compliance orders. Information on these orders would be required to be made public. The legislation would also set out penalties for non-compliance, including significant fines.

The Act provides for periodic review by the Minister.

Potential Implications for the College
The policy intent of this Schedule aligns with the College's Physicians' Relationship with Industry: Practice, Education and Research policy. Once passed, housekeeping amendments may be required to that policy. An analysis will be conducted once the Schedule is finalized into law.

Schedule 5, Long-Term Care Homes Act, 2007
Summary
Schedule 5 makes significant amendments to the *Long-Term Care Homes Act* (LTCHA) to minimize restraining and confining residents. The current provision related to "secure units" under the LTCHA would be repealed and replaced with a new a system to address the restraining and confining of residents.

Under the LTCHA, the Director who oversees the regulation of long-term care homes will have the power to suspend a licence, in addition to the current power to revoke a licence. The Minister of Health and Long-Term Care will also have the power to suspend a licence, and to issue operational and policy directives to homes. A major change relating to enforcement and long-term care homes is that the Director and inspectors will have the power to issue

administrative penalties of up to $100,000.00. The process for determining the amount of the penalty will be set out in regulation.

Schedule 5 also makes related amendments to the *Health Care Consent Act, 1996* in order for confinement in long-term care homes to be subject to the same consent requirements as all other decisions related to medical treatment.

Potential Implications for the College
There are no specific implications for the College but physicians working with patients in long-term care homes or retirement homes will need to be aware of these changes. Consideration will be given as to whether or in what manner information regarding these changes will be shared with the profession.

Schedule 6, Medical Radiation and Imaging Technology Act, 2017
Summary
Schedule 6 would repeal and replace the *Medical Radiation Technology Act* with the *Medical Radiation and Imaging Technology Act* to include diagnostic sonographers under this regulated health profession. The Health Professions Regulatory Advisory Council recommended to the government that these changes be made. Diagnostic medical sonographers are those practitioners who perform ultrasound procedures for diagnostic purposes. They are not currently a regulated health profession in Ontario.

Potential Implications for the College
Earlier this fall, the College of Medical Radiation Technologists of Ontario (CMRTO) consulted on regulatory amendments that would allow for the regulation of diagnostic sonographers under the CMRTO. The College responded to this consultation and supported the regulation of diagnostic medical sonography and the inclusion of this profession under the CMRTO. Schedule 6 of Bill 160 brings forward the necessary statutory amendments to these regulatory changes. No implications are anticipated for the College.

Schedule 7, Ontario Drug Benefit Act
Summary
This Act is amended to specify that regulations are not required in order for the Minister and the executive officer to disclose personal information. A change is also proposed to establishing reimbursements criteria for certain drug benefits listed on the ODB Formulary.

Potential Implications for the College
No implications anticipated.

Schedule 8, Ontario Mental Health Foundation Act

Summary
The *Ontario Mental Health Foundation Act* is repealed in order to complete the dissolution of that organization.

Potential Implications for the College
No implications anticipated.

Schedule 9, Oversight of Health Facilities and Devices Act, 2017
Please see separate briefing note included in Council package

Schedule 10, Retirement Homes Act, 2010
Summary
This schedules proposes changes to the *Retirement Homes Act, 2010* (RHA) on the permitted confinement of residents of a retirement home. The new requirement would be more specific than what is currently in the RHA and would mirror certain requirements under the LTCHA regarding confinement. For example, prior to any confinement, consent of the resident or Substitute Decision Maker (if the resident is incapable) would be required; alternatives to confinement would need to be considered; and rights advice would be required, amongst other requirements. Retirement homes would be required to ensure that no device prohibited for use in applicable regulations is used to restrain or confine a resident of the home.

The Minister would be provided with new authorities including the authority to unilaterally amend the memorandum of understanding between the government and the Retirement Homes Regulatory Authority (RHRA), to require the RHRA to create advisory committees, and to require policy, legislative and regulatory reviews of the RHRA. The RHRA would be required to make certain compensation information available to the public and the Auditor General would be provided with authority to audit the RHRA.

Potential Implications for the College
No implications anticipated.

Other issues
- This fall session of the legislature will be the last full session prior to the election being called. As a result of the proximity to the next election, parties are doing what they can to use this time to their advantage and raise their standing with the electorate.
- In particular, the government is looking to maximize the last months of their mandate and implement notable changes in the remaining time.
- As the government is approaching the end of its mandate, there are quite a few loose ends that they are working to tie up including scope of practice changes (RN prescribing), governance reforms, and other potential changes to the regulatory system and the *RHPA.*

- Many of these areas will be of interest to the College and we anticipate that we will have a busy winter contributing to and responding to these initiatives.
- Additionally, the College's work alongside and apart from government in areas such as MAID and the collaborative work to address Canada's opioids crisis will also remain a focus in the coming months.

INTERACTIONS WITH GOVERNMENT:

- The College is in contact with a variety of government decision-makers to ensure that they have accurate and up-to-date information about the College, our activities, and our role in protecting the public interest. We have regular interaction with the senior decision-makers and all political parties at Queen's Park.
- The College continues to work particularly closely with government decision-makers on areas of shared focus including medical assistance in dying, compensation of public members of council, the ongoing work to increase College transparency, and issues surrounding opioid and medication management.
- Given the number of very active files with government, and the nearing election, we anticipate that the next six months will be very busy.

Contact: Louise Verity, Ext. 466
Miriam Barna, Ext. 557

Date: November 10, 2017

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: 2017 District Council Elections

FOR INFORMATION

ISSUE:

- This note contains the 2017 district election results.

BACKGROUND:

- An election was held in District 5 (County of Simcoe; the District Municipality of Muskoka and the regional municipalities of Durham, Peel and York) between September 19 and October 10.

- Eligible voters elected two District Councilors.

- The nine candidates who put their names forward to serve on the Council were:
  - Dr. John Thomas Bertoia
  - Dr. Rakesh Bhargava
  - Dr. Geoffrey Bond
  - Dr. Nazim Damji
  - Dr. Naveen Dayal
  - Dr. Brian Levy
  - Dr. David Rouselle
  - Dr. Elizabeth Samson
  - Dr. Winnie Wong

RESULTS:

DISTRICT 5

- Drs. David Rouselle and Elizabeth Samson were elected in District 5.

- See Appendix A for the complete results of the District 5 election.

DISTRICT 10

- Four candidates in District 10 (City of Toronto) put their names forward for 4 positions so no election was required.

- Drs. Philip Berger, Haidar Mahmoud, Peeter Poldre and Patrick Safieh were acclaimed in District 10.

NEXT STEPS:

- We will continue to look at ways of improving and enhancing the election process.

This item is for information

Contact: Rocco Gerace
Louise Verity, ext. 466
Tanya Terzis, ext. 545

Date: October 20, 2017

Attachments:

Appendix A: District 5 Election Results

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMORANDUM

DATE: October 11th, 2017

TO: Dr. Rocco Gerace, Registrar

FROM: Dr. Preston Zuliani, Returning Officer

RE: Results of 2017 Election of Councillors to the College - District 5
(Ballots Counted October 11th, 2017)

Number of ballots cast: 1450

Number of votes for each candidate:

Dr. John Thomas Bertoia	332
Dr. Rakesh Bhargava	303
Dr. Geoffrey Bond	224
Dr. Nazim Damji	255
Dr. Naveen Dayal	252
Dr. Brian Levy	299
Dr. David Rouselle	395
Dr. Elizabeth Samson	346
Dr. Winnie Wong	206

Certificate of Returning Officer for District No. 5

I declare: David Rouselle and Elizabeth Samson elected as the members of Council for District 5 for the ensuing term of Council.

Respectfully submitted,

Dr. Preston Zuliani
Returning Officer

Oct 11/17.
Date

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Bill 163, the *Protecting a Woman's Right to Access Abortion Services Act, 2017.*

2. Ministry of Transportation Consultation - Regulation Regarding Mandatory Reporting.

3. Mandatory and Permissive Reporting Policy - Housekeeping Amendments

4. MAID: CPSO Response to Council of Canadian Academies

5. Policy Consultation Update:

    I. Medical Records
    II. Maintaining Appropriate Professional Boundaries and Preventing Sexual Abuse
    III. Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice Draft Policy
    IV. Physician Services During Disasters and Public Health Emergencies Draft Policy

6. Policy Status Table.

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1. Bill 163, the *Protecting a Woman's Right to Access Abortion Services Act, 2017.*

- Introduced by Attorney General Yasir Naqvi, Bill 163 passed 3rd reading and received Royal Assent on Oct 25, 2017.

- The Bill enables patients to access abortion services without fear of interference, being intimidated or harassed near the location of service provision. Physicians

who provide abortion services, or work in a facility that provides abortion services, are also protected from harassment and intimidation at their places of work and where they live.

- Details of the Bill are as follows:
    - The Bill creates automatic safe access zones of 50m around clinics where abortion services are provided, as well as the creation of automatic safe zones of 150m around the homes of clinic staff and health professionals who provide abortion services, unless a different distance is prescribed by regulation.
    - Facilities other than stand-alone clinics that provide abortion services (e.g. hospitals, health centres, pharmacies, and offices) could apply for safe access zones of up to 150 metres by regulation.
    - The Bill prohibits activities such as advising a person to refrain from accessing abortion services, abortion-related protests and activities that intimidate or interfere with individuals accessing or providing abortion services within these safe access zones.
    - Similar activities would be prohibited around the homes of providers and clinic staff if the activities are directly targeted at, or are about the clinic staff member or health professional that lives in the home.
- Analysis conducted prior to the Bill receiving Royal Assent identified that it has a positive impact for patients and physicians alike.
- The Bill also aligns with the College's mandate and efforts to support respect for patient autonomy and access to care.
- When Mifegymiso® was approved for use in Canada, the College supported patient access to this medication by issuing a statement to our membership providing clarification on the prescribing and dispensing process for Ontario physicians. In addition, the College's *Professional Obligations and Human Rights* policy supports patient autonomy and access to care by articulating the legal, ethical, and professional obligations of physicians to provide care to patients without discrimination.
- A letter of support for Bill 163 was finalized on the direction of Dr. Rouselle and Dr. Gerace and submitted to the Standing Committee on General Government on Thursday October 19th. A copy of the letter is attached as **Appendix A**

2. Ministry of Transportation Consultation - Regulation Regarding Mandatory Reporting.

- The *Highway Traffic Act* contains a mandatory reporting obligation related to fitness to drive. This obligation is captured in the College's Mandatory and Permissive Reporting policy.

- The mandatory reporting obligation is framed broadly with the Act requiring that every legally qualified medical practitioner report to the Registrar (of the Ministry of Transportation) the name, address and clinical condition of every person sixteen years of age or over attending upon the medical practitioner for medical services who, in the opinion of the medical practitioner, is suffering from a condition that may make it dangerous for the person to operate a motor vehicle.[1]

- The Ministry of Transportation (MTO) conducted a consultation on proposed amendments to regulations under the *Highway Traffic Act* in support of clarifying the mandatory reporting duty. The regulations would include a list of prescribed medical conditions, functional impairments and visual impairments that must be reported to the ministry. Medical practitioners would also be permitted to make permissive reports for conditions not listed, where they think an individual's ability to safely operate a motor vehicle may be compromised.

- In September 2017 the MTO released the regulations for formal public consultation. The proposed list of conditions and impairments for inclusion in the mandatory reporting obligation included:

  - Cognitive impairment where attention, judgment or insight is affected;
  - Impairment of consciousness or awareness that may be recurrent if uncorrected or untreated;
  - Motor or sensory impairment where such things as coordination, muscle strength or control are affected;
  - Visual impairment where prescribed regulatory standards are not met;
  - Substance use disorder if untreated, or where non-compliance with treatment recommendations exists; and
  - Psychiatric illness including acute psychosis or severe abnormalities of perception.

- The list included a caveat that reporting of these conditions and impairments may not be mandatory if they are of a distinctly temporary, non-recurrent or controllable nature.

[1] Section 203(1) of the *Highway Traffic Act*, R.S.O. 1990, c. H.8

College Response

- The College's response reflects direction from Dr. Bill McCauley (Medical Advisor) and the Executive Committee.

- The College's response to the consultation is attached as **Appendix B**. The response includes:

  - A statement that the College is generally supportive of the proposed amendments and an acknowledgement that the MTO was responsive to early informal feedback provided by the College.

  - Constructive comments to assist with improving the clarity of reporting requirements. These comments broadly included:

    - Clarity regarding the reporting threshold (i.e., include a preamble that explicitly states that all the listed conditions are reportable when they are likely to interfere with the individual's ability to safely drive a motor vehicle.)
    - Specific amendments to the reporting of conditions related to psychiatric illness (i.e., align the reporting requirements related to psychiatric illness with the DSM-V manual terminology, to specify the disorders that require reporting).
    - Other suggested amendments (i.e., add affected memory to the list of reportable conditions pertaining to cognitive impairment).

Next steps:

- The MTO is targeting July 1, 2018 as their implementation date.

- Council will be kept apprised of any further developments.

3. Mandatory and Permissive Reporting Policy- Housekeeping Amendments

- The College's Mandatory and Permissive Reporting policy sets out physician's mandatory reporting requirements as well as instances where the disclosure of patient and/or personal health information is permissible, but not required by law.

- Since the policy was last updated (2012), a number of legislative amendments have come into force. Housekeeping amendments have been made to align this policy with current legislation. The revised policy is now available online. An overview of the recent changes to legislation incorporated into the policy is set out below.

Bill 21, *Safeguarding Health Care Integrity Act, 2014*

- Among other provisions, the Bill amends Schedule 2 to the *Regulated Health Professions Act, 1991* (RHPA) and Section 33 of the *Public Hospitals Act* to expand reporting requirements of hospital administrators and anyone, including physicians, who employs, offers privileges to, or associates in partnership with regulated health professionals (referred to as "employers and affiliates" below).

Reporting Duties of Employers and Affiliates

- The RHPA has been amended to require two new instances of reporting for physician employers and affiliates:
    - The resignation, relinquishment or restriction of privileges of a regulated health professional is related to professional misconduct, incompetence or incapacity of the member;[2] or
    - The resignation, relinquishment or restriction takes place *during*, or *as a result of*, an investigation into concerns of professional misconduct, incompetence or incapacity.[3]

Hospital Administrators' Reporting Duties

- Reporting requirements under the *Public Hospitals Act* have expanded to include reporting where:
    - a physician resigns or restricts his or her practice within the hospital and the hospital administrator believes the resignation or restriction is related to the physician's competence, negligence or conduct; or
    - a physician resigns as a result of an investigation into his or her competence, negligence or conduct.[4]

Bill 84, *Medical Assistance in Dying Statute Law Amendment Act, 2016*

- Bill 84 amends the *Coroner's Act* (among other statutes) to require that a coroner be given notice of all MAID deaths. The amendment also gives the coroner discretion as to whether to hold an investigation into the death.[5]

- The updates align with the housekeeping amendments made to the College's Medical Assistance in Dying policy in August 2017 related to reporting.

[2] Section 85.5(2)1 of the *HPPC*.
[3] Section 85.5(2)2 of the *HPPC*.
[4] Section 33(c) and 33(d) of the *Public Hospitals Act.*
[5] Section 10.1(1) of the *Coroners Act*, R.S.O. 1990, c. C. 37.

Bill 119, *the Health Information and Protection Act, 2016*

- Among other provisions, Bill 119 creates a number of new instances of reporting of privacy breaches to health colleges as well as to the Information and Privacy Commissioner ("IPC"). The amendments also create new provisions with respect to notifying affected individuals of privacy breaches and double the maximum fines for privacy offences.[6]

- These amendments have been included in a new section of the policy related to reporting privacy breaches.

Next Steps:

- Further housekeeping amendments are anticipated when other legislation comes into force in 2018.

4. MAID: CPSO Response to Council of Canadian Academies

- As Council will recall, the federal legislation on MAID is comprised of a number of provisions that have been added to the *Criminal Code of Canada*.

- The legislation commits the federal Ministers of Justice and Health to initiate independent reviews relating to requests for MAID by mature minors[7], advance requests for MAID[8], and MAID in the context of mental illness as a sole underlying condition.[9]

- In December 2016, the federal government asked the Council of Canadian Academies (CCA)[10] to undertake independent reviews of these three topics.

[6] Maximum fines have increased from $50,000 to $100,000 for individuals and from $250,000 to $500,000 for organizations.
[7] 'Mature minors' refers to young adolescents with capacity to make health care decisions.
[8] Just as it sounds, advance requests refer to situations where an individual receives MAID by virtue of a previously stated wish or advance directive. As Council will note in the submission, it is unclear whether CCA's work on 'advance requests' will include requests made by a capable person who then loses capacity before MAID is provided, requests made on behalf of an incapable person or both.
[9] These issues speak directly to eligibility for MAID and are not addressed in the current legislation. At present, mature minors are not eligible for MAID: individuals must be 18 years of age or older before they can request MAID. MAID cannot currently be requested through an advance request. Patients must request MAID themselves, and must have capacity both at the time they request MAID *and* at the time MAID is provided. Patients who have a mental illness are not explicitly excluded from being eligible for MAID. Under the current legislation such patients must meet all of the eligibility criteria including that which requires their 'natural death' to be 'reasonably foreseeable'. As such, patients who only have a mental illness (and no physical illness) would not likely qualify for MAID under the current legislation.
[10] The CCA is an independent, not-for-profit organization that supports independent, authoritative and evidence-based expert assessments that information public policy development in Canada. The CCA's

- The CCA convened an Expert Panel on April 27, 2017 to carry out these independent reviews. The Expert Panel is chaired by the Honourable Marie Deschamps (former Justice of the Supreme Court of Canada), and is comprised of 43 individuals with expertise and perspectives from Canada and abroad, in the areas of law, medicine, ethics, social science and health sciences.

- The Expert Panel conducted a consultation on the three topics under review to help inform its work going forward. The College was asked to participate in this consultation.

- The Expert Panel stated explicitly that it was seeking input on **key issues** with respect to the three topics under study and links or references to any **resources or materials** that would assist the Expert Panel.

- A CPSO submission was developed in response to this consultation. The CPSO submission was directly informed by direction and advice from the Policy Working Group for MAID, CPSO Medical Advisors and the Executive Committee.

- The CPSO submission (available online) does not take a formal position on any of the three topics under review. For instance, the submission does not advocate in favour of or against mature minors gaining access to MAID. Instead, the submission is intended to highlight for the Expert Panel the issues and considerations the CPSO believes are critical in evaluating the three topics of study.

- The submission is written in two parts. Part I sets out core principles and considerations that relate to each of the three topics. Part II contains key considerations specific to each topic.

CPSO Submission: Highlights

- The core principles identified in Part I of the submission are: **Capacity, Consistency, Clinician Competence** and **Clarity and Confidence** for Clinicians.

- Part II of the submission provides detailed comments on each of the three topics under review, applying the core principles and providing comment on other important issues.

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work encompasses a broad definition of science, incorporating the natural, social, and health sciences as well as engineering and the humanities.

- With respect to **mature minors**, the submission highlights the role of capacity in healthcare decision making, and the inconsistency that exists between the federal legislation on MAID with respect to age and capacity. The submission also raises important considerations with respect to clinician competencies and safeguards.

- Regarding **advance requests,** the submission encourages the Expert Panel to clarify what is meant by an advance request and goes on to highlight relevant elements of the *Health Care Consent Act, 1996*. In doing so, the submission raises important points regarding the inconsistency between the federal legislation and Ontario legislation and encourages the Expert Panel to consider this inconsistency.

- With respect to **mental illness,** the submission raises a number of points including those regarding capacity, and the need for clarity in interpreting and applying current eligibility criteria for MAID in situations where the patient's sole underlying condition is mental illness. As part of those remarks, the impact of mental illness on emotional regulation is noted, as is the culture of 'recovery' that underlies the goals and objectives of treatment in psychiatry.

- The CCA will ultimately create a report or reports as a product of these independent reviews and will table those to Parliament by December 2018.

- Staff will continue to monitor developments on this issue, and update the Executive Committee and Council accordingly.

5. Policy Consultation Update

I. Medical Records

- The Medical Records policy is currently under review. The policy sets out requirements for both paper and electronic records, including general requirements for how medical records must be kept and the specific information that must be included in records. It also sets out requirements regarding the collection, use, security, storage, and disclosure of patients' personal health information, requirements regarding retention, access and transfer of records, and specific requirements in regard to records for procedural medicine.

- As part of the policy review process, a preliminary external consultation commenced following the September 2017 Council meeting.

- As of the Council submission date (November 10, 2017), the College received a total of 47 responses to this consultation (66% physicians, 13% members of the

public, 9% who preferred not to say, 6% organizations,[11] 4% other health care professionals, and 2% unknown). These include 12 comments on the College's online discussion page and 35 online surveys.[12]

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website once analysis is complete.

- Stakeholders provided feedback covering a range of issues pertaining to medical records. A few of the key themes that have emerged via the consultation to date are outlined below.

i. General Comments

- The majority of respondents felt that the current policy is clear and comprehensive.

- Some survey respondents provided suggestions on how to improve the clarity of the policy (e.g. by removing the distinction between family/procedural medicine roles as some family physicians may do procedures), and the OMA suggested clarifying physicians' responsibilities when they relocate, when a group practice dissolves, and when they cease to practice.

- Some survey respondents provided suggestions on how to improve the comprehensiveness of the policy (e.g. address "skeletal" or temporary notes, patient recording of clinical encounters, clinical notes that are "dictated but not read", use of email, etc.).

ii. Specific Comments and Suggestions

- **Physician experience:** The majority of physician respondents indicated that they have not experienced any specific challenges in regards to medical records in general; however, the majority of physician respondents indicated that they had challenges with their Electronic Medical Record (EMR) and/or the Electronic Health Record (EHR) (e.g. lack of narrative and nuances captured in that format, difficulties using systems, glitches/crashes that disrupt workflow, etc.).

- **Patient experience:** The majority of survey respondents had never asked their physician for a copy of their medical record; however, of those who had, a summary or copy of the record was provided in timely manner and the majority of respondents paid a fee for it. Some respondents described issues they had (e.g.

[11] Organizations include: Ontario Medical Association (OMA), Professional Association of Residents of Ontario (PARO), and Two Rivers Family Health Team.
[12] 37 respondents started the survey, but of these, 2 did not complete at least one substantive question, leaving 35 surveys for analysis.

didn't receive a response to request, records were difficult to read, fee was not reasonable, etc.).

- **Physicians' responsibilities when they are not Health Information Custodians:** The OMA believes physicians should not be responsible for meeting policy expectations in circumstances where they are not Health Information Custodians (e.g. the clinic or hospital is the Health Information Custodian and would be responsible for the records).

- **Reference new privacy requirement:** The OMA suggested referencing a new requirement[13] in the *Personal Health Information Protection Act, 2004* to notify the Information and Privacy Commissioner of a theft, loss or unauthorized use or disclosure of personal health information that meets the prescribed requirements.

- **Record retention:** The OMA suggested clarifying physicians' legal requirements to retain records under the *Medicine Act, 1991* and the *Personal Health Information Protection Act, 2004*, as they perceive there is conflict if the physician is not the Health Information Custodian. The majority of survey respondents do not think physicians should be required to retain records for longer than 10 years. Some survey respondents noted that it is quite a burden to retain records for 10 years or longer.

- **Templates/checklists:** The majority of survey respondents think that templates and/or checklists are appropriate and helpful to use provided that physicians are able to customize them and verify that the information is accurate and comprehensive.

- **Appendices:** The majority of survey respondents do not refer to the appendices attached to the policy and typically don't know if they are helpful. However, the majority of survey respondents think it is necessary to provide specific medical record-keeping requirements for particular types of encounters (as set out in Appendix D).

iii. Next Steps:

- All feedback received will be carefully reviewed by a Policy Working Group alongside the research findings as a revised draft policy is developed.

- Once a draft policy has been developed it will be presented, along with the full analysis of feedback received during the preliminary consultation, to the Executive Committee and Council for consideration.

[13] Section 12(3).

II. Maintaining Appropriate Boundaries and Preventing Sexual Abuse

- The Maintaining Appropriate Boundaries and Preventing Sexual Abuse policy is currently under review. The policy sets out the College's expectations of physicians to maintain appropriate boundaries and not become sexually involved with patients, former patients in certain circumstances, and persons closely associated with patients.

- As part of the policy review process, a preliminary external consultation commenced following the September 2017 Council meeting.

- As of the Council submission date (November 10, 2017), the College received a total of 34 responses to this consultation (85% physicians, 6% organizations,[14] 6% members of the public, and 3% who preferred not to say). These include 13 comments on the College's online discussion page and 21 online surveys.[15]

- All written feedback is posted on our website in keeping with regular consultation processes and posting guidelines. A report of the survey results will be available on the College's website once analysis is complete.

- Stakeholders provided feedback covering a range of issues pertaining to boundaries and sexual abuse. A few of the key themes that have emerged via the consultation to date are outlined below.

i. General Comments

- The majority of survey respondents felt that the current policy is clear and comprehensive.

- The OMA provided suggestions on how to improve the clarity of the policy by:

  - Separating and distinguishing the sections of the policy that are "sexual abuse" and "other sexual boundary and professional misconduct issues", given the explicit penalties for "sexual abuse" set out in the *Regulated Health Professions Act, 1991*.
  - Switching the order of Part A and B of the policy because logically it would make sense to first address whether a physician-patient relationship exists.
  - Clarifying how a former patient is defined to ensure it is consistent with the new definition of "patient" set out in the Health Professional Procedural Code once the Bill 87 amendments have been proclaimed.

[14] Organizations include: Ontario Medical Association (OMA), Professional Association of Residents of Ontario (PARO), and Prince Edward Family Health Team.
[15] 30 respondents started the survey, but of these, 9 did not complete at least one substantive question, leaving 21 surveys for analysis.

- A few consultation respondents felt that physicians needed to be protected as well (e.g. due process must be followed given the significant personal/professional impact a sexual abuse complaint could have on the physician).

ii. Specific Comments and Suggestions

- **Patient-specific content/materials:** The majority of survey respondents didn't know if patient-specific content should be added to the policy; however, they thought it would be helpful to develop separate patient-specific document(s) and some suggestions were provided (e.g. definition of sexual abuse, list of patient responsibilities, fact sheet, poster, etc.).

- **Foundational aspects of a physician-patient relationship:** The majority of survey respondents were supportive of the statements in the policy that describe trust and power as being the foundation of a physician-patient relationship; however, some respondents thought revisions should be made (e.g. trust should be used instead of power, and that it should be acknowledged that patients have power in the physician-patient relationship, etc.).

- **Use of third parties (i.e. chaperones):** The majority of survey respondents were supportive of the statements in the policy regarding the use of third parties. The OMA believes it should remain optional to have a third party present during intimate examinations; however, the policy should be revised to state that physicians can refuse to perform an intimate examination if a third party is not available or the patient refuses to have a third party present.

- **Appropriateness of sexual involvement with patient after termination:** The majority of survey respondents thought it would never be appropriate for a physician to be sexually involved with a patient after termination when the physician-patient relationship involved a significant component of psychoanalysis or psychotherapy; however, survey respondents noted the appropriateness of sexual involvement with any patient after termination would depend on the specific circumstances and should evaluated on a case-by-case basis.

- **Relationships between physicians and persons closely associated with patients:** The majority of survey respondents were supportive of the expectations for relationships between physicians and persons closely associated with patients.

- **Guidelines for Maintaining Professional Boundaries (Appendix A):** The majority of survey respondents were supportive of the guidelines and thought they were helpful; however, a few survey respondents provided some suggestions for how they could be revised (e.g. context and patient's past behavior/personality is important).

- **Non-Sexual Boundary Issues:** The majority of survey respondents did not think the College should set out expectations for physicians on non-boundary issues (e.g. physicians receiving gifts from patients, physicians employing patients, etc.). If the College decides to set out expectations for physicians on non-sexual boundary issues, the OMA recommends that this be done in a separate policy.

iii. Next Steps:

- All feedback received will be carefully reviewed by a Policy Working Group alongside the research findings as a revised draft policy is developed.

- Once a draft policy has been developed it will be presented, along with the full analysis of feedback received during the preliminary consultation, to the Executive Committee and Council for consideration.

III. Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice Draft Policy

- At its September 2017 meeting, Council considered the draft Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice policy.

- Council approved the draft policy be released for external consultation and the consultation commenced following the meeting.

- As of the Council submission date (November 10, 2017), the College received a total of 32 responses to this consultation (81%, physicians, 9% organizations[16], and 9% members of the public). These include 14 comments on the College's online discussion page and 18 online surveys.[17]

- 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 after the close of the consultation.

- Stakeholders provided feedback covering a range of issues pertaining to changing scope of practice and re-entering practice. A few of the key themes that have emerged are outlined below.

i. General Comments

- Broadly speaking, stakeholders expressed support for the draft policy.

[16] The organizational respondents were the OMA, the Medical Psychotherapy Association of Canada, and the Professional Association of Residents of Ontario.
[17] 21 respondents started the survey, but of these, 3 did not complete any substantive questions – leaving 18 for analysis.

- **Reasonableness of policy expectations:** The majority of survey respondents supported the draft policy expectations and agreed that it is important that physicians wishing to change their scope of practice and re-enter practice report this intention to the College, that physicians undergo the College process before changing scope and re-entering practice and that the College approves their request before they initiate the change or re-enter practice.

- **Clarity:** The majority of online survey respondents felt that the draft policy and appendices were clearly written, easy to understand, and well organized. A few stakeholders requested clarity regarding whether the performance of innovative techniques or procedures would constitute a significant change in scope.

- **Comprehensiveness:** Survey respondents were somewhat divided on whether they found the policy to be comprehensive. When asked how the policy could be made more comprehensive, respondents suggested the policy include more examples of what a significant change in scope would, and would not, be.

ii. Feedback on Substantive Policy Amendments

- **Two year reporting threshold:** Respondents were generally divided about whether they felt the requirement to report an intention to re-enter practice or return to a scope of practice after an absence of two years or more is reasonable. Of those that disagreed with the change to two years, a few respondents felt that that the threshold for reporting should be between 3-5 years.

- The Ontario Medical Association (OMA) provided that the new two year timeframe for reporting is mostly reasonable while highlighting that in some instances this may be challenging or unreasonable (i.e., for physicians taking parental leave, medical leave and leaves for research). They suggest instead encouraging physicians, to keep up on practice recommendations during an absence instead of having a formal policy that requires reporting of all 2 year absences.

- **Part-Time Practice:** Survey respondents were also generally divided about whether they supported the removal of part-time physicians from the draft policy. The OMA notes that some specialties and hospitals have minimum practise standards in place for certain procedures and suggested the College include a minimum practise standard in the policy to ensure that physicians in all specialities are treated equitably when it comes to minimum practice requirements.

iii. *Other Specific Comments and Suggestions*

CPSO's role in facilitating changes in scope of practice:

- Some stakeholders expressed concern that the CPSO change of scope process undermines the Royal College of Physicians and Surgeons of Canada's (RCPSC) credentialing process and allows physicians to practice in a speciality area without meeting rigorous RCPSC criteria. These stakeholders suggested that that the CPSO requirements for changing scope of practice should align with those of the RCPSC.

- The OMA echoed this sentiment and suggested that the CPSO defer to the RCPSC and the College of Family Physicians of Canada when determining whether a physician has the competence required to change their scope of practice.

- Several physician respondents expressed concern that physicians who have not completed the RCPSC subspecialty program in Gynecologic Reproductive Endocrinology and Infertility (GREI) can change their scope of practice to fertility medicine. In reviewing the stakeholder feedback, it was apparent that many respondents interpreted this example in the draft appendix to mean that undergoing the change in scope of practice process at the CPSO would allow a physician to practice within the full scope of the GREI speciality.

Significant changes in "Practice Environment" and impact on rural practice settings:

- A few stakeholders expressed concern about including "practice environment" in the definition of scope of practice and that a significant change in practice environment would be considered a significant change in scope of practice.

- Some respondents felt that its inclusion in the definition of scope of practice would hinder the ability to attract urban physicians to rural areas.

- The OMA echoed this sentiment and expressed concern about the impact of this policy on rural practices. The OMA suggested the policy recognize the unique challenges of practice in rural and northern areas and not require physicians to complete an unduly onerous process to obtain a change in scope of practice when pursuing work in a rural setting.

iv. Next Steps:

- All feedback received will be carefully reviewed and used to evaluate and revise the draft policy. The revised draft will be presented to the Executive Committee and Council for its consideration for final approval early next year.

IV. Physician Services During Disasters and Public Health Emergencies Draft Policy

- The Physicians and Public Health Emergencies policy is currently under review. The policy sets expectations for the profession during health emergencies.

- Council considered an updated and newly titled *Physician Services During Disasters and Public Health Emergencies* draft policy at its September meeting and approved it for external consultation.

- As of the Council submission date (Nov 10, 2017), the College received a total of 29 responses to this consultation (23 physicians, 2 other health care professions, 2 organizations[18], and 2 who preferred not to say). These include 9 comments on the College's online discussion page and 20 online surveys[19]

- 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.

- Stakeholders provided feedback covering a range of issues pertaining to physicians providing services during disasters and public health emergencies. A few of the key themes that have emerged in the consultation are described below.

i. General Comments

- Broadly speaking, the feedback was mixed. Some respondents were comfortable with the level of flexibility the draft policy affords. Some felt that the draft policy was too vague and superficial. Others displayed concern that this policy would be used post-disaster/public health emergency to punish physicians who did not volunteer assistance, did not document patient encounters or who practised outside their scope of practice temporarily.

- The majority of respondents were supportive of the draft policy, and made suggestions for ways it could be made clearer and more comprehensive.

ii. Specific Comments and Suggestions for Improvement

- **Adding to the title:** Although the majority of respondents indicated it was clear in which circumstances this draft policy would apply, a couple

[18] The organizational respondents were the Ontario Medical Association (OMA) and the Professional Association of Residents of Ontario (PARO).
[19] 22 respondents started the survey, but of these, 2 did not complete any substantive questions. This leaves 20 for analysis.

respondents noted that it may benefit from the addition of either “providing” or “expectations” to the title as a way to make it even clearer.

- **Terminology Section:** The inclusion of a terminology section was positively received. Several respondents requested that the policy itself include examples, or that a companion document include examples in order to illustrate the application of the policy.

- **Reasonableness of draft policy:** Although the majority of respondents supported the principles of the draft policy, several expressed concern with requiring physicians to provide services in general. Some respondents were concerned that the presence of physicians without the needed skillset in a disaster or public health emergency situation would require personnel management that would detract from direct patient care. Others were concerned that the requirement for physicians to provide services is not reasonable, does not account for their familial responsibilities nor does it account for physicians experiencing severe illness or who are immunocompromised. It appears these respondents have misread the content of the draft policy, as the draft policy accounts for familial responsibilities and ability limitations.

- **Beyond College mandate:** Several comments were made that fell outside of the College’s mandate to regulate the practice of medicine to protect and serve in the public interest. These included suggestions to include in the draft policy, criteria for when a disaster or public health emergency could be declared, assigning authority for which officials could declare a public health emergency, dictating how physicians should be compensated for the services they provide, and developing communications infrastructure and regional plans for emergency preparedness.

iii. Next Steps:

- All feedback received will be carefully reviewed and used to evaluate and revise the draft policy. The revised draft will be presented to the Executive Committee and Council for its consideration for final approval early next year.

6. Policy Status Table

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

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

DECISIONS/DISCUSSION FOR COUNCIL:

For information only

Contact: Andréa Foti, Ext. 387

Date: November 10, 2017

Appendices:

Appendix A: Letter of support for Bill 163.
Appendix B: 2017 CPSO Response to MTO Consultation re. Mandatory Reporting Amendments.
Appendix C: Policy Status Table.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Submission to the Standing Committee on General Government regarding Bill 163, the *Protecting a Woman's Right to Access Abortion Services Act*, 2017

College of Physicians and Surgeons of Ontario

October 19, 2017

Appendix A

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

October 19, 2017

MPP Grant Crack
Chair, Standing Committee on General Government
Whitney Block, Room 1405
Queen's Park, Toronto, ON
M7A 1A2

To the Members of the Standing Committee on General Government:

We write on behalf of the College of Physicians and Surgeons of Ontario to convey our support for Bill 163, the *Protecting a Woman's Right to Access Abortion Services Act*, 2017. The College regulates the province's medical profession and has a legal mandate to serve and protect the public interest.

The College strongly supports Bill 163. The Bill demonstrates respect for patient autonomy and access to care, two goals which underpin all of the College's activities as a regulatory authority. When Mifegymiso® was approved for use in Canada, the College supported patient access to this medication by issuing a statement to our membership providing clarification on the prescribing and dispensing process for Ontario physicians. In addition, the College's *Professional Obligations and Human Rights* policy supports patient autonomy and access to care by articulating the legal, ethical, and professional obligations of physicians to provide care to patients without discrimination.

The College supports the primary purpose of the Bill, which is to protect the safety and security of patients as they access services in a health care setting that provides abortion services. If passed, this Bill would allow for patients to access abortion services without fear of intimidation, harassment or interference. All patients should feel safe and secure when accessing health care services.

The College also supports provisions in the Bill that would provide protection to physicians and other health care professionals who provide abortion services, or work in a facility that provides abortion services, from harassment and intimidation at their places of work and where they live.

The College strongly supports the passage of Bill 163, the *Protecting a Woman's Right to Access Abortion Services Act*, 2017. We appreciate the opportunity to share our views on Bill 163 with the Committee.

Yours truly,

David Rouselle MD FRCSC
President

Rocco Gerace MD
Registrar

Appendix B

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Rocco Gerace MD
Registrar
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October 6, 2017

Ministry of Transportation
Road Safety Policy Office - Road Users
Room 212, 87 Sir William Hearst Avenue
Toronto, ON M3M 0B4

RE: Improvements to the Ministry of Transportation's Medical Reporting Program

Thank you for the opportunity to provide feedback on the proposed amendments to the regulations under the *Highway Traffic Act, 1990*. The College of Physicians and Surgeons of Ontario (CPSO) recognizes the importance of enhancing road safety and supports the Ministry's efforts to improve the Ontario reporting scheme related to fitness to drive.

We note that you have incorporated much of the feedback we provided on earlier drafts of the list of prescribed medical conditions, functional impairments and visual impairments that must be reported to the ministry and have addressed many of the initial concerns raised. We do, however, offer a number of constructive comments for consideration to assist with further updating and refining the list in order to further clarify the reporting requirements for the prescribed health care professionals.

Constructive Comments Regarding the Mandatory List of Reportable Conditions

a) Threshold for which conditions are reportable

i. Include Preamble to the Mandatory List

The CPSO still believes it would be useful to insert a preamble before the list of reportable conditions to explicitly state that all of the listed conditions are reportable when they are *likely to interfere with the individual's ability to safely drive a motor vehicle*. This would signal to prescribed health care professionals the threshold at which a condition becomes reportable.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

ii. Clarity Regarding Reporting

The CPSO suggests further clarity regarding whether the listed conditions always trigger a mandatory report, or whether reporting is at the health care professional's discretion. The caveat (*reporting of these conditions and impairments may not be mandatory if they are of a distinctly temporary, non-recurrent or controllable nature*) makes it difficult to determine when a mandatory reporting obligation exists, and suggests that the list of reportable conditions is actually discretionary.

iii. Change 'Controllable' to 'Controlled'

The caveat mentioned above specifies that reporting may not be required where conditions and impairments are of a 'controllable nature'. The CPSO still believes the reporting should be required where the conditions are 'uncontrolled' instead of 'uncontrollable'. If left unchanged, symptoms that are controllable but left uncontrolled would not trigger a mandatory reporting obligation even though the individual may pose a risk to public safety.

b) Reporting Conditions Related to Psychiatric Illness

i. Abnormalities of perception

The CPSO believes that *abnormalities of perception* is an ambiguous term and suggests aligning the reporting requirements related to psychiatric illness with the DSM-V manual terminology instead, to specify the disorders that require reporting. The CPSO recommends that the reportable conditions pertaining to psychiatric illness include:

- Schizophrenia or other psychotic disorders
- Bipolar disorders
- Trauma and stressor-related disorders
- Dissociative disorders
- Sleep-wake disorders
- Neurocognitive disorders

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

ii. Acute Psychosis

The CPSO suggests limiting the instances of reporting to those situations of acute psychosis that are not medically or pharmacologically managed. (i.e., require reporting only where acute psychosis is *untreated, or where non-compliance with treatment recommendations exists). The CPSO believes the risk to the public exists primarily where the condition is not being controlled.*

iii. Suicidal plan involving vehicle or intent to use vehicle to harm others

The CPSO recommends requiring reporting where an individual has a *suicidal plan involving a vehicle or intent to use a vehicle to harm others,* as was set out in an earlier version of the list. The CPSO believes this to be an important criterion for reporting.

c) Other Suggested Amendments

i. Cognitive Impairment

The CPSO suggests adding *affected memory* to the list of reportable conditions pertaining to cognitive impairment as the CPSO believes this to be an important criterion for reporting.

ii. *Motor or Sensory Impairment*

The CPSO suggests clarifying the reporting requirements pertaining to *motor or sensory impairment* as the CPSO believes they are overly broad and do not achieve the intended specificity that the MTO has indicated they would like to achieve.

iii. Substance Use Disorders

The CPSO suggests excluding *caffeine and nicotine* from the reporting requirements related to substance use disorders as was done in a previous version of the list. The CPSO believes this will eliminate unnecessary reports and limit the reportable conditions to only those that would impact an individual's ability to operate a motor vehicle.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The CPSO recognizes the work that has gone into drafting the amendments to the Regulations, and appreciates the opportunity to provide comments. We hope that the Ministry finds them helpful. In our view, clarity on the issues discussed above would assist the prescribed health care professionals in complying with their reporting obligations and will enhance road safety.

Yours very truly,

Rocco Gerace, MD
Registrar

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Re-entering Practice	The current policy sets out expectations for physicians who wish to re-enter practice after a prolonged absence from practice and sets out requirements of physicians in demonstrating their competence in the area of practice they are returning to.	This policy is currently under review and being reviewed in tandem with the Changing Scope of Practice policy. The two current policies have been combined into a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*. A consultation on the draft policy took place between September and November 2017. Further information on the consultation results and next steps can be found in the Policy Report contained in Council's December 2017 meeting materials.	2018
Changing Scope of Practice	The current policy sets out expectations for physicians who have changed or intend to change their scope of practice and sets out requirements of physicians in demonstrating their competence in the new area of practice.	This policy is currently under review and being reviewed in tandem with the Re-entering Practice policy. The two current policies have been combined into a new draft policy entitled *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*. A consultation on the draft policy took place between September and November 2017. Further information on the consultation results	2018

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		and next steps can be found in the Policy Report contained in Council's December 2017 meeting materials.	
Prescribing Drugs	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.	This policy is currently under review. Initial stages of the review are now underway and a preliminary consultation is expected to be undertaken following December Council.	2019
Block Fees and Uninsured Services	The current policy sets out the College's expectations of physicians who charge patients for services not paid for by the Ontario Health Insurance Plan (OHIP).	This policy is currently under review. A newly titled Uninsured Services: Billing and Block Fees draft policy was approved for external consultation by Council in February 2017. The draft policy has been revised in light of the feedback received and additional research that was undertaken. The revised draft policy will be presented at the December meeting of Council for consideration for final approval.	2017
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy helps physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991 (RHPA)* regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the	This policy is currently under review. The review will be informed by the College's Sexual Abuse Initiative, the Minister of Health and Long-Term Care's Task Force on the Prevention of Sexual Abuse of Patients, and Bill 87, the *Protecting Patients Act, 2017*. The initial stages of the review are underway and a preliminary consultation is being held between	2019

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	September and November 2017. Further information on preliminary consultation results and next steps may be found in the Policy Report included in your Council materials.	
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 have been complete, and a draft policy is being prepared. Further updates with respect to the status of this review will be provided at a future meeting.	2018
Physicians and Health Emergencies	The purpose of this policy is to reaffirm the profession's commitment to the public in times of health emergencies.	This policy is currently under review. A new draft policy entitled *Physician Services During Disasters and Public Health Emergencies* was approved for external consultation at the September meeting of Council. A consultation of the draft policy took place between September and November 2017. Further information can be found in the Policy Report contained in Council's December 2017 meeting materials.	2018

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	This policy is currently under review. A joint Working Group has been struck to undertake this review alongside the development of a new *Continuity of Care* policy. A preliminary consultation was undertaken between June and August, 2016. The working group has considered the feedback received and the research findings, and the development of a new draft policy that incorporates test results management is underway	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of the *Test Results Management* policy. A preliminary consultation was undertaken between June and August, 2016. The working group has considered the feedback received and the research findings and the development of a new draft policy is underway.	2018

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Confidentiality of Personal Health Information	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was held between May and July 2017. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Medical Records	This policy sets out the essentials of maintaining medical records.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation is being held between September and November 2017. Further information on preliminary consultation results and next steps may be found in the Policy Report included in your Council materials.	2019

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Disclosure of Harm	2015/16	This policy provides guidance to physicians on disclosing harm to patients. The review of this policy has been deferred, due to competing priorities.
Fetal Ultrasound for Non-Medical Reasons	2015/16	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds. The review of this policy has been deferred, due to competing priorities.
Female Genital Cutting (Mutilation)	2016/17	This policy sets out physicians' obligations with respect to female genital cutting/mutilation. The review of this policy has been deferred, due to competing priorities.
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine.
Dispensing Drugs	2016/17	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016/17	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Third Party Reports	2017/18	This policy clarifies the College's expectations regarding physicians' roles in and standards of care for conducting medical examinations and/or preparing reports for third parties.
Delegation of Controlled Acts	2017/18	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Mandatory and Permissive Reporting	2017/18	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.
Prescribing Drugs	2017/18	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.
Anabolic Steroids, Substances and Methods Prohibited in Sport	2018/2019	The current policy articulates the College's expectations of physicians regarding the use of anabolic steroids and other substances and methods for the purpose of performance enhancement in sport (i.e., doping).
Social Media – Appropriate Use by Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest:	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)		September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-of-Life Care (formerly Decision-Making for the End of Life)	2020/21	This policy sets out expectations of physicians regarding planning for and providing quality care at the end of life.
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.

POLICY STATUS REPORT – DECEMBER 2017 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Members		
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.
Accepting New Patients	2022/23	This policy sets out the College's expectations of physicians when accepting new patients.
Ending the Physician-Patient Relationship	2022/23	This policy sets out the College's expectations of physicians when ending the physician-patient relationship.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

November 2017

TOPIC: **Physician Assistants**

For Information

ISSUE:

- The Ministry of Health and Long-Term Care is currently undertaking work related to Physician Assistants (PAs).
- As part of this, Minister Hoskins has asked the College to work with the Ministry on an approach to provide appropriate regulatory oversight for PAs.
- Council is provided with an overview of this ongoing work. This item is for Council's information.

BACKGROUND:

- PAs have long been part of the Ontario health care landscape. PAs have been providing services in a variety of health care settings since the launch of various demonstration projects in 2006 and the operation of two training programs in Hamilton and Toronto.
- In 2011, the Health Professions Regulatory Advisory Council (HPRAC) produced a series of reviews (literature, jurisdictional, jurisprudence), and recommended to the Minister in 2012 that
    - PAs not be regulated under the *Regulated Health Professions Act, 1991* (RHPA), at this time; and
    - A compulsory registry be implemented under the governance and oversight of the College.
- Over 2013 and 2014 the College engaged in some preliminary discussions with the Ministry about the idea of a PA registry.
- Work on the proposed PA registry was ultimately deferred, due to competing priorities at the College and the Ministry.

CURRENT STATUS:

- In 2017, the Ministry renewed its work on PAs.

- The Ministry's 2017 work on PAs has largely been focused on integration of PAs into the health system, and regulatory oversight for PAs. The College has been involved in both streams of work.

1. Integration of PAs

- In March 2017, the Ministry struck a PA Integration Working Group. The College is included in the Working Group along with practicing PAs, the Ontario Chapter of the Canadian Association of Physician Assistants (CAPA), physicians involved in working with and training PAs, Government representatives from the Health Workforce Branch, the Negotiations Branch, Health Force Ontario and LHINs.

- The Working Group's purpose is to support the Ministry in developing and implementing initiatives that improve the integration of PAs into Ontario's health care system for the benefit of patients and the health system.

- The Working Group will meet regularly into 2019 and will focus on: Clarity of Role and Accountability for PAs; Recruitment and Retention of PAs and Funding Integration and Sustainability.

- In meetings to date, the College has been able to offer clarification and feedback related to the College's *Delegation of Controlled Acts* policy, CanMEDS roles, and scope of practice.

2. Regulatory Oversight for PAs: Ministry Request

- In August 2017, the Minister wrote to the College, seeking assistance related to PAs. This letter is attached as **Appendix A** for Council's reference.

- In the letter, the Minister asked the College to work with the Ministry on an approach to providing appropriate regulatory oversight for PAs. At minimum, the Minister indicated that this work should be informed by:

    - Existing mechanisms at the national level aimed at establishing common competencies, educational standards and standards of practice for PAs;
    - HPRAC's report, *The Health Profession Assistant: Consideration of the Physician Assistant Application for Regulation under the Regulated Health Professions Act, 1991;*
    - Existing oversight frameworks for PAs in other jurisdictions; and
    - The 2016 Conference Board of Canada Studies into the practice of Physician Assistants.

- The Minister has asked that a proposed approach for PAs be submitted for his consideration by December 31 2017.

- The College has been in discussions with Ministry staff about the Minister's request and next steps. It is anticipated that these discussions will continue over the coming months.

CONSIDERATIONS:

- Despite the current workloads at the College, the College is obliged to engage in the work requested by the Minister. Indeed, depending on the position the Ministry takes with respect to PAs, the College may indeed be obliged to take a role in any oversight mechanism specified for PAs.

- Discussions at the PA Integration Working Group suggest that the issue of a PA registry and/or full regulation of PAs will emerge.

- Council is reminded that in its submission to HPRAC in 2012, the College indicated that it would be prepared to maintain a proposed registry for PAs.

NEXT STEPS:

- The College will continue to attend Working Group meetings and engage with Ministry staff regarding regulatory oversight of PAs.

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

DECISIONS FOR COUNCIL:

- This item is for information only.

Contact: Dan Faulkner, ext. 228
Andréa Foti

Date: November 10, 2017

Attachments:

Appendix A: Letter from Minister Hoskins, August 18 2017

Appendix A

Ministry of Health and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
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www.ontario.ca/health

Ministère de la Santé et des Soins de longue durée

Bureau du ministre

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Ontario

AUG 18 2017

HLTC2968MC-2017-191

Dr. Rocco Gerace
Registrar
College of Physicians and Surgeons of Ontario
80 College Street
Toronto ON M5G 2E2

Dear Dr. Gerace:

Physician Assistants (PAs) were introduced to Ontario's health care system in 2007 as a new provider role through a series of demonstration projects. The goal was to reduce wait times and improve access to patient care in high need areas (e.g. emergency medicine, primary care).

In the last couple of years, a number of studies across Canada and work done here at the Ministry of Health and Long-Term Care (the "ministry") have shown that PAs have played a role in increasing access to primary care and emergency department services. Additionally, they have played an equally valuable role as "physician extenders" in supporting specialist services, particularly surgical services in the hospital setting.

The ministry has been considering how to more effectively integrate PAs into Ontario's health system to better meet the needs of patients. As a result, the ministry established the Physician Assistant Integration Working Group (PAIWG) in April 2017 and we were delighted that the College of Physicians and Surgeons of Ontario (CPSO) agreed to participate. As you may be aware, the working group's role is to support the ministry's efforts to:

- Bring clarity to the role of PAs as a health care provider;
- Recruit and retain physician assistants in key settings to enhance access to care; and
- Improve integration and sustainability of the PA's role.

While all of those elements are important to ensure more effective integration of PAs into our health system, it is just as important to ensure that PAs are providing safe, quality services within a clear accountability framework.

...2

Dr. Gerace

Although the Health Professions Regulatory Advisory Council (HPRAC) looked at the issue of regulating PAs in 2012, I believe that the time is right for more in-depth consideration of appropriate regulatory oversight.

In view of the role played by physicians in the practice of PAs, I am requesting that the CPSO work with the ministry on an approach to providing appropriate regulatory oversight for PAs.

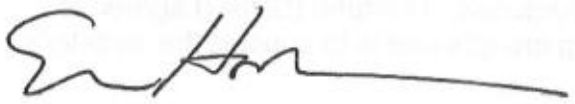
At a minimum, considerations on an appropriate approach should be informed by:

- Existing mechanisms at the national level aimed at establishing common competencies, education standards and standards of practice for PAs (e.g. CanMEDS-PA; the Canadian Association of Physician Assistants' Code of Ethics);
- HPRAC's report, The Health Profession Assistant: Consideration of the Physician Assistant Application for Regulation under the *Regulated Health Professions Act, 1991*, and recommendations;
- Existing oversight frameworks for PAs in other jurisdictions; and
- The 2016 Conference Board of Canada Studies into the practice of Physician Assistants.

I am requesting that the CPSO work with the ministry with the view to developing an approach for my consideration by December 31, 2017.

Please extend my appreciation to the CPSO Council for your support of this important work. Should you have questions, please contact Denise Cole, Assistant Deputy Minister, Health Workforce Planning and Regulatory Affairs Division at Denise.Cole@ontario.ca or at 416-212-7688.

Yours sincerely,



Dr. Eric Hoskins
Minister

c: Dr. Robert Bell, Deputy Minister, MOHLTC
Denise Cole, Assistant Deputy Minister, Health Workforce Planning and Regulatory Affairs Division, MOHLTC

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

December 2017

TOPIC: **Quality Management Partnership: Proposed changes to the companion document "Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy/Colonoscopy"- Role of the Medical Director**

FOR INFORMATION

ISSUE:

- This note provides Council with results of the targeted consultation on the Quality Management Partnership's proposed alignment of the Facility Lead role with that of the OHP (Out-of-Hospital Premise) Medical Director.
- Council is reminded the core standards for the Out of Hospital Premises Inspection Program (OHPIP) are not being re-opened to do include these new standards. Instead this role will be inserted into the companion document Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy /Colonoscopy Premises. As such, this item is brought to Council for information

BACKGROUND:

- The aim of embedding the colonoscopy QMP (Quality Management Program) Facility Lead role into OHPIP standards is to:
    - achieve alignment of expectations between the Partnership's colonoscopy QMP and the OHPIP;
    - assure a core level of participation in Partnership activities such as review of quality reports and responding to annual surveys that inform these reports;
    - support the Partnership objectives which are to; enhance the quality of care provided, improve patient safety, increase the consistency in the quality of care provided across facility types (e.g. hospitals and Out of Hospital Premises (OHP)), and to improve public confidence by increasing accountability and transparency.

- To support this effort, a Facility Lead Standards Working Group was formed in June 2016 and has been meeting on a regular basis to develop the language for standards to be incorporated into the Medical Director role. The Working Group consists of:

    - Dr. David Morgan, Colonoscopy QMP Provincial Lead
    - Dr. Jonathan Love, Colonoscopy QMP Regional Lead
    - Dr. Bob Byrick , Premises Inspection Committee
    - Dr. Hugh Kendall, Premises Inspection Committee (past)

- The Facility Lead having colonoscopy in their scope of practice) will be responsible for fostering quality improvement at the facility level, and will work with providers, staff at the facility and Regional and Provincial Leads to address and improve quality as needed. This includes:

    - Reviewing quality management reports with appropriate staff and documenting the review occurred;
    - Identifying and documenting issues and opportunities for Quality Improvement (QI);
    - facilitating and documenting QI plan to address opportunities for improvement with the OHP staff related to QMP reports; and
    - Identifying any patient safety concerns related to the provider quality indicators and facility quality standards reflected in QMP reports and referring them to the CPSO if required.

- In January 2017 Executive Committee was provided with the draft wording of standards to align the Facility Lead role with the Medical Director role.
    - When presented to PIC in May'17 the presentation stimulated discussion about the impact integrating these standards may have on OHPIP program costs while being mindful that the program is cost recovery. PIC agreed with the Facility Lead Standards Working Group that non-compliance with these standards would not necessarily lead to an outcome of "Fail".
    - On October 26 PIC was provided with an update about findings from the targeted stakeholder consultation held over the Summer of 2017 on aligning the additional Facility Lead activities with the Medical Director role.

CURRENT STATUS:

- An overview of the proposed Facility Lead activities that will be aligned to the role of Medical Director in endoscopy/colonoscopy OHPs is attached for ease of reference as Appendix A.

- Targeted invitations to participate were shared with stakeholders impacted by the update to the Medical Director role. This included the OHP Medical Directors for Colonoscopy; Quality Management Program (QMP) Colonoscopy Provincial Quality Committee; QMP Facility Leads in Colonoscopy; Ontario Association of Clinical Endoscopists (OACE); Ontario Association of General Surgeons (OAGS); Ontario Association of Gastroenterologists (OAG); Canadian Association of Gastroenterology (CAG); Canadian Society of Gastroenterology Nurses and Associates (CSGNA); Canadian Medical Protective Association; PIC members; the Ontario Medical Association Gastroenterology and General Surgery Section Heads and Ontario Medical Association, Clinical Endoscopists – Medical. The targeted consultation was held July 25 – September 11, 2017.

- The consultation was guided by six questions which included asking about the stakeholder perspective on how well the additional activities align with the Medical Director role with respect to their existing quality management role; any concerns or challenges participants foresee a Medical Director may have with the implementation of the facility lead activities; and supports that would be helpful to the Medical Director to meet the standard.

- High level consultation feedback included concern about financial resources required to take on the Facility Lead activities; need for implementation supports; acknowledgement that the Facility Lead activities align well with the Medical Director role, and; need for deeper understanding of the Facility Lead role, scope and responsibilities.

- The Facility Lead Standards Working Group reviewed the feedback and did not make any updates to the document but provided guidance to staff about the implementation supports required.

CONSIDERATIONS:

- Consultation feedback raising concerns about the cost of performing the Facility Lead activities is likely the result of the cancellation of a Ministry of Health and Long-Term Care payment scheme for OHPs performing colonoscopy to become licensed as IHFs. Some owners and Medical Directors of these OHPs have declined to participate fully in the Partnership quality management program. The thrust of their position being there will be additional costs associated to implement the quality management program. This position is supported by individuals as well as the Ontario Association of Gastroenterologists, Ontario Association of General Surgeons, and the Ontario Association of Clinical Endoscopists.

- Results from the consultation also pointed to the need to help Medical Directors interpret and operationalize the Facility Lead activities, and importantly to emphasize these are activities performed already and are consistent with their professional obligations. To support stakeholder implementation and to address the themes noted above, Partnership staff will develop a webcast and provide additional tools to support implementation of the new Facility Lead activities.

- The Facility Lead Standards Working Group also noted that they would expect that many facility leads will have difficulty in commenting on aspects of a colleagues practice. To this end staff have put a plan in place to provide facilitated feedback training to all colonoscopy QMP Regional and Facility Leads with the aim of helping these leads learn to engage and build relationships with colleagues.

NEXT STEPS:

- Staff are developing an implementation plan to support the onboarding of the Facility Lead activities for Medical Directors and orient OHPIP assessors.

DECISION FOR COUNCIL:

This item is for information

Contact: Robin Reece, ext. 396
Sarah Benn Orava, ext. 504
Wade Hillier, ext 636

Date: November 15, 2017

Attachments:

Appendix A: Overview of Facility Lead Activities for Alignment with Medical Directors of endoscopy/colonoscopy OHPs

Appendix B: Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in Endoscopy/Colonoscopy Premises

Appendix A: Overview of Facility Lead Activities for Alignment with Medical Directors of endoscopy/colonoscopy OHPs

Section 2.2 Medical Director Responsibilities

This section outlines the role of the Colonoscopy Program (QMP) Facility Lead. In addition to this standard, the Facility Lead will receive Quality Management Partnership information and act as a liaison between OHP staff and the Partnership including communicating with facility staff about tools, guidelines or other initiatives related the Colonoscopy QMP and documenting any feedback; providing Facility Lead and Medical Director names, addresses, email addresses and telephone numbers to the Partnership; and participate in surveys related to the Colonoscopy QMP.

Section 2.2.3 Appointment of Acting Medical Director

This section outlines that the acting medical director should assume the role of Facility Lead as long as they meet the qualifications outlined in section 5.1. Where the standard is not being met the appointment of the Facility Lead will be made by the QMP Provincial Lead or designate.

Section 5.1 OHP Medical Director Qualifications

This section outlines the qualifications that a Facility Lead shall hold and indicates that whenever possible the Medical Director will be the Facility Lead at OHP. Not only should the Facility Lead maintain certifications similar to the Medical Director but the Facility Lead must also actively have endoscopy as part of their scope of practice. Additional considerations have been addressed in this section to account for circumstances if the qualification criteria for a Facility Lead cannot be met by the Medical Director, then the Medical Director must work with the Regional Lead to appoint and document an appropriate Facility Lead who has endoscopy within their scope of practice. CPSO must be informed of the change. In addition, situations where there is a multi-site facility, each site does not need a separate Facility Lead and the Facility Lead must be performing colonoscopy procedures in at least one of the sites. Exceptional circumstances where volumes are not met will be reviewed individually...

Section 8 Quality Assurance (QA) Standards

This section summarizes the activities the Facility Lead must be responsible for when acting as a liaison between OHP staff and the Partnership; as well as additional duties related to the receipt of facility and provider level reports and using the reports to help identify quality improvement opportunities. This section further demonstrates how the Facility Lead duties can be integrated into the OHP facility through the Medical Director role. By embedding the role of Facility Lead into the QA section, this will aid in ensuring that facilities have increased accountability for patient related quality improvement and assurance issues that may arise.

Section 8 Quality Assurance (QA) 8.2 and 8.3

This section further outlines the duties that a Facility Lead has when there are persistent and or serious deviations in clinical quality indicators and facility standards related to the Colonoscopy

QMP reports which are not being met and result in patient safety concerns. Under these circumstances, the Facility Lead must communicate with the Medical Director to identify and document patient safety concerns and deviations in accordance with Quality Assurance reporting required by the Partnership, which is currently under development. This process correlates to the quality management reports and will not duplicate any efforts related to OHPIP adverse event requirements.

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Appendix A

Colonoscopy Quality Management Program Facility Lead

Background

In March 2013, the Ministry of Health and Long-Term Care (MOHLTC) established the Quality Management Partnership (the Partnership) with the purpose of designing quality management programs in colonoscopy, mammography, and pathology. Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO) lead this initiative. On December 1, 2015 the Ministry of Long Term Care (MOHLTC) mandated that the Partnership start implementation of quality management programs (QMPs) in all three health service areas. An integral component of a QMP is to identify appropriate clinical and administrative contacts in each facility that will champion and be responsible for fostering continuous quality improvement.

The clinical leadership structure of the QMPs consists of a network of clinical leads at the provincial, regional and facility levels. The colonoscopy QMP has a Provincial Quality Committee (PQC) that oversees overall quality and accountability at all levels. The Facility Lead will work collaboratively with the Regional Lead to support continuous quality improvement within each facility/OHP.

Role of the colonoscopy quality management program Facility Lead

As outlined in the OHPIP Program Standards, it is an expectation that facilities must have a Medical Director, to satisfy the requirements of the OHPIP core Standards and a Facility Lead to satisfy the requirements of the colonoscopy QMP.

The Facility Lead is responsible for quality management and improvement activities within the facility (OHP) as it relates to QMP reports. The Medical Director is responsible for overall quality assurance within the OHP.

5.1 OHP Medical Director Qualifications

Guidance to the Standard

OHP Medical Director Qualifications, Standard 5.1. In addition to the Medical Director qualifications, the Facility Lead's scope of practice must include colonoscopy. If the nature of the region of where they practice makes this not feasible, the scope of practice must include endoscopy.

5.1 OHP Medical Director Qualifications

A physician who is applying to become a Medical Director must hold a valid CPSO certificate of registration and must ***not*** be the subject of any disciplinary or incapacity proceeding in any jurisdiction.

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

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

5.2 Physician Performing Procedures Qualifications

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

1) Valid CPSO certificate of registration

And

2) a) One of the following: RCPSC or CFPC certification that confirms training and specialty designation pertinent to the procedures performed.

b) CPSO recognition as a specialist that would include, by training and experience (the procedures performed (as confirmed by the CPSO "Specialist Recognition Criteria in Ontario" policy.

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

Note:

1. Wherever possible, it is preferred that the Medical Director of an OHP assume the role of the Facility Lead. If the qualification criteria for a Facility Lead cannot be met by the Medical Director, then the Medical Director must work with the Regional Lead to appoint and document an appropriate Facility Lead who has colonoscopy within their scope of practice. If the nature of the region of where they practice makes this not feasible, the scope of practice must include endoscopy. CPSO must be informed of the change.
2. In situations where there is a multi-site facility, each site does not need a separate Facility Lead and the Facility Lead must be performing colonoscopy procedures in at least one of the sites.
3. The Facility Lead is accountable to the Medical Director and must participate in and document regular communication with the Medical Director regarding quality management and improvement activities and findings.

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4. In small facilities i.e. where there are two or three colonoscopists practicing at the facility, the Regional Lead will receive and review provider and facility level QMP reports with the providers at the facility in order to maintain privacy and confidentiality of individual provider level data.

8. Quality Assurance

Guidance to the Standard:
Section 8 Quality Assurance (QA)
Standards 8.1

In addition to the core OHP Standards the Facility Lead must be responsible for the following QA responsibilities:

- Receiving Partnership information and acting as a liaison between OHP staff and the Partnership including:
  - Communicating with facility staff about tools, guidelines or other initiatives related the Colonoscopy QMP and documenting any feedback.
  - Providing Facility Lead and Medical Director names, addresses, email addresses and telephone numbers to the Partnership and completed surveys related to the Colonoscopy QMP.

- Tracking that the OHP has received facility and provider level Colonoscopy QMP reports from the Partnership (Cancer Care Ontario) by:
  - Reviewing and documenting Partnership reports with appropriate staff.
  - Identifying and documenting issues and opportunities for quality improvement (QI)
  - Developing and documenting a QI plan to address opportunities for improvement with the OHP staff.

8 Quality Assurance (QA

The Medical Director is responsible for OHP compliance with external regulatory requirements including all Acts relevant to the practise of Medicine[1], including the CPSO OHP Standards, Companion documents to the Standards, and other guidelines, such as, the Provincial Infectious Diseases Advisory Committee's (PIDAC) *Infection Prevention and Control for Clinical Office Practice*, Malignant Hyperthermia Association of the United States (MHAUS), etc. The Medical Director is also individually responsible for OHP compliance with all internal CPSO policies, guidelines and directives within their Policy and Procedure Manual.
The Medical Director is responsible for appointing other individuals as necessary to **assist** with OHP staff compliance with policies and procedures set out by the Medical Director, especially as it relates to monitoring and reporting on the quality of anesthetic and surgical procedures.

OHP Quality Assurance Committee

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

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

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

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

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

1) Review of non-medical staff performance
2) Review of individual physician care to assess
a) patient and procedure selection are appropriate
b) patient outcomes are appropriate
c) adverse events (see8.2)
The suggested protocol is, annually, random selection 5-10 patient records to review:
i) records completion and documentation of informed consent
ii) percentage and type of procedures
iii) appropriate patient selection
iv) appropriate patient procedure
v) where required, reporting results in a timely fashion
vi) evaluation of complications (see 8.2)
vii) assessment of transfer to hospital, where required
viii) follow up of abnormal pathology and laboratory results
3) Review a selection of individual patient records to assess completeness and accuracy of entries by all staff
4) Review of activity related to cleaning, sterilization, maintenance, and storage of equipment
5) Documentation of the numbers of procedures performed: any significant increase/decrease
(>50% of the last reported assessment

- Documenting the implementation of the QI plan with the facility and staff.

Section 8 Quality Assurance (QA)
Standards, 8.2 and 8.3 – In addition to these Standards the Facility Lead role must be responsible for the following additional responsibilities:

- The Facility Lead must act on and report to the Medical Director and Regional Lead any persistent and or serious deviations where provider level quality indicators and facility level quality standards reflected in QMP reports are not being met.

- The Facility Lead must communicate with the Medical Director, to identify and document patient safety concerns and any persistent and or serious deviations in the provider level indicators and or facility level quality standards, in accordance with processes required by the Partnership.

- The Facility Lead in coordination with the Regional Lead must make any decisions about referring patient safety concerns to the CPSO in a timely way and document all decisions made in accordance with Partnership processes.

8.2 Monitoring and Reporting Adverse Event

1. All OHP staff must monitor adverse events. Indicators of adverse events generally include complications related to the use of sedation/anesthesia or to the procedure.
2. Every member who performs a procedure in an OHP shall report the following events to the College within 24 hours of learning of the event. These events are termed 'Tier 1 Events' to denote the potential serious nature of the event and the need to prevent a recurrence.

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

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

Tier 2 events include, but are **not limited to**:
a) unscheduled treatment of a patient in a hospital within ten (10) days of a procedure performed at a premises
b) complications such as infection, bleeding or injury to other body structures
c) cardiac or respiratory problems during the patient's stay at the OHP
d) allergic reactions
e) medication-related adverse events
4. All OHP staff should report adverse events as follows:
4.1 The member must report Tier 1 adverse events (see above) to the Medical Director and to the College in writing within 24 hours of learning of the event using the form provided on the College website. To access the form, the reporting physician must log in to his/her CPSO member portal on the CPSO website at https://www.cpso.on.ca/Login.aspx

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

4.3 The member should report in writing any Tier 2 adverse event (see above) to the Medical Director within 24 hours of the event.
The written report should include the following:

a) Name, age, and sex of the person(s) involved in the incident, includes staff and patients
b) name of the witness(es) to the event (if applicable)
c) time, date and location of the event
d) description of the incident and treatment rendered
e) date and type of procedure (if applicable)
f) analysis of reasons for the incident
g) outcome.
Note: OHPs should identify and adherence to quality indicators specific to procedures performed in their premises.

8.3 Review of Adverse Events and other QA Monitoring Activities

The Medical Director must:
1) Review all adverse events reports and QA monitoring findings occurring over a 12 month period
2) Document the review and any relevant corrective actions and quality improvement iniatives taken
3) Provider feedback to all staff regarding identified adverse events.

January 17th, 2017

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

DRAFT

Applying the Out-of-Hospital Premises Inspection Program (OHPIP) Standards in **Endoscopy/Colonoscopy Premises**

July 2017

College of Physicians and Surgeons of Ontario Mandate

The profession, through and with the College, has a duty to serve and protect the public interest by regulating the practice of the profession and governing in accordance with the *Regulated Health Professions Act*.

Our Vision – Quality Professionals, Healthy System, Public Trust

Our vision guides our thinking and actions. It defines who we are, what we stand for, the role we see for ourselves, our critical relationships, in what system we work, and the outcomes we seek.

Quality Professionals - as a profession and as professionals, we recognize and acknowledge our role and responsibility in attaining at a personal, professional, and at a system-level, the best possible patient outcomes.

Healthy System - the trust of the public and our effectiveness as professionals is influenced by the system within which we operate. We demonstrate leadership by active involvement in the design and function of an effective system, one which is accessible, integrated, informed by evidence and sustainable.

Public Trust – we earn trust of the public by ensuring quality professionals and safe care, working collaboratively with partners towards a healthy system, acting in the interests of patients and communities and being accountable and transparent.

Our Guiding Principles – Integrity, Accountability, Leadership and Collaboration

To fulfill our vision of **Quality Professionals, Healthy System, Public Trust** we are guided by the following principles:

Integrity in fulfillment of our mandate and pursuit of our vision, achieved by aligning our goals, behaviours and outcomes and adhering to a high ethical standard.

Accountability to the public and profession achieved through an attitude of service, accepting responsibility, transparency of process and dedication to improvement.

Leadership demonstrated by proactive regulation of our profession, management of risk and service to the public.

Collaboration with health system partners to ensure shared commitment, focus and resources for the common good of the profession and public.

Guiding Policies

It is expected that physicians will manage medical and surgical conditions within the scope of their certification and experience. For all CPSO members this means practicing with the appropriate qualifications or equivalency subject to requirements set out by the RCPSC, or CPSO "Specialist Recognition Criteria in Ontario" and "Changing Scope of Practice" policies.

Contact Information

Published and distributed by the College of Physicians and Surgeons of Ontario. For more information about the Out-of-Hospital Premises Inspection Program, contact:

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Background:

The **Out-of-Hospital Premises Inspection Program** (OHPIP) supports continuous quality improvement through developing and maintaining standards for the provision of medical care/procedures in Ontario out-of-hospital premises (OHPs), and inspecting and assessing for safety and quality of care. This is mandated by the amendment to Regulation 114/94 under the *Medicine Act* adding **Part XI, Inspection of Premises where Certain Procedures are Performed,** which was enacted on April 9th, 2010.

In November 2009, Council adopted the core Out-of-Hospital Premises Standards which are the basis of inspection-assessments for the variety of procedures performed in OHPs. An external review of the core OHP Standards identified opportunities to provide more practice specific information about the Standards and how they will be applied for the purpose of an inspection- assessment. To meet this opportunity, in 2010 the College engaged a working group consisting of a cross-section of practitioners (including academic and community-based physicians) to provide guidance about the application of the core OHP Standards in this specialty setting.

It is expected that physicians will manage medical and surgical conditions within the scope of their certification and experience. For members of the College of Physicians and Surgeons of Ontario (CPSO), this means practicing with the appropriate qualifications or equivalency subject to requirements set by the Royal College of Physicians and Surgeons of Canada (RCPSC), or CPSO "Specialist Recognition Criteria in Ontario" and "Changing Scope of Practice" policies.

The Purpose of this Document:

This document was developed to help practitioners plan for and participate in their inspection-assessments. It in no way replaces the core OHP 2013 Standards; rather, it helps the practitioner understand how the OHP Standards will be applied in their practice. This Guide should be considered a required companion document to the OHP Standards for practitioners as only those Standards requiring guidance are included. The core OHP Standards are available at www.cpso.on.ca>cpso members>out of hospital premises inspection program.

Note: *The standards are not intended to either replace a physician's clinical judgment or to establish a protocol for all patients with a particular condition. It is understood that some patients will not fit the clinical conditions contemplated by certain standards and that a particular standard will rarely be the only appropriate approach to a patient's condition.*

Updates have been made to this document in 2014 to incorporate additional quality standards.

Acknowledgements:

The College thanks the members of the Endoscopy/Colonoscopy Working Group (2011) for their contributions:

Ms. Mae Burke, RN, BScN	Dr. Hugh Kendall	Dr. Linda Rabeneck
Dr. Stanley Feinberg	Dr. Iain Murray	Dr. Peter Rossos
Dr. Michael Gould	Dr. Gerald O'Leary	Dr. Jill Tinmouth

ACRONYMS /TERMS

Note: Procedure/OR = Procedure room and/or operating room

ACLS	-Advanced Cardiac Life Support
AED	-Automated external defibrillator
ASA	-American Society of Anesthesiologists
BLS	-Basic Life Support
CFPC	-College of Family Physicians of Canada
CNS	-Central nervous system
CPSO	-College of Physicians and Surgeons of Ontario
CSA	-Canadian Standards Association
ECG	-Electrocardiogram
MHAUS	-Malignant Hyperthermia Association of the United States
MRP	-Most responsible physician
OHP	-Out-of-Hospital Premises
OHPIP	-Out-of-Hospital Premises Inspection Program
OR	-Operating Room
PALS	-Paediatric Advanced Life Support
QA	-Quality Assurance
RCPSC	-Royal College of Physicians and Surgeons of Canada
RHP	-Regulated Health Professional
RHPA	-Regulated Health Professions Act
RN	-Registered Nurse
RPN	-Registered Practical Nurse
SVT	-Supraventricular tachycardia
QMP	-Quality Management Program

Table of Contents

Section I

Index of Standards to Guide the Application of Out-of-Hospital Standards in Premises

Section II

Additional Quality Standards

Section I

2.2 Medical Director Responsibilities, Page 7

Guidance to the Standard

Role of the colonoscopy Quality Management Program (QMP) Facility Lead[1]

In addition to this standard, the Facility Lead will receive Quality Management Partnership information and act as a liaison between OHP staff and the Partnership including:

- Communicating with facility staff about tools, guidelines or other initiatives related the Colonoscopy QMP and documenting any feedback.

- Providing Facility Lead and Medical Director names, addresses, email addresses and telephone numbers to the Partnership.

- Participate in all Colonoscopy surveys related to the Colonoscopy QMP.

2.2 Medical Director Responsibilities

All OHPs must have a Medical Director. The Medical Director is the main contact for the College in relation to information about the premises. The Medical Director is responsible for all duties outlined in this document. In situations where a Medical Director is not present, an "Acting Medical Director" must be appointed. The term "Acting Medical Director" applies in the event that the OHP is being overseen by a physician other than the Medical Director (Refer to section 2.2.3).

[1]The clinical leadership structure of the QMP consists of a network of clinical leads at the provincial, regional and facility levels. The colonoscopy QMP has a Provincial Quality Committee (PQC) that oversees overall quality and accountability at all levels. The Facility Lead will work collaboratively with the Regional Lead to support continuous quality improvement within each facility/OHP.
For more information about the Quality Management Partnership and the colonoscopy QMP visit www.qmpontario.ca

2.2.3 Appointment of Acting Medical Director, Page 8

Guidance to the Standard

In addition to this standard, the acting Medical Director should assume the role of Facility Lead as long as they meet the qualifications outlined in section 5.1. Where the standard is not being met the appointment of Facility Lead will be made by the QMP Provincial Lead or designate.

2.2.3 Appointment of Acting Medical Director

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

• Within 24 hours for adverse events submissions (as indicated in College By-law No. 77)

• Within 14 days for regular CPSO requests, or otherwise specified timeframe as identified by the CPSO for other CPSO requests

The CPSO encourages Medical Directors to make prior arrangements that identify Acting Medical Director(s) at each of their premises to ensure systematic coverage during absences. The Acting Medical Director is deemed to be the Medical Director of the premises if he or she is in the role for more than three months - unless otherwise directed by the CPSO.

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

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

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

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

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

4.2 Procedure Room/Operating Room Physical Standards, Page 13

Guidance to the Standard

Ventilation, Standard 4.2.2 – Endoscopy/colonoscopy premises must ensure ventilation of any virucide used during reprocessing (whether automated or manual)
is in keeping with both occupational health and safety requirements, and the manufacturer's standards.

	Level 1	Level 2	Level 3
2 Ventilation	1. Ventilation must ensure patient and staff comfort; and fulfill occupational health and safety requirements. 2. Where applicable, ventilation and air circulation should be augmented to meet manufacturer's standards and address procedure-related air-quality issues; e.g., cautery smoke, endoscopy, disinfecting agents (e.g., Glutacide venting is separate from the other internal ventilation). 3. Where gas sterilization is used, a positive pressure outbound system is used, vented directly to the outside.		

5.1 OHP Medical Director Qualifications Page20

5.2 Physician Performing Procedures Qualifications, Page 21

Guidance to the Standards

- In addition to the Medical Director qualifications, the Facility Lead's scope of practice must include endoscopy.

- Wherever possible, it is preferred that the Medical Director of an OHP assume the role of the Facility Lead. If the qualification criteria for a Facility Lead cannot be met by the Medical Director, then the Medical Director must work with the Regional Lead to appoint and document an appropriate Facility Lead who has endoscopy within their scope of practice. CPSO must be informed of the change.

- In situations where there is a multi-site facility, each site does not need a separate Facility Lead and the Facility Lead must be performing colonoscopy procedures in at least one of the sites.

- Exceptional circumstances where volumes are not met will be reviewed individually.

5.1 OHP Medical Director Qualifications

A physician who is applying to become a Medical Director must hold a valid CPSO certificate of registration and must ***not*** be the subject of any disciplinary or incapacity proceeding in any jurisdiction.

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

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

5.2 Physician Performing Procedures Qualifications

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

1) Valid CPSO certificate of registration

And

2) a) <u>One of the following:</u> RCPSC or CFPC certification that confirms training and specialty designation pertinent to the procedures performed.

b) CPSO recognition as a specialist that would include, by training and experience (the procedures performed (as confirmed by the CPSO "Specialist Recognition Criteria in Ontario" policy.

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

6.4 Verification Process, Page 28

Guidance to the Standard

Second verification, Standard 6.4.1 – A two-stage verification process where the patient and the intended procedure is verified and documented by two different premises staff is sufficient for endoscopy/colonoscopy premises (see Standards 6.5 and 6.6, pg 25). A "time-out" or "surgical pause" is not required for endoscopy/colonoscopy premises.

1. Procedures Included

Procedures with any of the following components require a verification process; a) intravenous sedation; b) surgical incision (of any size); c) remova of tissue; d) primary procedure is itself an injection of any kind This requires verification of the correct patient, procedure, and correct site at two different times and locations, as follows:

	When	Where
First Verification	Before entering the procedure room/operating room	The pre-procedure area
Second Verification	During the time-out	In the procedure room/operating room

Note: Procedures exempted from site marking still require a verification process.

6.8 Intra-Procedure Patient Care for Sedation, Regional Anesthesia or General Anesthesia, Page 30

Guidance to the Standard

Standard 6.8 –
Note: In addition to this standard, the OHP Medical Director must ensure appropriate staffing flow for patient safety.

6.8 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia

Requirements for managing patients undergoing sedation, regional anesthesia, or general anesthesia, are as follows. Note: See physician qualification as well.

1. If the physician administering the sedation or regional anesthesia is also performing the procedure, the patient must be attended by a second individual (physician, respiratory therapist, RN or anesthesia assistant) 1) who is NOT assisting in the procedure and 2) who is trained to monitor patients undergoing sedation or regional anesthesia.

1.1 The second physician, respiratory therapist, RN or anesthesia assistant shall hold ACLS (and PALS if pediatric patients are being treated) certification and the following skills:

1) assessing and maintaining patient airway
2) monitoring vital signs
3) venipuncture
4) administering medications as required
5) assisting in emergency procedures including the use of a bag-valve-mask device
6) documenting in the Anesthesia/Sedation Record

2. Note: If assistance is required during the procedure, a third HCP must be available. The person monitoring the anesthetic shall remain with the patient at all times throughout the duration of anesthetic care until the patient is transferred to the care of a recovery-area staff in the recovery area.

3. Patients shall be attended for the duration of the anesthetic care as follows:

3.1 O2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals. Capnography must be available at the premises for use, where appropriate, on patients receiving deep sedation. Capnography is always required for patients receiving general anesthesia as defined in section 3.2.

3.2 Pulse, blood pressure and electrocardiography must be in continuous use during the duration of anesthetic care. Heart rate and blood pressure shall be documented at least every 5 minutes. During sedation (see section 3.2) in healthy patients without cardiac disease and for whom no cardiovascular disturbance is anticipated, it may be acceptable to waive ECG monitoring as long as pulse oximetry is in continuous use and ECG monitoring is immediately available.

3.3 Audible and visual alarms must not be indefinitely disabled. The variable pitch pulse tone and the low-threshold alarm of the pulse oximeter and the capnograph alarm must give an audible and visual alarm. Variable pitch tone pulse oximeter must be clearly audible at all times.

4. The **Anesthesia/Sedation Record** is completed; it includes the following:

1) pre-procedure anesthetic/sedation assessment
2) all drugs administered including dose, time, and route of administration
3) type and volume of fluids administered, and time of administration
4) fluids lost (e.g., blood, urine) where it can be measured or estimated
5) measurements made by the required monitors:
   - O_2 saturation must be continuously monitored and documented at frequent intervals. In addition, if the trachea is intubated or an LMA [5] is used, end-tidal carbon dioxide concentration must be continuously monitored and documented at frequent intervals
   - Pulse, blood pressure documented at least every 5 minutes until patient is recovered from sedation
6) complications and incidents (if applicable)
7) name of the physician responsible (and the name of the person monitoring the patient, if applicable)
8) start and stop time for anesthesia/sedation care

8. Quality Assurance (QA), Page 35

Guidance to the Standard:

Monitoring OHP Activity, Standard 8.1.2 – In addition to this Standard, it is required:

- That endoscopy/colonoscopy premises document which scope, including serial number, was used on which patient if not done automatically by the endoscope technology, and;
- That when reprocessing scopes the serial number of the scope and which patient it was used on be documented.

8 Quality Assurance (QA)

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

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

OHP Quality Assurance Committee

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

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

At minimum, every QA Committee meeting must address the following topics:

1) Reports on Quality of Care for each service (8.1)
2) Infection Control– duties as set out in Section 7
3) Adverse Events
4) Staffing credentials

8.1 Monitoring Quality of Care

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

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

1) Review of non-medical staff performance
2) Review of individual physician care to assess
a) patient and procedure selection are appropriate
b) patient outcomes are appropriate
c) adverse events (see8.2)

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

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

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

8. Quality Assurance (QA), Page 35

Guidance to the Standard:
In addition to the core OHP Standards the Facility Lead must be responsible for the following QA responsibilities

Tracking that the OHP has received facility and provider level Colonoscopy QMP reports from the Partnership (Cancer Care Ontario) by:

- Reviewing and documenting Partnership reports with all appropriate staff.
- Identifying and documenting issues and opportunities for quality improvement (QI).
- Facilitating and documenting a QI plan to address opportunities for improvement with all OHP staff related to the QMP Reports.
    - Documenting the implementation of the QI plan with all appropriate facility staff.

Note:

8.1.2 In small facilities i.e. where there are two or three colonoscopists practicing at the facility, the Regional Lead will receive and review provider and facility level QMP reports with the providers at the facility in order to maintain privacy and confidentiality of individual provider level data.

8.1.3 The Facility Lead (if they are not the same person) is accountable to the Medical Director and must participate in and document regular communication with the Medical Director regarding quality management and improvement activities and findings.

8 Quality Assurance (QA)

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

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

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Section 8 Quality Assurance (QA), Page 35

Guidance to the Standard

In addition to these Standards the Facility Lead role must be responsible for the following additional responsibilities:

- The Facility Lead must act on and report to the Medical Director (if not the same person) and Regional Lead any persistent and / or serious deviations where provider level quality indicators and facility level quality standards reflected in QMP reports are not being met.

- The Facility Lead must communicate with the Medical Director (if not the same person), to identify and document patient safety concerns and any persistent and / or serious deviations in the provider level indicators and facility level quality standards, in accordance with processes required by the Partnership.

- The Medical Director is responsible for reporting patient and/or facility safety concerns to the CPSO in a timely way and documenting all decisions made in accordance with the standards. They will report after consultation with the Facility Lead (if not the same person) and the Regional Lead.

8 Quality Assurance (QA)

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

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5) Documentation of the numbers of procedures performed: any significant increase/decrease (>50% of the last reported assessment).

Section II: Additional Quality Standards

Equipment

1. All equipment used for a colonoscopy and/or GI endoscopy procedure (e.g. cleaners and reprocessors) must be:
    a. Tracked and maintained with a log to ensure full equipment functionality and safety.
    b. Subject to compliance testing and certification where required by the Canadian Standards Association (CSA) or licensed for use in Canada.
    c. Subject to a regular quality control program. In addition, the specific piece of equipment used for a particular procedure is documented and readily accessible in the form of a log book.
    d. Replaced where necessary to maintain an up-to-date and high standard of service.

2. All Clinics must:
    a. Have standard equipment to remove polyps and manage complications; including but not limited to: thermal devices, vasoconstricting agents, clipping devices and tattooing equipment.
    b. Use automatic endoscopic reprocessors (AERs) for all procedures.
    c. Have enough AER capacity to ensure that the necessary endoscopes are cleaned and ready for use before the next scheduled patient.
    d. Have an automatic irrigator available for every patient.
    e. Have technology to capture, store and review clinically relevant landmarks or pathology during endoscopy procedures.

3. All colonoscopy procedures must be performed using a video colonoscope that must be maintained within manufacturer specifications.

Policies and Procedures

1. Clinics must have a documented process for the storage and retrieval of endoscopic images that identifies how each image is linked with a patient.

2. Clinics must have a policy for:
    - Following up on pathology as outlined in the CPSO test results policy: http://www.cpso.on.ca/policies-publications/policy/test-results-management.
    - Documented identification of a care path to follow up on findings where subsequent therapy or surgery is required.

3. Clinics must manage the continuum of care for their patients and have processes or procedures in place to promote quality patient care, including:
    - Referral criteria that are readily available to referring physicians and the public to ensure that the appropriate patients have their procedures in the appropriate setting.
    - An internal process to review referrals to ensure the appropriateness of the:
        a. Indication/reason for the endoscopy.
        b. Timing of the endoscopy.
        c. Procedure to be completed in an out-of-hospital facility).
    - A policy that guides the criteria and conditions 'direct to procedure' (i.e. open access) referrals to the clinic, as opposed to consultation prior to the procedure. A policy in place to ensure that post endoscopy, any findings and recommendations are communicated to the referring and other physicians.
    - Recommendations regarding the timing for the next colonoscopy.

Quality Improvement

1. Clinics must prescribe and document individual quality improvement processes to address any identified quality issues (i.e. from quality assurance and other).

Discipline Committee
Report of Completed Cases - November 2017

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between August 17, 2017 and November 10, 2017. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse - 3 cases

1. Dr. W.H. BAIRD

Name:	Dr. Wycliffe Hobart Baird
Practice:	Independent Practice
Practice Location:	Mississauga
Hearing:	Uncontested Facts and Contested Penalty
Finding Decision Date:	October 16, 2017
Penalty/Written Decision Date:	November 1, 2017

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Baird is a general practitioner who received his certificate of registration authorizing independent practice in Ontario in 1972. At.the relevant time, Dr. Baird practised Emergency Medicine at Trillium Health Partners ("the Hospital"), in Mississauga, Ontario.

Patient A: Dr. Baird's Comments of a Sexual Nature

In May 2011, Patient A attended the Hospital's emergency department in respect of a knee injury, sustained after falling off of her motorcycle. Mr. X, who was with Patient A at the time of her injury, attended at the Hospital with her. Patient A was provided with a hospital gown and removed her pants, so that her injury could be assessed by Dr. Baird.

When Patient A asked Dr. Baird when she would be able to stand on the leg, Dr. Baird responded that she could stand on the leg at whatever point she was able to handle the pain. Patient A then asked Dr. Baird when she would be able to ride her motorcycle. Dr. Baird looked at Mr. X and stated words to the effect of: "he looks like a motorcycle, you could ride him."

Patient A was shocked and offended by this comment, which she perceived as sexual harassment. She promptly complained to the Hospital.

When Dr. Baird was advised of the complaint, he expressed regret for his actions and remorse that the patient had been emotionally injured by the encounter. Dr. Baird agreed to write a letter of apology to the patient, including an assurance to the patient that as a result of this interaction being brought forward, he would change his behaviour.

The letter of apology was not sent to Patient A. Instead, the Hospital attempted to arrange a meeting between Patient A and Dr. Baird. However, Patient A rejected the invitation to meet with Dr. Baird.

Nurse A: Dr. Baird's Inappropriate Comments

During an evening shift on April 29, 2012, Dr. Baird was the attending Emergency Room doctor. Nurse A was standing at the nursing station together with her co-workers when Dr. Baird was speaking to a patient and providing indirect instructions to the nursing staff.

When the patient had left, Dr. Baird asked the nursing staff whether the instructions were understood. Nurse A jokingly stated that she did not understand. Dr. Baird turned around in his chair to face Nurse A, patted his knees and said: "Nurse A come and sit on my lap so that I can spank you." This comment was made in front of the nursing staff and two patients. Nurse A and her nursing colleagues then left the area.

Nurse A was upset and offended as a result of Dr. Baird's comments. At the end of the shift, Nurse A informed Dr. Baird that she felt uncomfortable, embarrassed and insulted by his comments. Dr. Baird apologized and stated that it should be taken as a joke. Nurse A filed a formal complaint against Dr. Baird.

As a result of the complaint, Dr. Baird agreed to provide a formal letter of apology and to seek professional coaching with respect to eliminating inappropriate comments in the workplace, demonstrating professional conduct and developing a sense of empathy in order to understand how his comments can impact others. Dr. Baird successfully completed the professional coaching.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Baird's certificate of registration for a period of two months, to commence thirty (30) days from the date of this Order.
- The Registrar impose the following term, condition and limitation on Dr. Baird's certificate of registration:
    - Dr. Baird successfully complete individualized (one-on-one) instruction in medical ethics, with an instructor approved by the College, at his own expense and provide proof of completion to the College prior to his resumption of practice.
- Dr. Baird reimburse the College for funding provided to Patient A under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty days of the date of this Order, in the amount of $16,060.00.
- Dr. Baird appear before the panel to be reprimanded within sixty (60) days of this Order.
- Dr. Baird pay costs to the College in the amount of $5,500.00 within thirty (30) days of this Order.

2. Dr. W.A.D. BEAIRSTO

Name:	Dr. William Arthur Damian Beairsto
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Contested
Finding/Written Decision Date	August 5, 2016
Penalty/Written Decision Date:	October 5, 2017

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Beairsto provided psychotherapy to patients in a converted office in his house in Toronto. Between 1997 and 2012, he provided treatment to Patient A in respect of a marital breakdown. The Committee found that he engaged in the following misconduct with regard to Patient A during their doctor-patient relationship:

<u>Dr. Beairsto Inappropriately Massaged Patient A's Back</u>

Patient A told Dr. Beairsto about her ongoing back pain. Dr. Beairsto suggested that a massage might help alleviate her pain, and he then offered to massage her back. She thought this was weird but she agreed.

Patient A put on a hospital gown but left her bra and underwear on. She lay face down on the examining table. Dr. Beairsto spent 20 minutes rubbing her neck, her back, her sides – including the incidental touching of the outside of both breasts – and her lower legs.

The Committee found that the nature and extent of Dr. Beairsto's touching of Patient A could not be confused with a back examination. The massage was for the purpose of relaxation and was not sexual in nature.

The Committee found that the back massage was inappropriate in the context of Dr. Beairsto's doctor-patient relationship with Patient A. The massage Dr. Beairsto gave to Patient A was a boundary violation that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

<u>Dr. Beairsto Stroked Patient A's Buttocks After A Psychotherapy Session</u>

Dr. Beairsto stroked Patient A's buttocks as she was getting ready to leave the office at the end of a psychotherapy session. Dr. Beairsto had quickly come around his desk and positioned himself so that he had one hand on her buttocks and one hand in front of her, restricting her movement somewhat. Patient A testified that this made her feel "like a deer in headlights." She therefore made efforts to leave the office quickly.

Dr. Beairsto put one of his hands on her buttocks with no clinical reason to do so. This incident occurred sometime in the middle of their doctor-patient relationship. She continued to see Dr. Beairsto despite her embarrassment at the time.

The Committee found that Dr. Beairsto touched and stroked Patient A's buttocks as she described, and that this was not a matter of incidental contact as Dr. Beairsto brushed by her. The Committee found that Dr. Beairsto's stroking of Patient A's buttocks at the end of a psychotherapy session with no clinical reason to do so was touching of a sexual nature, constituting sexual abuse within the meaning of the Code.

Dr. Beairsto Examined Patient A's Chest in an Inappropriate Manner

In 2011, Patient A had agreed to Dr. Beairsto examining her chest because of her bronchitis. Dr. Beairsto rolled up the front of her shirt above her bra near her collarbone, and Dr. Beairsto smiled and made a "woo" sound that sounded to her like a sound of "approval" while looking at her chest and breasts.

The Committee found that Dr. Beairsto made the aforementioned sounds while conducting a chest examination of Patient A, and that this would be regarded by members as inappropriate and unprofessional.

Dr. Beairsto Made Inappropriate Remarks to Patient A

Patient A testified that Dr. Beairsto would compliment her on her hair and/or outfit at every visit.

Patient A testified that Dr. Beairsto told her "a few times" that she "would be a good lover." The Committee finds that, by making this remark to Patient A, Dr. Beairsto engaged in conduct that, in the circumstances, would reasonably be regarded by members as unprofessional.

Dr. Beairsto Hugged and Kissed Patient A

Dr. Beairsto routinely ended his psychotherapy sessions with hugs and kisses. The Committee did not accept that the routine practice of hugging and kissing every patient in the course of every visit is appropriate.

Although the touching was not of a sexual nature, Dr. Beairsto's conduct would reasonably be regarded by members as crossing doctor-patient boundaries with a vulnerable therapeutic patient, and was disgraceful, dishonourable, or unprofessional.

Dr. Beairsto Touched His Crotch Inappropriately and Subsequently Sniffed His Fingers

Patient A testified that Dr. Beairsto touched himself near his genitals and then smelled his hand during an appointment. Patient A said that this incident left her feeling embarrassed.

Dr. Beairsto testified that he may have moved his hand from somewhere below the desk towards his nose as part a demonstration to explain that smelling one's vaginal discharge could be helpful in determining if a vaginal infection had resolved.

The Committee found that what Dr. Beairsto said and did was unprofessional. It is so outside the norm of what is a professional way to communicate medical information that, even if not a salacious gesture as alleged, it is completely inappropriate, and the Committee finds Dr. Beairsto's conduct to be disgraceful, dishonourable, or unprofessional.

Disposition

On November 4, 2016, the Discipline Committee granted an adjournment of the penalty hearing dates of November 8 and 11, 2016 on terms including that the Registrar suspend Dr. Beairsto's certificate of registration effective November 11, 2016, until such time as the matters currently referred to the Discipline Committee in the Notice of Hearing dated November 10th, 2014, were disposed of by a panel of the Discipline Committee.

On March 6, 7 and 31, 2017, the Committee heard evidence and submissions on penalty and costs, and received supplementary written submissions on penalty on April 7, 2017. Subsequent to the Committee's deliberations on the oral and written submissions but prior to the release of the Committee's decision on penalty, College counsel requested permission to provide submissions to the Committee on amendments to section 51 of the *Regulated Health Professions Act, 1991* that came into force on May 30, 2017. The Committee accepted this request and subsequently received further written submissions from counsel for the College and for Dr. Beairsto and written advice from Independent Legal Counsel with respect to the issues raised by counsel. The Committee met again on September 25, 2017 and considered these additional submissions and written comments on ILC advice.

The Discipline Committee ordered and directed that:

- The Registrar to revoke Dr. Beairsto's certificate of registration, effective immediately.
- Dr. Beairsto to appear before the Committee to be reprimanded, within three months of the date this Order becomes final.
- Dr. Beairsto to reimburse the College for funding for the patient under the program required under s.85.7, in the amount of $16,060.00, and to post a letter of credit acceptable to the College to guarantee the payment of any

amount he may be required to reimburse, within 30 days of the date this Order becomes final.
- Dr. Beairsto to pay to the College costs in the amount of $24,420.00, within 30 days of the date of this Order.

3. Dr. M.M.S. LEE

Name:	Dr. Martin M.S. Lee
Practice:	Rheumatology
Practice Location:	Mississauga
Hearing:	Contested
Finding/Written Decision Date	January 18, 2017
Penalty/Written Decision Date:	November 2, 2017

Allegations and Findings

- Sexual abuse of a patient – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Lee is a rheumatologist now practising in Mississauga. During the relevant time period, Dr. Lee practised in both Pickering and Mississauga. Dr. Lee saw these patients for the treatment of pain and fibromyalgia between January 2008 and June 2012.

Regarding Patient A, Dr. Lee engaged in sexual abuse by asking her inappropriate and personal questions about her sex life and by showing and discussing a pornographic magazine with her. These were remarks and gestures of a sexual nature. He engaged in conduct relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful dishonorable and unprofessional by (i) making remarks and gestures of a sexual nature as described above; (ii) asking her to pay cash for prescriptions; (iii) asking her to fill a prescription for Flamazine for him; and (iv) asking her to video or photograph other patients.

Regarding Patient C, Dr. Lee engaged in sexual abuse in that on one occasion, he inappropriately rubbed his groin against her right hip area while administering a trigger point injection. This was contact of a sexual nature. Dr. Lee also sexually abused Patient C by using sexually explicit and crude language when asking her personal questions about her sex life. These were remarks of a sexual nature.

Further, Dr. Lee's line of questioning with respect to Patient C's personal sex life, and his choice of words when asking these questions would reasonably be regarded by members of the profession as disgraceful, dishonorable or unprofessional.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Lee's certificate of registration effective immediately.
- Dr. Lee reimburse the College for funding provided to Patients A and C under the program required under section 85.7 of the Code, and shall post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts within thirty (30) days of the date this Order becomes final, in the amount of $32,120.00.
- Dr. Lee appear before the Committee to be reprimanded within thirty (30) days of the date this Order becomes final.
- Dr. Lee pay to the College costs in the amount of $20,500.00 within thirty (30) days of the date of this Order becomes final.

Failed to maintain the standard of practice - 2 cases

1. Dr. R.J. KAMERMANS

Name:	Dr. Rob Joseph Kamermans
Practice:	Family Medicine
Practice Location:	Coe Hill, Ontario
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date	July 25, 2017
Penalty/Written Decision Date:	September 25, 2017

Allegations and Findings

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Finding of professional misconduct in another jurisdiction – **proved**
- Incompetence - **withdrawn**

Summary

Dr. Kamermans is a family physician who had a practice in Coe Hill, Ontario.

Failing to Maintain the Standard of Practice

In October, 2013, the College received a letter of complaint expressing concern about Dr. Kamermans' prescribing of narcotics and controlled substances. The College retained a medical expert, who reviewed the standard of care provided by Dr. Kamermans. Upon review of twenty-five of Dr. Kamerman's patient charts, the medical expert reported that eleven out of twenty-five patient charts were deficient with respect to narcotic prescribing and the medical records in all the files were disorganized. Dr. Kamermans admitted to not reviewing his patients' old files, which resulted in him overlooking some crucial pieces of information.

The medical expert noted that the control over who and what was prescribed often seemed to be in the hands of the patients, and not Dr. Kamermans'. Also, that by failing to maintain tight prescribing boundaries in patients with current or prior addictions, both the patients and their communities were placed at risk.

Noting that during their interview Dr. Kamermans commented, "we are not the police", the medical expert emphasized in her report that the application of universal precautions in opiate prescribing is crucial, given that it is not possible to always know what patients may be doing with their medications and that despite Dr. Kamerman's

best intentions, safety was compromised by his benzodiazepine, hypnotic, and opioid prescribing practices.

In an addendum to her report dated March 9, 2015, the medical expert reiterated her concerns with respect to Dr. Kamerman's prescribing of controlled substances and confirmed her opinion that his medical records were "inadequate".

Failing to Notify Other Jurisdictions of Action Taken by Discipline Committee

On February 27, 2013, the Discipline Committee found that Dr. Kamermans committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession. Among other things, the Committee ordered and directed that Dr. Kamermans be reprimanded and imposed terms, conditions and limitations on Dr. Kamermans' certificate of registration.

In March 2014, the Disciplinary Subcommittee of the Michigan Medical Board (the "Michigan Medical Board") found that Dr. Kamermans violated the Public Health Code by failing to notify it, within 30 days, of the action taken by the Discipline Committee on February 27, 2013. As a result, the Michigan Medical Board imposed terms, conditions and limitations on Dr. Kamermans' licence in Michigan, and ordered that he pay a fine.

In January, 2015, the New Mexico Medical Board made an order reprimanding Dr. Kamermans for failing to make a timely report of the action taken by the Discipline Committee of this College on February 27, 2013 and failure to report the action taken by the Michigan Medical Board in April 2014, and imposed conditions on his licence in New Mexico.

Penalty

The following facts were presented during the penalty portion of the hearing:

Preceptorship and Reassessment arising out of 2013 Discipline Committee Order

As part of the Discipline Committee's Order dated February 27, 2013, Dr. Kamermans was required to undergo a one-year preceptorship, followed by a Comprehensive Practice Assessment by an assessor or assessors appointed by the College. Dr. Kamermans completed the practice preceptorship between April, 2013 and February, 2014 and then underwent the Comprehensive Practice Assessment. In her report dated March 31, 2015 the College assessor who conducted the Comprehensive Practice Assessment identified a number of concerns with respect to Dr. Kamermans' family medicine practice and made the following recommendations:

- Continue chart review to address issues
- CME regarding management of patients with chronic diseases
- CME regarding current Canadian Screening Guidelines
- CME regarding Immunizations

- CME regarding guidelines for care of infants and children
- CME regarding Osteoporosis
- CME regarding Menopause
- Equipping office to deal with medical emergencies
- Adopting procedure recommended by CMPA for firing patients in practice.

Discipline Committee Decision Resulting in Revocation

On November 7, 2014, the Discipline Committee found that Dr. Kamermans committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession. The Committee also found that Dr. Kamermans is incompetent. Dr. Kamermans failed to maintain the standard of practice of the profession in his care and treatment in the Emergency Department of six patients and in his medical documentation regarding nine patients. Dr. Kamermans' deficiencies in his care and treatment of the six patients displayed a lack of knowledge and judgment of a nature and to an extent that the allegation of incompetence was proved. The Committee ordered and directed that:

- The Registrar revoke Dr. Kamermans' certificate of registration;
- Dr. Kamermans appear before the Committee to be reprimanded; and
- Dr. Kamermans pay costs to the College in the amount of $28,098.00.

On August 24, 2016, Dr. Kamermans appealed the Discipline Committee's decision to the Divisional Court of the Ontario Superior Court of Justice.

Inquiries, Complaints and Reports Committee Caution – 2013

In September, 2013, the Inquiries, Complaints and Reports Committee cautioned Dr. Kamermans about offering appropriate analgesics and arranging proper follow-up treatment

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Kamermans' certificate of registration, effective immediately.
- Dr. Kamermans appear before the panel to be reprimanded.
- Dr. Kamermans pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order becomes final.

2. Dr. D.C. SWEET

Name:	Dr. Daniel Charles Sweet
Practice:	Family Medicine
Practice Location:	Ottawa
Hearing:	Agreed Facts and Joint Submission on Penalty
Decision Date:	July 14, 2017
Written Decision Date:	September 11, 2017

Allegations and Findings

- Failure to maintain standards of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Incompetence - **withdrawn**

Summary

Dr. Sweet is a family physician who was practising in Ottawa. He received his certificate of registration authorizing independent practice in Ontario in June 1982 and was certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Anesthesiology on June 7, 1989. Dr. Sweet transitioned from Anesthesiology to family medicine in 1994.

On August 6, 2002, the Discipline Committee ordered the Registrar to impose terms, limitations and conditions on Dr. Sweet's certificate of registration, including restricting him from prescribing any controlled substances as defined by the *Controlled Drugs and Substances Act, 1996*. On October 5, 2006, Dr. Sweet entered into an Undertaking with the College, and agreed to cease to practise addiction medicine, chronic pain medicine and psychotherapy.

DISGRACEFUL, DISHONOURABLE AND UNPROFESSIONAL CONDUCT

<u>Breach of 2002 Discipline Committee Order</u>

Dr. Sweet breached the 2002 Order of the Discipline Committee by prescribing controlled substances on three occasions:

- On October 17, 2014, Dr. Sweet prescribed Androgel to Patient B;
- On January 3, 2015, Dr. Sweet renewed a prescription of Clonazepam to Patient C;
- On December 14, 2016, Dr. Sweet prescribed a hormone replacement therapy containing Testosterone to Patient E.

Prescribing Botox to Patient E

Dr. Sweet was Patient E's family physician. In 2013, the College commenced an investigation into whether Patient E, who is not a regulated health professional, was performing rhinoplasties and injecting Botox at a clinic in her home.

In 2014, in the course of its investigation of Patient E, the College interviewed Dr. Sweet. Dr. Sweet indicated that Patient E was his patient since approximately 2010. He noted that about one or two years prior, Patient E informed him that she was performing face lifts and injections and tried to "lure" him into her cosmetic work by asking him to order local anaesthetics for her. Dr. Sweet indicated that he advised Patient E that these are obtained through a prescription and declined to order them. He stated that he had never purchased Botox or injected Botox in his entire career.

Following a temporary injunction order, dated March 6, 2014 and final injunction order, dated May 22, 2014 obtained by the College from the Superior Court of Justice, Patient E was ordered to permanently refrain from performing all controlled acts and other acts relating to the practice of medicine, including administering a substance by injection.

In 2016, the College conducted an investigation into whether Patient E was in breach of these Orders. A College investigator learned that Dr. Sweet had prescribed Botox to Patient E.

On November 10, 2016, Dr. Sweet indicated to the College investigator that since his last interview with the College in relation to Patient E and her esthetic business, he had taken a Botox training course to treat migraine headaches. He stated that he prescribed Botox to Patient E on two occasions:

- On April 25, 2016, Dr. Sweet prescribed Botox to Patient E on the assumption that she needed it for an injection to be performed by another physician for treatment of her chronic pain. He did not confirm with the other physician the reason for the prescription and never followed up with Patient E regarding the injection by the other physician.
- On September 28, 2016, Dr. Sweet prescribed Botox to Patient E again and she was to return for the injection on October 1, 2016. However, she did not show up. Dr. Sweet was unsuccessful in following up with Patient E to determine why she did not attend for her appointment.

Dr. Sweet indicated that it did not occur to him that Patient E might be diverting the Botox given the small amount he prescribed.

Breach of October 5, 2006 Undertaking – Care and Treatment of Patient D

In February 2015, a community social worker at a homeless shelter informed the College that a shelter client (Patient F), who was a former addict, had received free samples of Ralivia (also known as Tramadol) from Dr. Sweet for pain management. The College commenced an investigation into whether Dr. Sweet had breached his October 5, 2006 Undertaking to cease practising addiction and chronic pain medicine. The College retained an expert who reviewed 25 patient charts and interviewed Dr. Sweet. Dr. Sweet retained an expert who reviewed the same charts.

The College expert, a specialist in family medicine, opined that Dr. Sweet engaged in the practice of chronic pain management and in the practice of addiction management in respect to one of the patients, Patient D, as follows:

- Between September 2012 and October 2014, fifteen of Patient D's appointments with Dr. Sweet involved some level of assessment or treatment of Patient D's chronic pain, and on at least two occasions tramadol prescriptions were provided outside of a clinic visit;
- Dr. Sweet failed to adequately attempt to transfer Patient D to another physician for the treatment of Patient D's pain symptoms;
- Dr. Sweet prescribed clonidine and tramadol to Patient D and utilized tramadol for the treatment of addiction.

Dr. Sweet's expert, also a specialist in family medicine, did not provide an opinion whether Dr. Sweet engaged in the practice of chronic pain management and in the practice of addiction management in respect of Patient D.

FAILURE TO MAINTAIN THE STANDARD OF PRACTICE OF THE PROFESSION

Patient Charts reviewed by College Expert and Dr. Sweet's Expert

The College expert who reviewed the patient charts in respect of Patient D and others concluded that Dr. Sweet failed to maintain the standard of practice of the profession in respect of fifteen of the twenty-five patients whose charts were reviewed.

Dr. Sweet's expert concluded that Dr. Sweet failed to maintain the standard of practice of the profession in his care and treatment of Patient F, the person about whom the community social worker had contacted the College on February 25, 2015.

Reassessment pursuant to August 16, 2013 Undertaking

As a result of a prior College process, Dr. Sweet entered into an Undertaking dated August 16, 2013, pursuant to which he was to undergo a period of clinical supervision for 6 months, followed by a reassessment of his practice. The College assessor, a different family physician

from the College expert who reviewed the patient charts in respect of Patient D and others, reviewed additional twenty-five patient charts and concluded that Dr. Sweet failed to maintain the standard of practice of the profession in respect to fifteen patients, in that:

- Dr. Sweet failed to document a patient encounter with Patient G at which an injection was administered and at which he prescribed a medication;
- Dr. Sweet did not provide adequate preventative care and failed to adequately work up or manage the Patient H's diagnosis of reflex sympathetic dystrophy;
- Dr. Sweet failed to document that he discussed the risks and side effects of prescribing Imovane, a sedative, as a sleep aid to Patient I who was a 90-year-old patient with poor mobility requiring the use of a cane and had a history of pelvic fracture due to fall;
- Dr. Sweet's charting and documentation in relation to Patient J had inconsistencies, including two different chart notes for the same clinical encounter;
- Dr. Sweet's charting and documentation in relation to Patient K was inconsistent and that he prescribed Myrbetriq for enuresis to this 9-year-old patient at a time when Myrbetriq was not approved for use in children;
- Dr. Sweet's pediatric patient's immunizations for Patient L were incomplete or incompletely documented;
- Dr. Sweet failed to investigate and rule out a possible G.I. source for Patient M's anemia, in circumstances where the patient may have had a hysterectomy.

Dr. Sweet's expert reviewed the same patient charts and agreed with the College assessor that Dr. Sweet failed to maintain the standard of practice of the profession with respect to three patients (Patients I, K, and M). Dr. Sweet's assessor further opined that Dr. Sweet may have failed to maintain the standard of practice of the profession in that:

- Dr. Sweet prescribed to Patient N a year-long course of Wellbutrin, an anti-depressant ten days after she had been assessed in the Emergency Room for depression and without a clinical encounter at the time of the prescription;
- Dr. Sweet's pediatric patient's (Patient O) immunizations were incomplete or incompletely documented.

Disposition

On July 12, 2017, Dr. Sweet signed an undertaking and agreed to resign from the College effective July 12, 2017 and not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction after July 12, 2017.

In light of the undertaking to resign and to not re-apply, the Discipline Committee ordered and directed that:

- Dr. Sweet attend before the panel to be reprimanded.
- Dr. Sweet pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order becomes final.

Disgraceful, Dishonourable, or Unprofessional Conduct - 4 cases

1. Dr. N.N.R. GHABBOUR

Name:	Dr. Nagi Nazmi Riad Ghabbour
Practice:	Psychiatry
Practice Location:	Toronto
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	February 21, 2017
Penalty Decision Date:	August 22, 2017
Written Decision Date:	August 22, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Sexual abuse – **withdrawn**

Summary

The College investigation began after Patient A's mother complained to the College on May 25, 2015, alleging that Dr. Ghabbour was involved in a romantic relationship with Patient A.

Beginning in the summer of Year 1, Dr. Ghabbour was the treating psychiatrist for Patient A. Patient A was married with children. In the course of providing treatment to Patient A, Dr. Ghabbour wrote letters and filled out reports on her behalf to her employer and provided prescriptions to Patient A to help her deal with anxiety and depression. Dr. Ghabbour had one joint session with Patient A and her husband.

Over the course of her therapy appointments with Dr. Ghabbour, Patient A developed romantic feelings for him. In a final appointment in the late spring of Year 2, as recorded in the patient chart, Patient A confirmed that she wished to terminate the doctor-patient relationship. According to Patient A and Dr. Ghabbour, following the termination of the doctor-patient relationship, they began to date a couple of weeks later. Their relationship became sexually intimate approximately another two weeks later, according to Patient A, and approximately one month later, according to Dr. Ghabbour. They have lived together since early Year 3, and they plan to marry.

Dr. Ghabbour admitted and the Committee found that he engaged in an act or omission relevant to the practise of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Disposition

The Discipline Committee ordered and directed that:
- the Registrar revoke Dr. Ghabbour's certificate of registration, effective immediately.
- Dr. Ghabbour appear before the panel to be reprimanded within three (3) months of this Order becoming final.
- Dr. Ghabbour pay costs to the College in the amount of $11,000.00 within thirty (30) days of the date of this Order becoming final.

2. Dr. M.M. GUTMAN

Name:	Dr. Mory Mayer Gutman
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts, Contested Penalty
Finding Decision Date	August 24, 2017
Penalty/Written Decision Date:	November 10, 2017

Allegations and Findings

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

Summary

Dr. Gutman is a physician practising family medicine in Toronto.

Previous Discipline History with the College

In 2011, Dr. Gutman was found to have engaged in professional misconduct, in that he failed to maintain the standard of practice and engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Further to the Order of the Discipline Committee, Dr. Gutman was, among other things, prohibited from prescribing Narcotic Drugs/Preparations, Controlled Drugs, Benzodiazepines and other Targeted Substances and he was prohibited from engaging in professional encounters with any female patients.

Prescribing Contrary to the Discipline Committee's restrictions

In January of 2013 the College received information from a pharmacist, that Dr. Gutman had prescribed Testosterone gel, which is a controlled substance, to a male patient in 2012 and 2013, contrary to the terms of his prescribing restriction by the Order of the Discipline Committee. In May of 2014, the Inquiries, Complaints and Report Committee (ICRC) advised Dr.

Gutman to be vigilant to ensure that he does not breach the terms of his certificate of registration. In 2016 information from the Narcotics Monitoring System (NMS) for the time period of April 1, 2013 to August 13, 2015, was received by the College, raising concerns that Dr. Gutman had prescribed contrary to the terms of the Discipline Committee Order.

The College commenced an investigation.

Prescribing Controlled Substances:

Testosterone: Dr. Gutman prescribed ten repeats of Testosterone gel to Patient 1 in October 2012. He was unaware that Testosterone was a controlled substance and therefore a medication he was prohibited from prescribing.

Sublinox: Dr. Gutman prescribed Sublinox to Patient A on two occasions in October 2014; to Patient B on three occasions in September 2014; to Patient C on two occasions (with 8 refills on a second occasion) in October 2014; to Patient D on two occasions in February 2014 and in April 2016; to Patient E on two occasions in October 2014 and April 2016. Dr. Gutman was unaware that Sublinox was a controlled substance and therefore a medication that he was prohibited from prescribing. The prescribing occurred prior to a pharmacist bringing to his attention that this substance was designated as a controlled drug.

Phenobarbital: Dr. Gutman authorized eight refills of phenobarbital to Patient F, an elderly patient who suffers from intellectual impairment and seizures, in March 2014. Dr. Gutman was aware that Phenobarbital is a controlled substance at the time he prescribed it. The prescribing occurred in error when Dr. Gutman was renewing batch prescriptions of medication prescribed by Patient F's previous physician.

Clobazam: Dr. Gutman prescribed Clobazam to Patient G, a young man with recurrent seizures, on one occasion in February 2016. Dr. Gutman was asked to authorize a refill Patient G's anti-convulsant medications. Dr. Gutman authorized a refill of Levetiracetam (an anti-convulsant, but not a controlled drug) and also authorized Clobazam (also used as an anti-convulsant, but which is a benzodiazepine which Dr. Gutman is prohibited from prescribing). Dr. Gutman was not aware that Clobazam is a benzodiazepine at the time he prescribed it. The prescribing occurred in error when Dr. Gutman was renewing batch prescriptions for medication prescribed by Patient G's previous physician.

Assessing a Female Patient contrary to the Discipline Committee's Restriction

The College received information in November of 2016, that Dr. Gutman may have conducted an assessment of a female patient, contrary to the terms of the Discipline Committee restrictions. The College commenced an investigation.

Dr. Gutman was contacted by a member of Patient H's family, with a request that Dr. Gutman find a physician to assess a female patient, who was in her mid-90s at the time. At issue was the

patient's capacity to vary her will and execute a new Power of Attorney. Dr. Gutman had conducted a prior assessment of this patient ten years earlier, prior to his restriction from seeing female patients.

On October 14, 2016, Dr. Gutman conducted a capacity assessment of this female patient. He did not retain a record of the encounter and did not bill OHIP.

Dr. Gutman understood that there was a degree of urgency to the request made to him as the family was having difficulty finding a physician to conduct the assessment. He believed that the Order of the Discipline Committee and the terms of his certificate of registration did not encompass the assessment of this female patient, given that the patient was in her mid-90s.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Gutman's Certificate of Registration for a period of seven (7) months, effective 30 days from the date of this Order.
- The Registrar impose the following terms, conditions, and limitations on Dr. Gutman's Certificate of Registration:
    - Dr. Gutman will successfully complete one-on-one instruction in medical ethics with an instructor approved by the College, at his own expense, and shall provide proof of completion to the College prior to his resumption of practice;
    - Dr. Gutman will successfully complete instruction in understanding boundaries through a course approved by the College, at his own expense, and shall provide proof of completion to the College prior to his resumption of practice;
- Dr. Gutman appear before the Committee to be reprimanded within 90 days of the date of this Order.
- Dr. Gutman pay to the College costs in the amount of $5,500.00 within thirty (30) days of the date of this Order.

3. Dr. A. E. KOFFMAN

Name:	Dr. Allyson Enid Koffman
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	August 15, 2017
Written Decision Date:	September 13, 2017

Allegations and Findings

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

Summary

Dr. Koffman is a family physician who received her certificate of registration authorizing independent practice in June of 2000 and has been providing episodic walk-in care and primary care at the Earl Bales Walk-in Clinic since 2011. Between January 2004 and December 2010, Dr. Koffman provided episodic walk-in care and primary care at the Bathurst Walk-in Clinic and Family practice.

Unwanted Rostering

The College received complaints from three patients about being rostered to Dr. Koffman's practice without their knowledge and consent after they attended with Dr. Koffman at the Walk-In Clinics and she requested them to complete "Patient Enrolment and Consent to Release Personal Health Information" form:

- Patient A complained that when she first attended the Bathurst Walk-In Clinic, she indicated on the Clinic registration form the name of her family physician. When several months later Patient A visited the Clinic and was seen by Dr. Koffman, she was told by Dr. Koffman that in order to make a referral to a specialist, she had to complete "Patient Enrolment and Consent to Release Personal Health Information" form. Patient A was not informed that by completing the form she would change her family physician to Dr. Koffman. She had no intention to de-roster from her family physician's practice when she completed the form.
- Patient B complained about being surprised and upset to find out that his care had been switched from his family doctor to Dr. Koffman after he completed the "Patient Enrolment and Consent to Release Personal Health Information" form when being treated by Dr. Koffman at the Earl Bales Walk-In Clinic. Patient B indicated in the clinic registration form that he had a "previous" family physician.
- Patient C received episodic care from physicians other than Dr. Koffman. When she attended the Bathurst Walk-In Clinic and was treated by Dr. Koffman, Dr. Koffman requested her to sign a Patient Enrollment Form. Patient C did not understand that in doing so she would be rostered to Dr. Koffman's practice and found out that she was listed as Dr. Koffman's patient several years later, when she contacted the Ministry of Health and Long Term Care. She indicated that it was stressful experience for her to have been rostered without her knowledge and the subsequent need to undo the rostering.

The College commenced an investigation of Dr. Koffman's office practices, which revealed that Dr. Koffman engaged in inappropriate rostering with respect to an additional eleven (11) patients at the Bathurst Walk-In Clinic:

- Patient E signed the Patient Enrollment form when she attended the Clinic with her daughter Patient F who was an infant and was ill. Patient E was relatively new to Canada

at the time she signed the form, and already had a family physician. Patient E does not recall whether the form was explained to her, stating that at that time she did not understand the health care system and that she was willing to sign any form that would help her daughter to get medical attention. When interviewed by the College, Patient E expressed confusion about why she would be asked to sign a Patient Enrollment Form when she already had a family physician.

- Patient F signed a Patient Enrollment Form at the Clinic for herself and her daughter, Patient G, while the remainder of the data in the form was completed by someone other than herself. At the time she signed the form, Patient E had a family physician and her daughter had a pediatrician. Patient F took her children to the Clinic when the children needed to be seen quickly or when it was off-hours for her children's pediatrician. She indicated that had she known the purpose of the Patient Enrollment Form, she would not have signed it.
- Patient H does not recall any details related to completing the consent form for herself and her son, Patient I, at the Clinic. The only item on the consent form in her handwriting is her signature. At the time the form was signed, Patient H had a family physician and her son, Patient I, had a pediatrician. Patient H had no intention of switching family physicians or rostering with Dr. Koffman. Patients H and I only attended the Clinic when their family physician was unavailable.
- Patient J does not recall any details related to completing the consent form for herself and her son, Patient K, at the Clinic. The only item on the consent form in her handwriting is her signature. Patients J and K attended the Clinic when it was more convenient to do so and saw Dr. Koffman only twice. Patient K recalls being asked at the Clinic if she had intended to switch to another family physician when she had signed the consent form, but she replied that she had not intended to roster with any physician other than her existing family physician at the time. She was then provided with paperwork to de-roster from Dr. Koffman's practice, which she completed.
- Patient L does not recall any details related to completing the consent form at the Clinic. The only item on the consent form in her handwriting is her signature. Patient L did not intend to switch doctors at the time the form was signed. She went to the Clinic on a few occasions, when her doctor wasn't available or she needed something urgently.
- Patient M does not recognize the handwriting in the Patient Enrollment Form containing her information and Dr. Koffman's signature. She does not recall completing the consent form at the Clinic. Patient M has had a family physician for over 20 years when the form was signed and had no intention of changing to another family physician. She attends the walk-in clinics only when it is convenient to do so and does not recall anybody at the Clinic ever asking her to switch family physicians.
- Patient N does not recall any details related to completing the consent form for herself and her son, Patient O, at the Clinic. The only item on the consent form in her handwriting is her signature. At the time the form was signed she has had a family physician for 4 years and her son, Patient O, had a pediatrician for 11 years. Patient N went to the Clinic only occasionally and had no intention of switching family physicians for her son or herself. Given that Patient O had special needs, patient N wanted continuity of care with her son's pediatrician.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Koffman's certificate of registration for a period of four (4) months commencing at 12:01 a.m. on September 1, 2017.
- the Registrar impose the following as a term, condition and limitation on Dr. Koffman's certificate of registration:
  i) At her own expense, Dr. Koffman shall participate in and successfully complete, within 4 months of the date of this Order, individualized instruction in medical ethics with an instructor approved by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Koffman.
  ii) At her own expense, Dr. Koffman shall participate in and successfully complete, within 4 months of the date of this Order, individualized instruction with respect to OHIP billing with an instructor approved by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Koffman.
- Dr. Koffman attend before the panel to be reprimanded.
- Dr. Koffman pay costs to the College in the amount of $5,500.00 within thirty (30) days of the date this Order becomes final.

4. Dr. D. R. MARSHALL

Name:	Dr. Daniel Robert Marshall
Practice:	Pediatrics
Practice Location:	Hamilton
Hearing:	Uncontested Facts and Joined Submission Penalty
Finding/Penalty Decision Date:	June 29, 2017
Written Decision Date:	August 22, 2017

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Sexual impropriety – **withdrawn**
- Sexual abuse – **withdrawn**
- Failure to maintain standards of practice of the profession – **withdrawn**

Summary

Dr. Daniel Robert Marshall ("Dr. Marshall") is a paediatrician who received his certificate of registration authorizing independent practice in 1983. At all material times, Dr. Marshall conducted a general paediatric clinical practice in Hamilton, Ontario, focusing primarily on

treating children with behavioural, attention and mood problems, particularly involving attention deficit disorder.

Criminal Charges and Sentencing

On September 17, 2012, Dr. Marshall was charged with 32 counts of touching for a sexual purpose and sexual assault and 1 count of breach of recognizance:

- 29 counts of touching for a sexual purpose and sexual assault based on allegations related to genital exams conducted by Dr. Marshall on 20 former patients (patients B to U), who were all young boys treated by him prior to, or during puberty.
- 3 counts involved 2 complainants who alleged that Dr. Marshall had touched them improperly on occasions outside of his office.
- 1 count of breach of recognizance based on Dr. Marshall's alleged contact with one of the complainants after the imposition of a bail condition that he was not to have any such contact.

After a trial on the charges in the Ontario Superior Court of Justice in Hamilton Ontario (the "2013 Criminal Trial"), Mr. Justice Reid found Dr. Marshall guilty of sexual assault in respect of one of the complainants who alleged that Dr. Marshall had touched him improperly on occasions outside of his office**.**

Dr. Marshall was acquitted on the balance of the charges, including with respect to his genital examinations of the 20 patients. Justice Reid found that the Crown had not proved that Dr. Marshall's touching of the genitals of the 20 patients (patients B to U) was of a sexual nature or for a sexual purpose and acquitted Dr. Marshall of the charges in respect of these patients.

On July 3, 2013, Dr. Marshall was sentenced to eight months imprisonment, less six days pre-trial custody.

On July 6, 2015, the Ontario Court of Appeal dismissed Dr. Marshall's appeal of his conviction. His application for leave to appeal to the Supreme Court of Canada was denied on January 28, 2016.

Revocation of Certificate of Registration

On March 28, 2016, the Discipline Committee found that Dr. Marshall engaged in conduct that was disgraceful, dishonourable or unprofessional and that he had been found guilty of an offence relevant to his suitability to practise and ordered revocation of Dr. Marshall's Certificate of Registration. Dr. Marshall's Certificate of Registration was revoked on September 16, 2016.

Disgraceful, dishonourable or unprofessional conduct - Patients B to U

On June 29, 2017, the Discipline Committee held a hearing in respect to the allegations of Dr. Marshall's 20 former patients (patients B to U) arising from the evidence of these patients in the 2013 Criminal Trial.

Patients B to U were all seen by Dr. Marshall for behavioural or mood disorders as adolescents or pre-adolescents between 1987 and 2010. Each of Patients B to U gave evidence at the 2013 Criminal Trial about genital examinations conducted by Dr. Marshall. In addition, three experts testified at the 2013 Criminal Trial regarding the genital examinations conducted by Dr. Marshall. At the 2013 Criminal Trial, evidence from both the Crown and Defence experts established that:

- In respect of some of the complainants, Dr. Marshall failed to provide a clear explanation in advance to either the patients and/or their parents as to the purpose of the genital examinations. The experts agreed that a clear and detailed explanation of the purpose and procedure of a genital examination is required prior to conducting such an examination.
- In respect of some of the complainants, Dr. Marshall conducted genital examinations of patients in their street clothes. The experts agreed that patients should be gowned for genital examinations, particularly those patients seen after 1999 when the Canadian Pediatric Society released its position statement on "Ethical approach to genital examination of children".
- Most of the complainants testified that Dr. Marshall did not wear gloves when conducting genital examinations. The experts agreed that, for genital examinations conducted prior to 1999, while it was not necessarily standard of practice to wear gloves, it would have been preferable for Dr. Marshall to wear gloves. For genital examinations conducted after 1999, it was the standard of practice to wear gloves.

Disposition

The Committee noted that on September 16, 2016, Dr. Marshall's certificate of registration was revoked by the Order of the Discipline Committee. In addition, the Committee reviewed the May 7, 2017 undertaking of Dr. Marshall to not apply or re-apply for registration as a physician to practise medicine in Ontario, or any other jurisdiction as of the date of the undertaking. Furthermore, on May 8, 2017, Dr. Marshall requested that his OHIP billing number be deactivated.

The Discipline Committee ordered and directed that:
- Dr. Marshall appear before the panel to be reprimanded.
- Dr. Marshall pay costs to the College for a one day hearing in the amount of $5,500.00 within 30 days of the date of this Order.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Council Meeting Minutes of September 8, 2017**

Date of Meeting: **November 30, 2017**

It is moved by _____,

and seconded by_____, that:

The Council accepts the minutes of the meeting of the Council held on September 8, 2017

- OR -

The Council accepts the minutes of the meeting of the Council held on September 8, 2017 with the following corrections:

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **Uninsured Services: Billing and Block Fees Policy**

Date of Meeting: **November 30, 2017**

It is moved by_____,

and seconded by_____, that:

The Council approves the revised policy "Uninsured Services: Billing and Block Fees", formerly titled "Block Fees and Uninsured Services", (a copy of which forms Appendix " " to the minutes of this meeting).

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **In Camera Motion**

Date of Meeting: **November 30, 2017**

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 clauses 7(2)(b), and (d) of the Health Professions Procedural Code.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **BY-LAW AMENDMENTS TO CHANGE NAME OF FINANCE COMMITTEE**

Date of Meeting: **November 30, 2017**

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. 118:

By-law No. 118

1. Subsections 2(1), 4(1)(d), 4(3)(b)(ii) and 6(7)(a) of the General By-Law are amended by deleting all references in those subsections to "finance committee" and substituting them with "finance and audit committee".

2. Section 41 of the General By-Law is amended by revoking "3 Finance Committee" and substituting it with "3 Finance and Audit Committee".

3. Section 43 of the General By-Law is amended:

   (a) by deleting all references in that section to "finance committee" and substituting them with "finance and audit committee"; and

   (b) by deleting the title "Finance Committee" and substituting it with the title "Finance and Audit Committee".

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **SAFE DISCLOSURE POLICY**

Date of Meeting: **November 30, 2017**

It is moved by_____,

and seconded by_____, that:

the Council approve the Safe Disclosure Policy (a copy of which forms Appendix " " to the minutes of this meeting) as presented.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **BUDGET APPROVAL**

Date of Meeting: **November 30, 2017**

It is moved by_____,

and seconded by_____, that:

the Council approve the "Budget for 2018" (a copy of which forms Appendix " " to the minutes of this meeting) authorizing expenditures for the benefit of the College during the year 2018.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **COUNCIL AND COMMITTEE REMUNERATION FOR 2018**

Date of Meeting: November 30, 2017

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. 117:

By-law No. 117

Paragraphs 20(3)(a)(i),(ii), and (iii) of By-Law No. 2 (the Fees and Remuneration By-Law) are revoked and the following are substituted, effective January 1, 2018:

Council and Committee Remuneration

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

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

(i) $633 per half day for the president,

(ii) $522 per half day for the vice-president, and

(iii) $486 per half day for the other members, and

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **2018 ANNUAL FEE**

Date of Meeting: **November 30, 2017**

It is moved by_____,

and seconded by_____, that:

the Council of the College of Physicians and Surgeons of Ontario proposes to make the following By-law No. 116, after circulation to stakeholders:

By-law No. 116

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

Annual Fees

4. Annual fees for the year beginning June 1, 2018, are as follows:

   (a) $1725 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration; and

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: **2018 Governance Committee Election**

Date of Meeting: December 1, 2017

It is moved by_____,

and seconded by_____, that:

The Council appoints _____ (as physician member),

_____(as public member),

_____(as public member),

to the Governance Committee for 2017-18.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Appointment of Vice Chair of the Methadone Specialty Panel of the Quality Assurance Committee

Date of Meeting: December 1, 2017

It is moved by_____,

and seconded by_____, that:

The Council appoints Dr. Meredith MacKenzie as Vice Chair of the Methadone Specialty Panel of the Quality Assurance Committee for 2017-18.

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: 2017-2018 Committee Nominations

Date of Meeting: December 1, 2017

It is moved by_____,

and seconded by_____, that:

The Council appoints the following people to the following committees:

Council Award Selection Committee:

Dr. Steven Bodley
Ms. Lynne Cram
Dr. Joel Kirsh
Dr. Carol Leet
Dr. David Rouselle

Discipline Committee:

Dr. Ida Ackerman
Dr. Philip Berger
Dr. Vinita Bindlish
Dr. Carole Clapperton
Dr. Pamela Chart
Dr. Paul Casola
Dr. Melinda Davie
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Mr. Pierre Giroux
Dr. Kristen Hallett

Dr. Deborah Hellyer
Dr. Paul Hendry
Major Abdul Khalifa
Dr. William L. M. King
Mr. John Langs
Dr. Barbara Lent
Dr. Bill McCready
Ms. Ellen Mary Mills
Dr. Veronica Mohr
Dr. Tracey Moriarity
Dr. Joanne Nicholson
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Dr. John Rapin
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Harvey Schipper
Dr. Robert Sheppard
Dr. Fay Sliwin
Ms. Gerry Sparrow
Dr. Eric Stanton
Dr. Peter Tadros
Dr. Andrew Turner
Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Scott Wooder
Dr. Sheila-Mae Young
Dr. Paul Ziter

Education Committee:

Dr. Mary Bell
Dr. Brenda Copps
Dr. Paul Hendry
Dr. Barbara Lent
Dr. Akbar Panju
Ms. Joan Powell
Dr. Suzan Schneeweiss
Dr. Robert Smith
Dr. Janet Van Vlymen

Finance Committee:

Dr. Thomas Bertoia
Dr. Steven Bodley
Mr. Pierre Giroux
Mr. Harry Erlichman
Mr. Peter Pielsticker
Dr. Peeter Poldre
Dr. Jerry Rosenblum

Fitness to Practise Committee:

Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. William L. M. King
Dr. Barbara Lent
Dr. Bill McCready
Dr. Tracey Moriarity
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. John Watts
Dr. Paul Ziter

Governance Committee:

Dr. Steven Bodley
Dr. Peeter Poldre
Dr. David Rouselle
Physician member of Council
Public member of Council
Public member of Council

Inquiries, Complaints and Reports Committee:

Dr. George Arnold
Dr. Haig Basmajian
Dr. Mary Bell
Dr. Harvey Blankenstein
Dr. Brian Burke
Dr. Bob Byrick
Dr. Angela Carol
Dr. Anil Chopra
Ms. Lynne Cram
Dr. Nazim Damji
Dr. Naveen Dayal
Dr. William Dunlop
Dr. James Edwards
Mr. Harry Erlichman
Ms. Joan Fisk
Dr. Rob Gratton
Dr. Daniel Greben
Dr. Andrew Hamilton
Dr. Christine Harrison
Dr. Keith Hay
Dr. Elaine Herer
Dr. Robert Hollenberg
Dr. Nasimul Huq

Dr. Francis Jarrett
Dr. John Jeffrey
Dr. Carol Leet
Dr. Edith Linkenheil
Dr. Haidar Mahmoud
Dr. Jack Mandel
Dr. Edward Margolin
Dr. Bill McCauley
Dr. Robert McMurtry
Dr. Patrick McNamara
Dr. Dale Mercer
Ms. Judy Mintz
Dr. Lawrence Oppenheimer
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Peter Prendergast
Dr. Anita Rachlis
Dr. Jerry Rosenblum
Dr. Nathan Roth
Dr. David Rouselle
Dr. Ken Shulman
Dr. Wayne Spotswood
Dr. Michael Szul
Mr. Emile Therien
Dr. Lynne Thurling
Dr. Donald Wasylenki
Dr. Stephen White
Dr. Stephen Whittaker
Dr. Lesley Wiesenfeld
Dr. Jim Wilson

Outreach Committee:

Dr. Steven Bodley
Ms. Lynne Cram
Mr. Pierre Giroux
Dr. Deborah Hellyer
Mr. John Langs
Dr. Peeter Poldre
Dr. Jerry Rosenblum
Dr. David Rouselle
Ms. Gerry Sparrow

Patient Relations Committee:

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

Premises Inspection Committee:

Dr. Bob Byrick
Dr. Wayne Carman
Dr. John Davidson
Dr. Bill Dixon
Dr. Marjorie Dixon
Dr. Pawan Kumar
Ms. Ellen Mary Mills
Dr. Gillian Oliver
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Jerry Rosenblum
Dr. Andrew Turner
Dr. James Watson

Quality Assurance Committee:

Dr. Lisa Bromley
Dr. Brenda Copps
Dr. Jacques Dostaler
Dr. Miriam Ghali Eskander
Dr. Michael Franklyn
Ms. Debbie Giampietri
Dr. Trevor Gillmore
Mr. Pierre Giroux
Dr. Natasha Graham
Dr. Deborah Hellyer
Dr. Hugh Kendall
Mr. John Langs
Dr. Barbara Lent
Dr. Meredith MacKenzie
Dr. Bill McCready
Mr. Peter Pielsticker
Dr. Deborah Robertson
Dr. Patrick Safieh
Dr. Bernard Seguin
Dr. Robert Smith
Dr. Leslie Solomon
Dr. Tina Tao
Dr. Smiley Tsao
Dr. Janet Van Vlymen
Dr. James Watters

Registration Committee:

Dr. Bob Byrick
Mr. Harry Erlichman
Dr. John Jeffrey
Dr. Barbara Lent
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Jay Rosenfield

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: 2017-2018 Committee Nominations

Date of Meeting: December 1, 2017

It is moved by_____,

and seconded by_____, that:

The Council appoints the following people to the following committees:

Council Award Selection Committee:

Dr. Steven Bodley
Ms. Lynne Cram
Dr. Joel Kirsh
Dr. Carol Leet
Dr. David Rouselle

Discipline Committee:

Dr. Ida Ackerman
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Dr. Vinita Bindlish
Dr. Carole Clapperton
Dr. Pamela Chart
Dr. Paul Casola
Dr. Melinda Davie
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Mr. Pierre Giroux

Dr. Kristen Hallett
Dr. Deborah Hellyer
Dr. Paul Hendry
Major Abdul Khalifa
Dr. William L. M. King
Mr. John Langs
Dr. Barbara Lent
Dr. Bill McCready
Ms. Ellen Mary Mills
Dr. Veronica Mohr
Dr. Tracey Moriarity
Dr. Joanne Nicholson
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Peeter Poldre
Dr. John Rapin
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Harvey Schipper
Dr. Robert Sheppard
Dr. Fay Sliwin
Ms. Gerry Sparrow
Dr. Eric Stanton
Dr. Peter Tadros
Dr. Andrew Turner
Dr. David Walker
Dr. James Watters
Dr. John Watts
Dr. Scott Wooder
Dr. Sheila-Mae Young
Dr. Paul Ziter

Education Committee:

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Dr. Brenda Copps
Dr. Paul Hendry
Dr. Barbara Lent
Dr. Akbar Panju
Ms. Joan Powell
Dr. Suzan Schneeweiss
Dr. Robert Smith
Dr. Janet Van Vlymen

Finance Committee:

Dr. Thomas Bertoia
Dr. Steven Bodley
Mr. Pierre Giroux
Mr. Harry Erlichman
Mr. Peter Pielsticker
Dr. Peeter Poldre
Dr. Jerry Rosenblum

Fitness to Practise Committee:

Dr. Pamela Chart
Dr. Carole Clapperton
Dr. Melinda Davie
Dr. Marc Gabel
Dr. Paul Garfinkel
Ms. Debbie Giampietri
Dr. Deborah Hellyer
Major Abdul Khalifa
Dr. William L. M. King
Dr. Barbara Lent
Dr. Bill McCready
Dr. Tracey Moriarity
Dr. Dennis Pitt
Dr. Robert Sheppard
Dr. Eric Stanton
Dr. John Watts
Dr. Paul Ziter

Governance Committee:

Dr. Steven Bodley
Dr. Peeter Poldre
Dr. David Rouselle
Physician member of Council
Public member of Council
Public member of Council

Inquiries, Complaints and Reports Committee:

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Dr. Haig Basmajian
Dr. Mary Bell
Dr. Harvey Blankenstein
Dr. Brian Burke
Dr. Bob Byrick
Dr. Angela Carol
Dr. Anil Chopra
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Dr. Naveen Dayal
Dr. William Dunlop
Dr. James Edwards
Mr. Harry Erlichman
Dr. Thomas Faulds
Ms. Joan Fisk
Dr. Rob Gratton
Dr. Daniel Greben
Dr. Andrew Hamilton
Dr. Christine Harrison
Dr. Keith Hay

Dr. Elaine Herer
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Dr. Nasimul Huq
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Dr. John Jeffrey
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Dr. Edith Linkenheil
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Dr. Jack Mandel
Dr. Edward Margolin
Dr. Bill McCauley
Dr. Robert McMurtry
Dr. Patrick McNamara
Dr. Dale Mercer
Ms. Judy Mintz
Dr. Lawrence Oppenheimer
Dr. Akbar Panju
Dr. Judith Plante
Ms. Joan Powell
Dr. Peter Prendergast
Dr. Anita Rachlis
Dr. Jerry Rosenblum
Dr. Nathan Roth
Dr. David Rouselle
Dr. Ken Shulman
Dr. Wayne Spotswood
Dr. Michael Szul
Mr. Emile Therien
Dr. Lynne Thurling
Dr. Donald Wasylenki
Dr. Stephen White
Dr. Stephen Whittaker
Dr. Lesley Wiesenfeld
Dr. Jim Wilson

Methadone Committee:

Dr. Lisa Bromley
Dr. Michael Franklyn
Dr. Trevor Gillmore
Dr. Barbara Lent
Dr. Meredith MacKenzie

Outreach Committee:

Dr. Steven Bodley
Ms. Lynne Cram
Mr. Pierre Giroux
Dr. Deborah Hellyer
Mr. John Langs
Dr. Peeter Poldre
Dr. Jerry Rosenblum
Dr. David Rouselle
Ms. Gerry Sparrow

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

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Dr. Dennis Pitt
Dr. Jerry Rosenblum
Dr. Andrew Turner
Dr. James Watson

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Dr. Michael Franklyn
Ms. Debbie Giampietri
Dr. Trevor Gillmore
Mr. Pierre Giroux
Dr. Natasha Graham
Dr. Deborah Hellyer
Dr. Hugh Kendall
Mr. John Langs
Dr. Barbara Lent
Dr. Meredith MacKenzie
Dr. Bill McCready
Mr. Peter Pielsticker
Dr. Deborah Robertson

Dr. Patrick Safieh
Dr. Bernard Seguin
Dr. Robert Smith
Dr. Leslie Solomon
Dr. Tina Tao
Dr. Smiley Tsao
Dr. Janet Van Vlymen
Dr. James Watters

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

Council Motion

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Motion Title: Appointment of Chair of 2017-2018 Methadone Committee

Date of Meeting: December 1, 2017

It is moved by_____,

and seconded by_____, that:

The Council appoints Dr. Meredith MacKenzie as Chair of the Methadone Committee for 2017-18.